American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

COUNCIL MEETING

October 23-24, 2021

Westin Boston Seaport District Hotel and Boston Convention & Exhibitions Center (BCEC)
Boston, MA

acep Scientific Assembly BOSTON 21

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:

- 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.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

POLICY STATEMENT

Conflict of Interest

Approved January 2017

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

Reaffirmed by the ACEP Board of Directors October 2001

Revised by the ACEP Board of Directors September 1997

Approved by the ACEP Board of Directors January 1996

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

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

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

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

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

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

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

A. General

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

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

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

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

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

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

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

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

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

B. Disclosure Form

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

C. Additional Rules of Conduct

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

a. The individual;

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

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

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

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

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

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

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

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,

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.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2021 Council Meeting

October 23-24, 2021
Pre-Meeting Events Occur Friday Evening, October 22, 2021 at Westin Boston Seaport District
Boston Convention & Exhibitions Center, Ballroom (Level 3)
Boston, MA

TIMED AGENDA

Saturday, October 23, 2021

Coffee, water soft drinks available – Ballroom (BCEC, Level 3) ***7:30 am***

1.	Call to Order A. Meeting Dedication B. Pledge of Allegiance C. National Anthem	Dr. Katz	8:00 am
2.	Introductions	Dr. Katz	8:10 am
3.	Welcome from MA Chapter President	Dr. Kerrigan	8:12 am
4.	Tellers, Credentials, & Election Committee A. Credentials Report B. Meeting Etiquette	Dr. Kraus	8:14 am
5.	Changes to the Agenda	Dr. Katz	8:16 am
6.	Council Meeting Website	Mr. Joy	8:16 am
7.	EMF Challenge	Dr. Wilcox	8:21 am
8.	NEMPAC Challenge	Dr. Jacoby	8:23 am
9.	Review and Acceptance of Minutes A. Council Meeting – October 24-25, 2020	Dr. Katz	8:25 am
10.	Approval of Steering Committee Actions A. Steering Committee Meeting – January 26, 2021 B. Steering Committee Meeting – April 26, 2021	Dr. Katz	
11.	Call for and Presentation of Emergency Resolutions	Dr. Katz	
12.	Steering Committee's Report on Late Resolutions A. Reference Committee Assignments of Allowed Late Resolutions B. Disallowed Late Resolutions	Dr. Katz	8:30 am
13.	Nominating Committee Report A. Speaker 1. Slate of Candidates 2. Call for Floor Nominations B. Vice Speaker 1. Slate of Candidates 2. Call for Floor Nominations C. President-Elect 1. Slate of Candidates 2. Call for Floor Nominations D. Board of Directors 1. Slate of Candidates 2. Call for Floor Nominations	Dr. Katz	8:35 am

Saturday, October 23, 2021 (*Continued*)

14. Candidate Opening Statements	Dr. Katz	
A Speaker Candidates (2 minutes each)		8:40 am
B. Vice Speaker Candidates (2 minutes each)		8:42 am
C. President-Elect Candidates (5 minutes each)		8:47 am
D. Board of Directors Candidates (2 minutes each)		9:00 am
15. Reference Committee Assignments	Dr. Katz	9:20 am
BREAK		***9:20 am – 9:30 am***
16. Reference Committee Hearings –		9:30 am – 12:30 pm
A – Governance & Membership – *204 A-B (BCEC, Level 2)*		
B – Advocacy & Public Policy – *205 A-C (BCEC, Level 2)*		
C – Emergency Medicine Practice – *206 A-B (BCEC, Level 2)*		
D – Scope of Practice & Workforce – *210 A-C (BCEC, Level 2)*		
Boxed Lunches Available – Northwest Prefunction Area (BCEC, Level 2)		***11:00 am – 12:30 pm***
17. Reference Committee Executive Sessions		12:30 pm – 2:30 pm
A – *204 A-B (BCEC, Level 2)*		
B – *205 A-C (BCEC, Level 2)*		
C – *206 A-B (BCEC, Level 2)*		
D – *210 A-C (BCEC, Level 2)*		
BREAK – Return to main Council meeting room – Ballroom (BCEC, Level 3)		***12:30 pm – 12:45 pm***
18. Town Hall Meeting – *Ballroom (BCEC, Level 3)*	Dr. Katz	12:45 pm – 1:45 pm
A. ACEP's Strategic Plan	Ms. Sedory/Dr. Rosenberg/Dr. Schmitz	
19. Candidate Forum for the President-Elect Candidates – *Ballroom (BCEC, Level 3)*		2:00 pm – 2:30 pm
BREAK – Return to Reference Committee meeting rooms		***2:30 pm – 2:45 pm***
20. Candidate Forum for Board of Directors Candidates – *204 A-B, 205 A-C, 206 A-B, 210 A-C*		2:45 pm – 4:30 pm
Candidates rotate through Reference Committee meeting rooms.		
BREAK – Return to main Council meeting room – Ballroom (BCEC, Level 3)		***4:30 pm – 4:45 pm***
21. Speaker's Report	Dr. Katz	4:45 pm
22. In Memoriam	Dr. Katz	5:00 pm
A. Reading and Presentation of Memorial Resolutions	Dr. Gray-Eurom	5:00 pm
Adopt by observing a moment of silence.		
23. ABEM Report	Dr. ___	5:10 pm
24. AOBEM Report	Dr. ___	5:15 pm
25. Secretary-Treasurer's Report	Dr. Terry	5:20 pm
26. EMRA Report	Dr. Sontag	5:25 pm
27. EMF Report	Dr. Wilcox	5:30 pm
28. NEMPAC Report	Dr. Jacoby	5:35 pm
29. President's Address	Dr. Rosenberg	5:40 pm
RECESS		***6:00 pm***

Candidate Reception ● 6:15 pm – 7:15 pm ● *Marina Ballroom I (Westin, Lobby Level)*

Sunday, October 24, 2021

Keypad Distribution – Ballroom Foyer (BCEC, Level 3)		***7:00 am***
Coffee, water, soft drinks available – Ballroom Foyer (BCEC, Level 3)		***7:30 am***
1. Call to Order	Dr. Katz	8:00 am
2. Tellers, Credentials, & Elections Committee Report	Dr. Kraus	8:00 am
3. Electronic Voting A. Keypad Testing/Demographic Data Collection	Dr. Kraus	8:05 am
4. Executive Directors Report	Ms. Sedory	8:30 am
5. Video – How to Submit Amendments Electronically		8:55 am
6. Reference Committee Reports A. Reference Committee ___ B. Reference Committee ___		9:00 am
Boxed Lunches Available – Ballroom Foyer (BCEC, Level 3)		
7. Awards Luncheon – ***Ballroom (BCEC, Level 3)***		*12:00 pm*
A. Welcome	Dr. Katz	12:45 pm
1. Recognition of Past Speakers and Past Presidents		
2. Recognition of Chapter Executives		
B. ACEP Awards Announcements	Dr. Rosenberg	12:55 pm
C. Reading and Presentation of Commendation Resolutions	Dr. Katz/Dr. Gray-Eurom	
D. Council Award Presentations	Dr. Katz/Dr. Gray-Eurom	
1. Council Service Milestone Awards – *5, 10, 15, 20, 25, 30, 35+ Year Councillors*		
2. Council Teamwork Award		
3. Council Horizon Award		
4. Council Champion in Diversity & Inclusion Award		
5. Council Curmudgeon Award		
6. Council Meritorious Service Award		
8. Luncheon Adjourns		***1:30 pm***
9. Reference Committee Reports Continue C. Reference Committee ___ D. Reference Committee ___		1:45 pm
10. President-Elect's Address	Dr. Schmitz	4:45 pm
11. Installation of President	Dr. Rosenberg/Dr. Schmitz	5:05 pm
12. Elections A. Speaker B. Vice Speaker C. Board of Directors D. President-Elect	Dr. Kraus	5:10 pm
13. Announcements	Dr. Katz	5:40 pm
ADJOURN		***5:45 pm***

2021 Council Meeting

Table of Contents

2021 Council Steering Committee

Updated April 2021

Gary R. Katz, MD, MBA, FACEP
Speaker

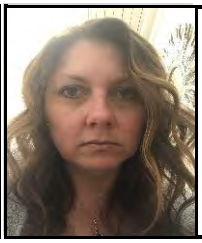
Dublin, OH

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

Jacksonville, FL

Eileen F. Baker, MD, PhD, FACEP

Bowling Green, OH



Lisa M. Bundy, MD, FACEP

Tupelo, MS

Angela P. Cornelius, MD, FACEP

Burleson, TX

Carrie de Moor, MD, FACEP

Frisco, TX

Hilary E. Fairbrother, MD, FACEP

Houston, TX

William D. Falco, MD, MS, FACEP

Libertyville, IL

Steven B. Kailes, MD, FACEP

Orange Park, FL

Rami R. Khoury, MD, FACEP

Northville, MI

Kurtis A. Mayz, JD, MD, FACEP

Champaign, IL

Kristin McCabe-Kline, MD, FACEP

Palm Coast, FL

Christina Millhouse, MD, FACEP

Simpsonville, SC

James B. Mullen, MD, FACEP

Freeport, ME

Randy L. Pilgrim, MD, FACEP

Lafayette, LA

Michael Ruzek, DO, FACEP

Westfield, NJ

Larisa May Traill, MD, FACEP

Commerce Township, MI

Tracy Marko, MD, PhD, MS
(EMRA REP to Steering Committee)

Eagan, MN

Procedures for Councillor and Alternate Seating

Councillor Credentialing

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Voting Cards and Electronic Keypads

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

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

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

Seating Exchange Between Credentialed Councillors and Alternates

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

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

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

2021 Councillor Seating Chart

SECRETARY	PARLIAMENTARIAN	SPEAKER	VICE SPEAKER

PROJECTION STAFF

446 Councillors + 31 past leaders = 477 seats

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

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

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

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

Past presidents, past Council speakers, and past Chairs of the Board are invited to sit with their delegation on the Council floor (see seating chart). The 2021 councillor seating chart includes the following:

California	35 councillors + 5 past leaders attending not serving as councillors = 40 seats
Colorado	7 councillors + 2 past leader attending not serving as a councillor =9 seats
Connecticut	5 councillors + 2 past leader attending not serving as a councillors = 7 seats
Florida	23 councillors + 2 past leader attending not serving as a councillors = 25 seats
Georgia	9 councillors + 1 past leader attending not serving as a councillors = 10 seats
Government Services	12 councillors + 1 past leaders attending not serving as councillor = 13 seats
Louisiana	5 councillors + 1 past leader attending not serving as councillor = 6 seats
Maryland	7 councillors + 1 past leader attending not serving as councillor = 8 seats
Michigan	21 councillors + 1 past leaders attending not serving as councillors = 22 seats
New Jersey	10 councillors +1 past leader attending and not serving as councilor = 11 seats
New Mexico	3 councillors + 1 past leader attending and not serving as councillor = 4 seats
New York	31 councillors + 1 past leader attending not serving as a councillor = 32 seats
North Carolina	11 councillors + 1 past leaders attending not serving as councillors = 12 seats
Ohio	16 councillors + 4 past leaders attending not serving as councillors = 20 seats
Texas	22 councillors + 3 past leaders attending not serving as a councillor = 25 seats
Virginia	10 councillors + 1 past leader not serving as a councillor = 11 seats
Washington	9 councillors + 2 past leaders attending not serving as a councillor = 11 seats
West Virginia	3 councillors + 1 past leader attending not serving as a councillor = 4 seats

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2021 COUNCILLORS & ALTERNATE COUNCILLORS

Chapter/Section	Position	Name
ALABAMA CHAPTER	Councillor	Melissa Wysong Costello, MD, FACEP
	Councillor	Muhammad N Husainy, DO, FACEP
	Councillor	Bobby R Lewis, MD, DMD, FACEP
	Councillor	Annalise Sorrentino, MD, FACEP
	Alternate	Stephen William Knight, MD, FACEP
	Alternate	Sean Vanlandingham, MD, FACEP
ARIZONA CHAPTER	Councillor	Patricia A Bayless, MD, FACEP
	Councillor	Bradley A Dreifuss, MD, FACEP
	Councillor	Nicole R Hodgson, MD, FACEP
	Councillor	Paul Andrew Kozak, MD, FACEP
	Councillor	Wendy Ann Lucid, MD, FACEP
	Councillor	Steven Maher, MD, FACEP
	Councillor	Rebecca B Parker, MD, FACEP
	Councillor	Todd Brian Taylor, MD, FACEP
	Councillor	Dale P Woolridge, MD, PhD, FACEP
ARKANSAS CHAPTER	Councillor	J Shane Hardin, MD, PhD, FACEP
	Councillor	Brian L Hohertz, MD, FACEP
	Councillor	Robert Thomas VanHook, MD, FACEP
ASSOCIATION OF ACADEMIC CHAIRS OF EMERGENCY MEDICINE	Councillor	Theodore A Christopher, MD, FACEP
CALIFORNIA CHAPTER	Councillor	Zahir I Basrai, MD
	Councillor	Patsy Chenpanas, MD
	Councillor	Carrieann E Drenten, MD, FACEP
	Councillor	Irv E Edwards, MD, FACEP
	Councillor	Andrew N Fenton, MD, FACEP
	Councillor	Jorge A Fernandez, MD, FACEP
	Councillor	William E Franklin, DO, FACEP
	Councillor	Marc Allan Futernick, MD, FACEP
	Councillor	Michael Gertz, MD, FACEP
	Councillor	Douglas Everett Gibson, MD, FACEP
	Councillor	Vikant Gulati, MD, FACEP
	Councillor	Puneet Gupta, MD, FACEP
	Councillor	Omar Guzman, MD, FACEP
	Councillor	Roneet Lev, MD, FACEP
	Councillor	Jon Keith Ludwig, MD, FACEP
	Councillor	Aimee K Moulin, MD, FACEP
	Councillor	Taylor S Nichols, MD
	Councillor	Valerie C Norton, MD, FACEP
	Councillor	Bing S Pao, MD, FACEP
	Councillor	Hunter M Pattison, MD
	Councillor	Vikram Raj, DO
	Councillor	Vivian Reyes, MD, FACEP
	Councillor	Rebecca Ruiz, MD
	Councillor	Alex Schmalz, MD

2021 COUNCILLORS & ALTERNATE COUNCILLORS

	Councillor	Peter Erik Sokolove, MD, FACEP
	Councillor	Susanne J Spano, FACEP, FACEP
	Councillor	Melanie T Stanzer, DO, FACEP
	Councillor	Lawrence M Stock, MD, FACEP
	Councillor	Thomas Jerome Sugarman, MD, FACEP
	Councillor	Gary William Tamkin, MD, FACEP
	Councillor	David Terca, MD
	Councillor	Patrick Um, MD, FACEP
	Councillor	Andrea M Wagner, MD, FACEP
	Councillor	Lori D Winston, MD, FACEP
	Councillor	Randall J Young, MD, FACEP
	Alternate	Harrison Alter, MD, FACEP
	Alternate	Rodney W Borger, MD, FACEP
	Alternate	Fred Dennis, MD, MBA, FACEP
	Alternate	Andrea M Brault Fuelling, MD, FACEP
	Alternate	Ramon W Johnson, MD, FACEP
	Alternate	Nicolas Sawyer, MD, MBA, FACEP
	Alternate	Anna L Webster, MD, FACEP
	Alternate	Babak Yekta, MD
	Alternate	Bradley Alan Zlotnick, MD, FACEP
COLORADO CHAPTER	Councillor	Jasmeet Singh Dhaliwal, MD, MPH, MBA
	Councillor	Ramnik S Dhaliwal, MD, JD
	Councillor	Anna Engeln, MD, FACEP
	Councillor	Rachelle M Klammer, MD, FACEP
	Councillor	Rebecca L Kornas, MD, FACEP
	Councillor	Carla Elizabeth Murphy, DO, FACEP
	Councillor	Allison Marie Trop, MD, FACEP
	Alternate	Alexis Garza, MD
	Alternate	Douglas M Hill, DO, FACEP
	Alternate	Matthew E Mendes
	Alternate	Neal P O'Connor, MD, FACEP
CONNECTICUT CHAPTER	Councillor	Thomas A Brunell, MD, FACEP
	Councillor	Daniel Freess, MD, FACEP
	Councillor	Elizabeth Schiller, MD, FACEP
	Councillor	Gregory L Shangold, MD, FACEP
	Councillor	David E Wilcox, MD, FACEP
DELAWARE CHAPTER	Councillor	Emily M Granitto, MD, FACEP
	Councillor	Kathryn Groner, MD, FACEP
	Alternate	John T Powell, MD, MHCDS, FACEP
DISTRICT OF COLUMBIA CHAPTER	Councillor	James M Gaylor, MD
	Councillor	James D Maloy, MD
	Councillor	Rita A Manfredi-Shutler, MD, FACEP
EMERGENCY MEDICINE RESIDENTS' ASSOCIATION	Councillor	Angela Cai, MD, MBA

2021 COUNCILLORS & ALTERNATE COUNCILLORS

	Councillor	Nicholas Paul Cozzi, MD
	Councillor	Hannah R Hughes, MD, MBA
	Councillor	Tracy Marko
	Councillor	Maggie Moran, MD
	Councillor	George RJ Sontag, MD
	Councillor	Sophia Spadafore, MD
	Councillor	Ashley Tarchione, MD
	Alternate	Michaela Skylar Banks, MD
	Alternate	Christopher Counts, MD
	Alternate	Breanne M Jaqua, DO, MPH
	Alternate	Deena Khamees, MD
	Alternate	Priyanka Lauber
	Alternate	Yevgeniy Maksimenko, MD
	Alternate	Nicholas R Salerno, MD
	Alternate	Miya A Smith, MD
FLORIDA CHAPTER	Councillor	Andrew I Bern, MD, FACEP
	Councillor	Damian E Caraballo, MD, FACEP
	Councillor	Jordan GR Celeste, MD, FACEP
	Councillor	Andrzej T Dmowski, MD, FACEP
	Councillor	Vidor E Friedman, MD, FACEP
	Councillor	Eliot Goldner, MD, FACEP
	Councillor	Shayne M Gue, MD, FACEP
	Councillor	Omar Hammad, MD, FACEP
	Councillor	Steven B Kailes, MD, FACEP
	Councillor	Mike Lozano, Jr, MD, MSHI, FACEP
	Councillor	Kristin McCabe-Kline, MD, FACEP
	Councillor	Ryan T McKenna, DO, FACEP
	Councillor	Ashley Norse, MD, FACEP
	Councillor	David J Orban, MD, FACEP
	Councillor	Sanjay Pattani, MD, FACEP
	Councillor	Martin Johann Pontasch, MD, FACEP
	Councillor	Danyelle Redden, MD
	Councillor	Todd L Slesinger, MD, FACEP
	Councillor	John Caleist Soud, DO, FACEP
	Councillor	Stephen C Viel, MD, MBA, FACEP
	Councillor	L Kendall Webb, MD, FACEP
	Councillor	Cristina Zeretzke, MD, FACEP
	Councillor	Christian C Zuver, MD, FACEP
	Alternate	Gary W Gillette, MD, FACEP
	Alternate	Amy S Kelley, MD, FACEP
	Alternate	Tracy G Sanson, MD, FACEP
	Alternate	David Charles Seaberg, MD, CPE, FACEP
GEORGIA CHAPTER	Councillor	Matthew R Astin, MD, FACEP
	Councillor	Brett H Cannon, MD, FACEP
	Councillor	James Joseph Dugal, MD(E), FACEP(E)
	Councillor	Matthew Taylor Keadey, MD, FACEP
	Councillor	Jeffrey F Linzer, Sr, MD, FACEP

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2021 COUNCILLORS & ALTERNATE COUNCILLORS

	Councillor	DW "Chip" Pettigrew, III, MD, FACEP
	Councillor	James L Smith, Jr, MD, FACEP
	Councillor	Johnny L Sy, DO, FACEP
	Councillor	Matthew J Watson, MD, FACEP
	Alternate	Talitha A Ashby, MD
	Alternate	Shamie Das, MD, FACEP
	Alternate	Mark A Griffiths, MD, FACEP
	Alternate	Brendan Hawthorn, MD, FACEP
	Alternate	Benjamin Lefkove, MD, FACEP
	Alternate	Matthew Lyon, MD, FACEP
	Alternate	Matthew Rudy, MD, FACEP
	Alternate	Carmen D. Sulton, MD, FACEP
	Alternate	Michelle P Wan, MD
	Alternate	John L Wood, MD, FACEP
	Alternate	Dawn Angela Louise Zellner, MD
GOVT SERVICES CHAPTER	Councillor	Andrea Austin, MD, FACEP
	Councillor	Gerald Delk, MD, FACEP
	Councillor	Amy Follmer Hildreth, MD, FACEP
	Councillor	John Knight, MD
	Councillor	Grace Landers, MD
	Councillor	Maximilian S Lee, MD, FACEP
	Councillor	David S McClellan, MD, FACEP
	Councillor	Torree M McGowan, MD, FACEP
	Councillor	Paul James Diggins Roszko, MD, FACEP
	Councillor	Justine K Stremick, MD
	Councillor	Sean Stuart, DO
	Councillor	Laura Tilley, MD, FACEP
	Alternate	Manuel Amando Celedon, MD
	Alternate	William D Goldenberg, MD, FACEP
	Alternate	Alan Jeffrey Hirshberg, MD, MPH, FACEP
HAWAII CHAPTER	Councillor	Daniel Cheng, MD
IDAHO CHAPTER	Councillor	Nathan R Andrew, MD, FACEP
	Councillor	Ken John Gramyk, MD, FACEP
	Alternate	Heather S Hammerstedt, MD, FACEP
	Alternate	Travis Aaron Newby, DO, FACEP
ILLINOIS CHAPTER	Councillor	Amit D Arwindekar, MD, FACEP
	Councillor	Christine Babcock, MD, FACEP
	Councillor	Shu Boung Chan, MD, FACEP
	Councillor	Cai Glushak, MD, FACEP
	Councillor	John W Hafner, MD, FACEP
	Councillor	Jason A Kegg, MD, FACEP
	Councillor	Napoleon B Knight, Jr, MD, FACEP
	Councillor	Janet Lin, MD, FACEP
	Councillor	Kurtis A Mayz, JD, MD, MBA, FACEP
	Councillor	Christopher M McDowell, MD, FACEP

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2021 COUNCILLORS & ALTERNATE COUNCILLORS

	Councillor	Howard K Mell, MD, MPH, CPE, FACEP
	Councillor	Henry Pitzele, MD, FACEP
	Councillor	Yanina Purim-Shem-Tov, MD, FACEP
	Councillor	Ernest Enjen Wang, MD, FACEP
	Alternate	Halleh Akbarnia, MD, FACEP
	Alternate	E Bradshaw Bunney, MD
	Alternate	Benjamin A Feinzimer, DO, FACEP
	Alternate	Scott A Heinrich, MD, FACEP
	Alternate	George Z Hevesy, MD, FACEP
	Alternate	Adnan Hussain, MD, FACEP
	Alternate	John N Moustoukas, MD, FACEP
	Alternate	Laura D Napier, MD, FACEP
	Alternate	Regina Royan Stamm, MD
	Alternate	Willard W Sharp, MD, FACEP
	Alternate	Deborah E Weber, MD, FACEP
INDIANA CHAPTER	Councillor	Michael D Bishop, MD, FACEP(E)
	Councillor	Timothy A Burrell, MD, MBA, FACEP
	Councillor	Daniel W Elliott, MD, FACEP
	Councillor	Tyler G Johnson, DO, FACEP
	Councillor	Lauren Stanley, MD, FACEP
	Councillor	Lindsay Zimmerman, MD, FACEP
	Alternate	Sara Ann Brown, MD, FACEP
	Alternate	Emily M Fitz, MD, FACEP
	Alternate	Nicholas George Sansone, DO, FACEP
IOWA CHAPTER	Councillor	Ryan M Dowden, MD, FACEP
	Councillor	Nicholas Holden Kluesner, MD, FACEP
	Councillor	Rachael Sokol, DO, FACEP
	Alternate	Thomas E Benzoni, DO, FACEP
	Alternate	Jacqueline E Kitchen, MD
KANSAS CHAPTER	Councillor	Howard Chang, MD, FACEP
	Councillor	John M Gallagher, MD, FACEP
	Councillor	John F McMaster, MD, FACEP
	Councillor	Jeffrey G Norvell, MD, MBA, RDMS, FACEP
KENTUCKY CHAPTER	Councillor	David Wesley Brewer, MD, FACEP
	Councillor	Christopher W Pergrem, MD, FACEP
	Councillor	Melissa Platt, MD, FACEP
	Councillor	Hugh W Shoff, MD, FACEP
	Alternate	Steven Joseph Stack, MD, MBA, FACEP
LOUISIANA CHAPTER	Councillor	James B Aiken, MD, FACEP
	Councillor	Deborah D Fletcher, MD, FACEP
	Councillor	Phillip Luke LeBas, MD, FACEP
	Councillor	Randy L Pilgrim, MD, FACEP
	Councillor	Michael D Smith, MD MBA CPE, FACEP
	Alternate	Julius (Jay) A Kaplan, MD, FACEP

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2021 COUNCILLORS & ALTERNATE COUNCILLORS

MAINE CHAPTER	Councillor	Thomas C Dancoes, DO, FACEP
	Councillor	Garreth C Debiegun, MD, FACEP
	Councillor	Charles F Pattavina, MD, FACEP
	Alternate	Timothy Arthur Coury, MD, PhD
	Alternate	Nathan G Donaldson, DO, FACEP
	Alternate	Andrew Ehrhard, MD
	Alternate	Brandon E Giberson, DO
	Alternate	James B Mullen, III, MD, FACEP
	Alternate	Laurel Parker, MD, FACEP
MARYLAND CHAPTER	Councillor	Michael C Bond, MD, FACEP
	Councillor	Arjun S Chanmugam, MD, FACEP
	Councillor	Timothy P Chizmar, MD, FACEP
	Councillor	Kyle Fischer, MD, MPH, FACEP
	Councillor	Kerry Forrestal, MD, FACEP
	Councillor	Jonathan Lewis Hansen, MD, FACEP
	Councillor	Edana Denise Mann, MD, FACEP
	Alternate	Sydney E DeAngelis, MD, FACEP
	Alternate	Michael P Murphy, MD, FACEP
MASSACHUSETTS CHAPTER	Councillor	Brien Alfred Barnewolt, MD, FACEP
	Councillor	Stephen K Epstein, MD, MPP, FACEP
	Councillor	Laura Janneck, MD, FACEP
	Councillor	Kathleen Kerrigan, MD, FACEP
	Councillor	Matthew B Mostofi, DO, FACEP
	Councillor	Mark D Pearlmutter, MD, FACEP
	Councillor	Jesse Rideout, MD, FACEP
	Councillor	Brian Sutton, MD, FACEP
	Councillor	Joseph C Tennyson, MD, FACEP
	Councillor	Scott G Weiner, MD, FACEP
	Alternate	Kathleen Cara Coan, MD
	Alternate	Farah Dadabhoy, MD
	Alternate	Joseph William Kopp, MD
	Alternate	Ira R Nemeth, MD, FACEP
	Alternate	Heikki E Nikkanen, MD, FACEP
MICHIGAN CHAPTER	Councillor	Michael J Baker, MD, FACEP
	Councillor	Sara S Chakel, MD, FACEP
	Councillor	Nicholas Dyc, MD, FACEP
	Councillor	Gregory Gafni-Pappas, DO, FACEP
	Councillor	Michael Vincent Gratson, MD, FACEP
	Councillor	Rami R Khoury, MD, FACEP
	Councillor	Warren F Lanphear, MD, FACEP
	Councillor	Robert T Malinowski, MD, FACEP
	Councillor	Therese G Mead, DO, FACEP
	Councillor	Emily M Mills, MD, FACEP
	Councillor	James C Mitchiner, MD, MPH, FACEP
	Councillor	Diana Nordlund, DO, JD, FACEP

2021 COUNCILLORS & ALTERNATE COUNCILLORS

	Councillor	David T Overton, MD, FACEP
	Councillor	Paul R Pomeroy, Jr, MD, FACEP
	Councillor	Luke Christopher Saski, MD, FACEP
	Councillor	Jennifer B Stevenson, DO, FACEP
	Councillor	Larisa May Traill, MD, FACEP
	Councillor	Bradley J Uren, MD, FACEP
	Councillor	Gregory Link Walker, MD, FACEP
	Councillor	Bradford L Walters, MD, FACEP
	Councillor	Mildred J Willy, MD, FACEP
	Alternate	Kathleen Cowling, DO, MS, MBA, FACEP
	Alternate	Antony P Hsu, MD, FACEP
	Alternate	Zachary Joseph Jarou, MD, MBA
	Alternate	Sean Michael Mohon, DO
	Alternate	Gee Yoon Suzie Park, DO
	Alternate	Jacob Sinkoff, DO
	Alternate	Andrew Taylor, DO, FACEP
	Alternate	James Michael Ziadeh, MD, FACEP
MINNESOTA CHAPTER	Councillor	Paul C Allegra, MD, FACEP
	Councillor	Heather Ann Heaton, MD, FACEP
	Councillor	Timothy James Johnson, MD, FACEP
	Councillor	Donald L Lum, MD, FACEP
	Councillor	David Nestler, MD, MS, FACEP
	Councillor	Lisa M Roazen, MD, FACEP
	Councillor	Thomas E Wyatt, MD, FACEP
	Councillor	Andrew R Zinkel, MD, MBA, FACEP
MISSISSIPPI CHAPTER	Councillor	Fred E Kency, Jr, MD
	Councillor	Chester Duane Shermer, MD, FACEP
	Councillor	Sherry D Turner, DO
	Alternate	James Wilkinson, DO
MISSOURI CHAPTER	Councillor	Douglas Mark Char, MD, FACEP
	Councillor	Jonathan Heidt, MD, MHA, FACEP
	Councillor	Louis D Jamtgaard, MD, FACEP
	Councillor	Kevin A Journagan, MD, FACEP
	Councillor	Marc Mendelsohn, MD, MPH, FACEP
	Councillor	Robert Francis Poirier, Jr, MD, MBA, FACEP
	Councillor	Evan Schwarz, MD, FACEP
	Alternate	Sabina A Braithwaite, MD, FACEP
	Alternate	Dennis E Hughes, DO, FACEP
	Alternate	Christopher S Sampson, MD, FACEP
MONTANA CHAPTER	Councillor	Harry Eugene Sibold, MD, FACEP
NEBRASKA CHAPTER	Councillor	Renee Engler, MD, FACEP
	Councillor	Benjamin L Fago, MD, FACEP
	Alternate	Jason G Langenfeld, MD, FACEP

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2021 COUNCILLORS & ALTERNATE COUNCILLORS

NEVADA CHAPTER	Councillor	John Dietrich Anderson, MD, FACEP
	Councillor	Bret Frey, MD, FACEP
	Councillor	Gregory Alan Juhl, MD, FACEP
	Councillor	Brian M Trimmer, MD, FACEP
	Alternate	Ian Joseph Isby, MD
NEW JERSEY CHAPTER	Councillor	Victor M Almeida, DO, FACEP
	Councillor	Jenice Baker, MD, FACEP
	Councillor	Rachelle Ann Greenman, MD, FACEP
	Councillor	Patrick Blaine Hinfey, MD, FACEP
	Councillor	Steven M Hochman, MD, FACEP
	Councillor	Marjory E Langer, MD, FACEP
	Councillor	Jessica M Maye, DO, FACEP
	Councillor	J Mark Meredith, MD, FACEP
	Councillor	Amy Ondeyka, MD, FACEP
	Councillor	Michael Ruzek, DO, FACEP
	Alternate	Shivani Adhyaru, DO
	Alternate	Navin Ariyaprakai, MD, EMT-P, FAEMS, FACEP
	Alternate	Joseph J Calabro, DO, FACEP
	Alternate	Gregory Scott Corcoran, MD
	Alternate	Barnet Eskin, MD, FACEP
	Alternate	William Basil Felegi, DO, FACEP
	Alternate	Marianna Karounos, DO, MS, FACEP
	Alternate	Dennis Lucas McGill, DO, FACEP
	Alternate	Carol Pak-Teng, DO
	Alternate	Svetlana Zakharchenko, DO, FACEP
NEW MEXICO CHAPTER	Councillor	David A Cheever, MD
	Councillor	Tatsuya Norii, MD, FACEP
	Councillor	Tony B Salazar, MD, FACEP
NEW YORK CHAPTER	Councillor	Brahim Ardolic, MD, FACEP
	Councillor	Joseph Basile, MD, FACEP
	Councillor	Nicole Berwald, MD, FACEP
	Councillor	Kirby Black, MD, FACEP
	Councillor	Erik Blutinger, MD, MSc
	Councillor	Robert M Bramante, MD, FACEP
	Councillor	Jay Miller Brenner, MD, FACEP
	Councillor	Bernard P Chang, MD, PhD, FACEP
	Councillor	Brandon Joseph Chavez, DO
	Councillor	Joshua R Codding, MD
	Councillor	Lauren J Curato, DO, FACEP
	Councillor	Mark Curato, DO, FACEP
	Councillor	Mathew Foley, MD, FACEP
	Councillor	Keith Grams, MD, FACEP
	Councillor	Sanjey Gupta, DO, FACEP
	Councillor	Abbas Husain, MD, FACEP
	Councillor	Marc P Kanter, MD, FACEP
	Councillor	Stuart Gary Kessler, MD, FACEP

2021 COUNCILLORS & ALTERNATE COUNCILLORS

	Councillor	Daniel Lakoff, MD, FACEP
	Councillor	Penelope Chun Lema, MD, FACEP
	Councillor	Laura D Melville, MD
	Councillor	Joshua B Moskovitz, MD, MBA, MPH, FACEP
	Councillor	Nestor B Nestor, MD, FACEP
	Councillor	William F Paolo, MD, FACEP
	Councillor	Louise A Prince, MD, FACEP
	Councillor	Jeffrey S Rabrich, DO, FACEP
	Councillor	Livia M Santiago-Rosado, MD, FACEP
	Councillor	Sarah E Secor-Jones, DO, FACEP
	Councillor	Virgil W Smaltz, MD, FACEP
	Councillor	Asa Viccellio, FACEP, FACEP
	Councillor	Luis Carlos Zapata, MD, FACEP
	Alternate	David O Andonian, MD
	Alternate	Kurien Mathews, DO
	Alternate	Mary E McLean, MD
	Alternate	David L Ng, DO, FACEP
	Alternate	James Gerard Ryan, MD, FACEP
	Alternate	Gururaj Shan, MD
	Alternate	Joseph A Zito, MD, FACEP
NORTH CAROLINA CHAPTER	Councillor	Thomas N Bernard, III, MD
	Councillor	Scott W Brown, MD, FACEP
	Councillor	Gregory J Cannon, MD, FACEP
	Councillor	Jennifer Casaletto, MD, FACEP
	Councillor	Thomas Lee Mason, MD, FACEP
	Councillor	Eric E Maur, MD, FACEP
	Councillor	Abhishek Mehrotra, MD, MBA, FACEP
	Councillor	Bret Nicks, MD, MHA, FACEP
	Councillor	Sankalp Puri, MD, FACEP
	Councillor	Sean S Ray, MD, FACEP
	Councillor	Stephen A Small, MD, FACEP
NORTH DAKOTA CHAPTER	Councillor	K J Temple, MD, FACEP
	Alternate	Leah Gustafson Ista, MD
OHIO CHAPTER	Councillor	Eileen F Baker, MD, PhD, FACEP
	Councillor	Dan Charles Breece, DO, FACEP
	Councillor	Christina Campana, DO, FACEP
	Councillor	B Bryan Graham, DO, FACEP
	Councillor	Purva Grover, MD, FACEP
	Councillor	Erika Charlotte Kube, MD, FACEP
	Councillor	Thomas W Lukens, MD, PhD, FACEP
	Councillor	Catherine Anna Marco, MD, FACEP
	Councillor	Daniel R Martin, MD, MBA, FACEP
	Councillor	Michael McCrea, MD, FACEP
	Councillor	Ashley Diana McMellen, MD
	Councillor	John R Queen, MD, FACEP
	Councillor	Matthew J Sanders, DO, FACEP

2021 COUNCILLORS & ALTERNATE COUNCILLORS

	Councillor	Imran Shaikh, MD, FACEP
	Councillor	Ryan Squier, MD, FACEP
	Councillor	Nicole Ann Veitinger, DO, FACEP
	Alternate	Andrew Aten, MD
	Alternate	Laura Michelle Espy-Bell, MD, FACEP
	Alternate	Tyler Hill, DO, FACEP
	Alternate	Ryan Marino, MD, FACEP
	Alternate	Jordan Miller, DO
	Alternate	Richard N Nelson, MD, FACEP
	Alternate	Crystal Williams Nock, MD
	Alternate	Bradley D Raetzke, MD, FACEP
	Alternate	Dacia Russell Goman, MD
	Alternate	Joseph P Tagliaferro, III, DO, FACEP
OKLAHOMA CHAPTER	Councillor	Cecilia Guthrie, MD, FACEP
	Councillor	Jeffrey Johnson, MD, FACEP
	Councillor	Chad A Phillips, MD
	Councillor	Carolyn Kay Synovitz, MD, MPH, FACEP
	Alternate	James Raymond Kennedye, MD, FACEP
	Alternate	W Craig Sanford, Jr, MD, FACEP
OREGON CHAPTER	Councillor	Samuel H Kim, MD, FACEP
	Councillor	John C Moorhead, MD, FACEP
	Councillor	Chris F Richards, MD, FACEP
	Councillor	Christian Smith, MD
	Councillor	Christopher Strear, MD, FACEP
PENNSYLVANIA CHAPTER	Councillor	Blake C Bailey, DO, FACEP
	Councillor	Monisha Bindra, DO, MPH, FACEP
	Councillor	Karen M Custodio, DO
	Councillor	Eleanor Dunham, MD, FACEP
	Councillor	Clairisse Hafey, DO
	Councillor	Ronald V Hall, MD, FACEP
	Councillor	Richard Hamilton, MD, FACEP
	Councillor	F Richard Heath, MD, FACEP
	Councillor	Annahieta Kalantari, DO, FACEP
	Councillor	Erik Ian Kochert, MD, FACEP
	Councillor	Chadd K Kraus, DO, DrPH, CPE, FACEP
	Councillor	Michael J Lynch, MD
	Councillor	Hannah M Mishkin, MD, FACEP
	Councillor	Dhimitri Nikolla, DO
	Councillor	Shawn M Quinn, DO, FACEP
	Councillor	Jennifer L Savino, DO, FACEP
	Councillor	Robert J Strony, DO, FACEP
	Councillor	Theresa Ann Walls, MD, MPH
	Councillor	Elizabeth Barrall Werley, MD, FACEP
	Alternate	Nil Akgul, DO
	Alternate	Dana R Bacharach, DO
	Alternate	Andrew J Bleinberger, MD

2021 COUNCILLORS & ALTERNATE COUNCILLORS

	Alternate	Merle Andrea Carter, MD, FACEP
	Alternate	Dave Delnegro, MD
	Alternate	Ankur A Doshi, MD, FACEP
	Alternate	Jessica Duell, MD
	Alternate	Todd Fijewski, MD, FACEP
	Alternate	Maria Koenig Guyette, MD, MPPM, FACEP
	Alternate	John Alexander Hafycz, Jr, MD
	Alternate	Marilyn Joan Heine, MD, FACEP
	Alternate	Damian C Lai
	Alternate	Jodi Arthur Mao, MD
	Alternate	Patrick McGuire, MD
	Alternate	Danielle Nesbit, DO
	Alternate	Thomas Douglas Sallade, DO
	Alternate	Loren Touma, DO
	Alternate	Michael A Turturro, MD, FACEP
	Alternate	Melissa A Yu, MD
PUERTO RICO CHAPTER	Councillor	Angelisse M Almodovar Bernier, MD
	Councillor	Edwin J Garcia La Torre, MD, FACEP
	Alternate	Alexandra Ubilla, MD, FACEP
RHODE ISLAND CHAPTER	Councillor	Nadine T Himelfarb, MD, FACEP
	Councillor	Achyut B Kamat, MD, FACEP
	Councillor	Jessica Smith, MD, FACEP
	Alternate	Michael Stephen Siclari, MD, FACEP
	Alternate	Christopher P Zabbo, DO, FACEP
SOCIETY OF ACADEMIC EMERGENCY MEDICINE	Councillor	Kathleen J Clem, MD, FACEP
SOUTH CAROLINA CHAPTER	Councillor	Matthew D Bitner, MD, FACEP
	Councillor	Allison Leigh Harvey, MD, FACEP
	Councillor	Kelly M Johnson, MD , FACEP
	Councillor	Christina Millhouse, MD, FACEP
	Councillor	Angel Lee Rochester, MD, FACEP
	Councillor	Stewart Oliver Sanford, MD
	Alternate	Stephen A D Grant, MD, FACEP
SOUTH DAKOTA CHAPTER	Councillor	Donald Neilson, MD
	Alternate	Nathan W Long, MD, FACEP
TENNESSEE CHAPTER	Councillor	Kenneth L Holbert, MD, FACEP
	Councillor	Thomas R Mitchell, MD, FACEP
	Councillor	Matthew Neal, MD
	Councillor	John H Proctor, MD, MBA, FACEP
	Councillor	Sullivan K Smith, MD, FACEP
	Alternate	Sanford H Herman, MD, FACEP
	Alternate	Sudave D Mendiratta, MD, FACEP
TEXAS CHAPTER	Councillor	Sara Andrabi, MD

2021 COUNCILLORS & ALTERNATE COUNCILLORS

	Councillor	Carrie de Moor, 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	Heidi C Knowles, MD, FACEP
	Councillor	Jason A Lesnick, MD
	Councillor	Laura N Medford-Davis, MD, FACEP
	Councillor	Sterling Evan Overstreet, MD, FACEP
	Councillor	Heather S Owen, MD, FACEP
	Councillor	Anant Patel, DO, FACEP
	Councillor	Daniel Eugene Peckenpaugh, MD, FACEP
	Councillor	R Lynn Rea, MD, FACEP
	Councillor	Richard Dean Robinson, MD, FACEP
	Councillor	Marcus Lynn Sims, II, DO, FACEP
	Councillor	Theresa Tran, MD, FACEP
	Councillor	Gerad A Troutman, MD, FACEP
	Councillor	James M Williams, DO, FACEP
	Councillor	Sandra Williams, DO, MPH, FACEP
	Alternate	Jessica Ann Best, MD
	Alternate	Angela Pettit Cornelius, MD, FACEP
	Alternate	Mark P Dresselhouse, MD
	Alternate	Bryan M Dunn, MD, FACEP
	Alternate	Justin B Evans, MD
	Alternate	Hilary E Fairbrother, MD, FACEP
	Alternate	Angela F Gardner, MD, FACEP
	Alternate	Edward Kuo, MD
	Alternate	Erin W Lincoln, MD
	Alternate	Craig Meek, MD, FACEP
	Alternate	Colten Jacob Philpott, MD
	Alternate	Angela Siler Fisher, MD, FACEP
	Alternate	Phillip L Singer, DO, MBA, FACEP
	Alternate	Jessica Tolbert, MD
	Alternate	Brianna L Wapples, MD
UTAH CHAPTER	Councillor	Jim V Antinori, MD, FACEP
	Councillor	Stephen Carl Hartsell, MD, FACEP
	Councillor	David Brent Mabey, MD
	Councillor	Alison L Smith, MD, MPH, FACEP
	Alternate	Jordan Mabey, MD
	Alternate	Henry T Yeates, DO, FACEP
VERMONT CHAPTER	Councillor	Alexandra Nicole Thran, MD, FACEP
VIRGINIA CHAPTER	Councillor	Trisha Danielle Anest, MD, MPH, FACEP
	Councillor	Caroline Hollis Cox, MD
	Councillor	Kenneth Hickey, MD, FACEP

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2021 COUNCILLORS & ALTERNATE COUNCILLORS

	Councillor	Sarah Klemencic, MD, FACEP
	Councillor	Joseph Mason, MD, FACEP
	Councillor	Cameron K Olderog, MD, FACEP
	Councillor	Todd Parker, MD, FACEP
	Councillor	Joran Sequeira, MD, FACEP
	Councillor	Robert Solberg, MD
	Councillor	Jesse Duane Spangler, MD
	Alternate	Jason A Bavarian, DO
	Alternate	Matthew E Bisgaier
	Alternate	Benjamin Blackwood, MD
	Alternate	Darwin T Castillo, MD, MBA, FACEP
	Alternate	James R Humble, MD
	Alternate	Bruce M Lo, MD, MBA, RDMS, FACEP
	Alternate	Aubrey B Miner, MD
	Alternate	Jessica Nguyen, MD
	Alternate	Scott Sparks, MD, FACEP
	Alternate	Theodore I Tzavaras, MD
WASHINGTON CHAPTER	Councillor	Roderick W Beaver, MD
	Councillor	Herbert C Duber, MD, MPH, FACEP
	Councillor	Carlton E Heine, MD, PhD, FACEP
	Councillor	Elizabeth A McMurtry, FACEP, FACEP
	Councillor	Gregg A Miller, MD, FACEP
	Councillor	Karolyn K Moody, DO, MPH, FACEP
	Councillor	Nathaniel R Schlicher, MD, JD, MBA, FACEP
	Councillor	Susan Amy Stern, MD
	Councillor	Jessica J Wall, MD
WEST VIRGINIA CHAPTER	Councillor	Adam Thomas Crawford, DO, FACEP
	Councillor	David Benjamin Deuell, DO, FACEP
	Councillor	Christopher S Goode, MD, FACEP
	Alternate	Frederick C Blum, MD, FACEP
WISCONSIN CHAPTER	Councillor	Bradley Burmeister, MD
	Councillor	Jeffrey J Pothof, MD, FACEP
	Councillor	Michael Dean Repplinger, MD, PhD, FACEP
	Councillor	Jamie Schneider, MD
	Councillor	Brian Sharp, MD, FACEP
	Councillor	Christopher Torkilsen
	Alternate	William D Falco, MD, MS, FACEP
	Alternate	Lisa J Maurer, MD, FACEP
WYOMING CHAPTER	Councillor	Carol Lea Wright Becker, MD, FACEP
	Alternate	Stephen Pecevich, MD
AIR MEDICAL TRANSPORT SECTION	Councillor	Samuel J Slimmer, MD, FACEP
	Alternate	Henderson D McGinnis, MD, FACEP

2021 COUNCILLORS & ALTERNATE COUNCILLORS

AMERICAN ASSOCIATION OF WOMEN EMERGENCY PHYSICIANS SECTION	Councillor	Elizabeth Dubey, MD, FACEP
	Alternate	Peta-Gay S Nolan, MD
CAREERS IN EMERGENCY MEDICINE SECTION	Councillor	Constance J Doyle, MD, FACEP
	Alternate	Sanford H Herman, MD, FACEP
CRITICAL CARE MEDICINE SECTION	Councillor	Nicholas M Mohr, MD, FACEP
	Alternate	Susan R Wilcox, MD, FACEP
DEMOCRATIC GROUP PRACTICE SECTION	Councillor	David Hall, MD, FACEP
	Alternate	James B Mullen, III, MD, FACEP
DISASTER MEDICINE SECTION	Councillor	Justin W Fairless, DO, NRP, FAEMS, FACEP
	Alternate	Samantha Noll, MD, FACEP
DIVERSITY & INCLUSION SECTION	Councillor	Ugo A Ezenkwele, MD, FACEP
	Alternate	Adetolu Olufunmilayo Odufuye, MD, FACEP
DUAL TRAINING SECTION	Councillor	Vinay Mikkilineni, MD
	Alternate	Carissa J Tyo, MD, FACEP
EMERGENCY MEDICAL INFORMATICS SECTION	Councillor	Zachary Joseph Jarou, MD, MBA
	Alternate	Mark Baker, MD, FACEP
EMERGENCY MEDICAL SERVICES-PREHOSPITAL CARE SECTION	Councillor	Michael O'Brien, MD, FACEP
EMERGENCY MEDICINE LOCUM TENENS SECTION	Councillor	Pamela Andrea Ross, MD, FACEP
	Alternate	John R Dayton, MD, FACEP
EMERGENCY MEDICINE PRACTICE MANAGEMENT AND HEALTH POLICY SECTION	Councillor	Robert M McNamara, MD
	Alternate	Richard Lee Austin, Jr, MD, FACEP
EMERGENCY MEDICINE WORKFORCE SECTION	Councillor	Leslie Mukau, MD, FACEP
	Alternate	Thomas Belanger, MD
EMERGENCY TELEHEALTH SECTION	Councillor	David C Ernst, MD, FACEP
	Alternate	Deborah A Mulligan, MD, FACEP
EMERGENCY ULTRASOUND SECTION	Councillor	Kenton L Anderson, MD, FACEP
	Alternate	Jeremy Boyd, MD, FACEP

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2021 COUNCILLORS & ALTERNATE COUNCILLORS

EVENT MEDICINE SECTION	Councillor	Paul E Pepe, MD, FAEMS, FACEP
	Alternate	Melissa D Kohn, MD, FACEP
FORENSIC MEDICINE SECTION	Councillor	Monika Pitzele, MD, FACEP
	Alternate	Jessica Elizabeth Hobbs, DO, FACEP
FREESTANDING EMEGENCY CENTERS	Councillor	Lonnie R Schwirtlich, MD, FACEP
	Alternate	Harvey Castro, MD, FACEP
GERIATRIC EMERGENCY MEDICINE SECTION	Councillor	Shan W Liu, MD, FACEP
	Alternate	Phillip David Magidson, MD, FACEP
INTERNATIONAL EMERGENCY MEDICINE SECTION	Councillor	Jesica Valeria Bravo Gutierrez, MD
	Alternate	Shama Patel, MD
MEDICAL DIRECTORS SECTION	Councillor	C Ryan Keay, MD, FACEP
	Alternate	Thomas F Spiegel, MD, MBA, MS, FACEP
MEDICAL HUMANITIES SECTION	Councillor	Zayir Malik, MD
	Alternate	Robert C Solomon, MD, FACEP
OBSERVATION SERVICES SECTION	Councillor	Alexei Wagner, MD
	Alternate	Adam J Rodos, MD, FACEP
PAIN MANAGEMENT SECTION	Councillor	Eric Michael Ketcham, MD, MBA, FASAM, FACHE, FAAEM, FACEP
	Alternate	Alexis M LaPietra, DO, FACEP
PALLIATIVE MEDICINE SECTION	Councillor	David Wang, MD
	Alternate	Rebecca R Goett, MD, FACEP
PEDIATRIC EMERGENCY MEDICINE SECTION	Councillor	Eric R Schmitt, MD, MPH, FACEP
	Alternate	Jason T Lowe, DO
QUALITY IMPROVEMENT AND PATIENT SAFETY SECTION	Councillor	Robert Sands Redwood, MD, MPH, FACEP
	Alternate	William Colwell Dalsey, MD, FACEP
RESEARCH, SCHOLARLY ACTIVITY, AND INNOVATION SECTION	Councillor	Richard Gentry Wilkerson, MD, FACEP
	Alternate	Justin B Belsky, MD MPH
RURAL EMERGENCY MEDICINE SECTION	Councillor	Stephen John Jameson, MD, FACEP
SOCIAL EMERGENCY MEDICINE SECTION	Councillor	Laura Janneck, MD, FACEP
	Alternate	Katherine A Dowdell, MD

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2021 COUNCILLORS & ALTERNATE COUNCILLORS

SPORTS MEDICINE SECTION	Councillor	Calvin E Hwang, MD, FACEP
	Alternate	Dustin M Harris, MD
TACTICAL EMERGENCY MEDICINE SECTION	Councillor	Amado Alejandro Baez, MD, MSc, MPH, PhD, FACEP
	Alternate	Ameen Mohammad Jamali, MD, FACEP
	Alternate	David Q McArdle, MD, FACEP
TOXICOLOGY SECTION	Councillor	Jennifer Hannum, MD, FACEP
	Alternate	Jason B Hack, MD, FACEP
	Alternate	Eric J Lavonas, MD, FACEP
TRAUMA & INJURY PREVENTION SECTION	Councillor	Gregory Luke Larkin, MD, FACEP
	Alternate	Mark Robert Sochor, MD, FACEP
UNDERSEA & HYPERBARIC MEDICINE SECTION	Councillor	Stephen Hendriksen, MD, FACEP
	Alternate	Robert W Sanders, MD, FACEP
WELLNESS SECTION	Councillor	Karolyn K Moody, DO, MPH, FACEP
	Alternate	Susan T Haney, MD, FACEP
	Alternate	Julia Marie Huber, MD, FACEP
	Alternate	Wendy Christine Laine, MD
	Alternate	Kristen Nordenholz, MD, FACEP
	Alternate	Rosanna D Sikora, MD, FACEP
WILDERNESS MEDICINE SECTION	Councillor	Brendan Harry Milliner, MD
	Alternate	Justin P Hensley, MD, FACEP
YOUNG PHYSICIANS SECTION	Councillor	Nnenna Cynthia Ejesieme, DO
	Alternate	Scott H Pasichow, MD, MPH

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

TEMPORARY 2020 VIRTUAL COUNCIL MEETING STANDING RULES

Due to emergency declarations, Stay at Home Orders, and the impossibility of holding an in-person 2020 Council meeting, the following Rules governing the virtual 2020 Council meeting are recommended for adoption, upon advice of ACEP's General Counsel and Parliamentarian:

Rule 1. The Council meeting shall be conducted using the LUMI platform.

Rule 2. Participation during the Council meeting shall be limited to councillors, alternate councillors, members of the Board of Directors, past presidents, past speakers, past chairs of the Board, ACEP members, and authorized ACEP staff or guests.

Rule 3. Reference Committee hearings shall be held virtually in succession and limited to one hour each. Reference Committees shall include within their consideration asynchronous comments made prior to the virtual hearing on the ACEP platform.

Rule 4. Following any Reference Committee hearing, the Reference Committee may propose amendments to resolutions and Bylaws proposals and shall determine resolutions to be placed on a consent agenda. Any councillor may remove an item from the consent agenda using the LUMI platform.

Rule 5. During Council debate on any matter, anyone wishing to speak shall use the recognition feature of the LUMI platform and shall be recognized in order.

Rule 6. Upon recognition by the Council speaker, anyone wishing to speak shall identify themselves by stating their name, affiliation, and whether they are speaking "for" or "against" the motion.

Rule 7. No individual shall speak more than once on the same item, nor longer than one (1) minute.

Rule 8. No seconds to motions shall be necessary, and there shall be no amendments to resolutions or Bylaws proposals from the floor.

Rule 9. Total debate time allotted for each Bylaws amendment or resolution shall be ten (10) minutes. If there are speakers in the queue when the debate time expires, a vote shall be taken on whether to extend debate for an additional five (5) minutes.

Rule 10. Each candidate for president-elect shall be given an opportunity to speak for five (5) minutes. Each candidate for the Board of Directors shall be given the opportunity to speak for two (2) minutes. Candidate speeches may be live or prerecorded.

Rule 11. Except as expressly provided in these Temporary Rules, all other Council Standing Rules shall remain in effect.

American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

Councillor Handbook

Councillor Handbook

Table of Contents

I. COMPOSITION OF THE COUNCIL

Introduction

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

What is the Council?

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

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

What Does the Council Do?

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

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

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

II. COUNCILLOR PREPARATION

How Does a Councillor Prepare for the Annual Meeting?

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

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

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

How Does the Council Conduct its Business?

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

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

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

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

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

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

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

What is a Resolution?

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

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

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

Amendments to Resolutions

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

Late Resolutions

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

Emergency Resolutions

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

What if I Have Questions About the Council?

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

How are Nominations and Elections Conducted?

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

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

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

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

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

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

What is the Steering Committee?

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

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

2021 Council Steering Committee

Gary R. Katz, MD, MBA, FACEP, Chair
Kelly Gray-Eurom, MD, MM, FACEP, Vice Chair
Eileen F. Baker, MD, PhD, FACEP (OH)
Lisa M. Bundy, MD, FACEP (AL)
Angela P. Cornelius, MD, FACEP (LA)
Carrie de Moor, MD, FACEP (TX)
Hilary E. Fairbrother, MD, FACEP (TX)
William D. Falco, MD, FACEP (WI)
Steven B. Kailes, MD, FACEP (FL)
Rami Khoury, MD, FACEP (MI)
Kurtis Mayz, MD, JD, MBA, FACEP (IL)
Kristin McCabe-Kline, MD, FACEP (FL)
Christina Millhouse, MD, FACEP (SC))
Jay Mullen, MD, FACEP (ME)
Randy Pilgrim, MD, FACEP (LA)
Michael Ruzek, DO, FACEP (NJ)
Larisa M. Traill, MD, FACEP (MI)

III. COUNCIL REFERENCE COMMITTEES

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

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

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

Asynchronous Testimony

Resolutions that have been submitted by the deadline and assigned to a Reference Committee will be available for asynchronous testimony on the ACEP website by September 23, 2021. Asynchronous testimony is open to all members of the College and will close at 12:00 noon on Thursday, October 14, 2021. 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.

Procedures

The preliminary Reference Committee reports will be the starting point for the Reference Committee hearings on October 23, 2021. This is the opportunity to inform the Reference Committee of changes to their preliminary recommendations that would make the proposed language more palatable or to correct a misunderstanding published in the preliminary report's testimony section when such a correction may change the opinion of the Reference Committee or your peers.

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

The Reference Committee hearings will be held concurrently and are scheduled from 9:30-12:30 on Saturday, October 23, 2021. Reference Committees may take brief breaks if the chair determines that time is available. The Reference Committee chair is requested to designate a member of the committee to keep track of all pro and con comments pertaining to each resolution.

Proceedings

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

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

If an individual arrives to present testimony before or after the time the resolution was scheduled for discussion, it is at the discretion of the chair as to when that member may speak to the resolution. When presenting testimony, the individual should state their name, component body, and whether speaking in

support of or against the resolution. No one should speak more than once on a resolution unless it is to clarify a point. Prior to closing debate, the chair will ask Board members, officers, staff, and others with particular expertise for their testimony.

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

Reports

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

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

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

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

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

Examples of our common variants employing the procedure are:

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

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

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

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

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

Summary of Council Actions on Reference Committee Reports

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

Definition of Council Action

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

ADOPT
Approve resolution as recommendation implemented through the Board of Directors

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

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

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

V. PRINCIPLE RULES GOVERNING MOTIONS

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

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

VI. INCIDENTAL MOTIONS

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

* Per the Council Standing Rules.

VII. GUIDELINES FOR WRITING ACEP COUNCIL RESOLUTIONS

Definition

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

Submission and Deadline

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

All resolutions should be submitted to:

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

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

Bylaws and regular resolutions are due 90 days before the annual Council meeting. The 2021 Council meeting will be held on Saturday, October 23 and Sunday, October 24, 2021. Therefore, the deadline for resolutions for the 2021 Council meeting is July 27, 2021.

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

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

Questions

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

Format

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

Whereas Statements

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

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

Resolved Statements

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

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

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

Bylaws Amendments

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

General Resolutions

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

Council Actions on Resolutions

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

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

Board Actions on Resolutions

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

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

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

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

Sample Resolutions

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

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

RESOLUTION 9(06)

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

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

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

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

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

ARTICLE XI – COMMITTEES
Section 2 – Executive Committee

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

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

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

RESOLUTION 23(06)

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

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

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

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

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

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

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

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

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

RESOLUTION 16(99)

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

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

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

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

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

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

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

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

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

VIII.

ACEP Parliamentary Motions Guide

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

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

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

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

[1] As modified by the ACEP Council Standing Rules

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

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

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

(36) **Amend a previous action**	I move to amend the motion that was …	No	Yes	Yes	Yes	Varies
(38) Reconsider motion	I move to **reconsider** ...	Yes	Yes	Yes	No	Majority
(42) Cancel previous action	I move to **rescind**...	No	Yes	Yes	No	Majority
(44) Take from table	I move to **resume consideration** of ...	No	Yes	No	No	Majority

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

Council Standing Rules

Revised October 2020

Council Standing Rules

Revised October 2020

Preamble

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

Alternate Councillors

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

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

Amendments to Council Standing Rules

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

Announcements

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

Appeals of Decisions from the Chair

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

Board of Directors Seating

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

Campaign Rules

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

Conflict of Interest Disclosure

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

Councillor Allocation for Sections of Membership

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

Councillor Seating

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

Credentialing and Proper Identification

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

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

Debate

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

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

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

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

Distribution of Printed or Other Material During the Annual Meeting

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

Election Procedures

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

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

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

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

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

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

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

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

Electronic Devices

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

Leadership Development Advisory Committee

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

Limiting Debate

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

Nominating Committee

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

Nominations

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

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

Parliamentary Procedure

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

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

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

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

Policy Review

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

Reference Committees

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

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

A Reference Committee may recommend that a resolution:

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

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

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

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

Reports

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

Resolutions

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

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

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

Background information, including financial analysis, will be prepared by staff on all resolutions, 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, except for Bylaws resolutions, shall be placed on a Unanimous Consent Agenda.

The Unanimous Consent Agenda will be listed at the beginning of the Reference Committee report along with the committee's recommendation for adoption, referral, amendment, substitution, or not for adoption for each resolution listed. A request for extraction of any resolution from the Unanimous Consent Agenda by any credentialed councillor is in order at the beginning of the Reference Committee report. Thereafter, the remaining items on the Unanimous

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

Voting Immediately

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

Voting on Resolutions and Motions

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

BYLAWS

Revised January 2021

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Bylaws

Table of Contents

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

BYLAWS

Revised January 2021

ARTICLE I — NAME

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

ARTICLE II — MISSION, PURPOSES, AND OBJECTIVES

Section 1 — Mission

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

Section 2 — Purposes and Objectives

The purposes and objectives of the College are:

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

ARTICLE III — COLLEGE MEETINGS

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

ARTICLE IV — MEMBERSHIP

Section 1 — Eligibility

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

Section 2 — Classes of Membership

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

Section 2.1 — Regular Members

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

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

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

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

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

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

Section 2.2 — Honorary Members

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

Section 2.3 — Candidate Members

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

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

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

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

Section 2.4 — International Members

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

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

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

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

Section 3 — Agreement

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

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

Section 4 — Disciplinary Action

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

Section 5 — Dues, Fees, and Assessments

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

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

Section 6 — Official Publications

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

ARTICLE V — ACEP FELLOWS

Section 1 — Eligibility

Fellows of the College shall meet the following criteria:

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

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

Section 2 — Fellow Status

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

ARTICLE VI — CHAPTERS

Section 1 — Charters

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

Section 2 — Chapter Bylaws

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

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

Section 3 — Qualifications

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

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

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

Section 4 — Component Branches

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

Section 5 — Charter Suspension – Revocation

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

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

Section 6 — Ultimate Authority by College

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

ARTICLE VII — SECTIONS

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

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

ARTICLE VIII — COUNCIL

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

Section 1 — Composition of the Council

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

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

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

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

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

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

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

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

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

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

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

Section 2 — Powers of the Council

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

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

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

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

Section 3 — Meetings

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

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

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

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

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

Section 4 — Quorum

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

Section 5 — Voting Rights

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

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

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

Section 6 — Resolutions

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

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

Section 7 — Nominating Committee

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

Section 8 — Board of Directors Action on Resolutions

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

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

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

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

ARTICLE IX — BOARD OF DIRECTORS

Section 1 — Authority

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

Section 2 — Composition and Election

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

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

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

Section 3 — Meetings

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

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

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

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

Section 4 — Removal

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

Section 5 — Vacancy

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

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

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

ARTICLE X — OFFICERS/EXECUTIVE DIRECTOR

Section 1 – Officers

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

Section 2 — Election of Officers

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

Section 3 — Removal

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

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

Section 4 — Vacancy

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

Section 4.1 — President

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

Section 4.2 — President-Elect

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

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

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

Section 4.4 — Council Officers

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

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

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

Section 4.5 — Vacancy by Removal of a Board Officer

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

Section 4.6 — Vacancy by Removal of a Council Officer

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

Section 5 — President

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

Section 6 — Chair

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

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

Section 7 — Vice President

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

Section 8 — President-Elect

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

Section 9 — Secretary-Treasurer

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

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

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

Section 10 — Immediate Past President

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

Section 11 — Speaker

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

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

Section 12 — Vice Speaker

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

Section 13 — Executive Director

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

Section 14 — Assistant Secretary-Treasurer

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

ARTICLE XI — COMMITTEES

Section 1 — General Committees

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

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

Section 2 — Executive Committee

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

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

Section 3 — Steering Committee

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

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

Section 4 — Bylaws Interpretation Committee

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

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

Section 5 — Finance Committee

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

Section 6 — Bylaws Committee

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

Section 7 — Compensation Committee

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

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

ARTICLE XII — ETHICS

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

ARTICLE XIII — AMENDMENTS

Section 1 — Submission

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

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

Section 2 — Notice

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

Section 3 — Amendment Under Initial Consideration

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

Section 4 — Contested Amendment

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

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

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

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

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

ARTICLE XIV — MISCELLANEOUS

Section 1 — Inspection of Records

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

Section 2 — Annual Report

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

Section 3 — Parliamentary Authority

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

Section 4 — College Manual

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

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

ARTICLE XV — MANDATORY INDEMNIFICATION

Section 1 — Policy of Indemnification and Advancement of Expenses

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

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

Section 2 — Definitions

For purposes of this Article XV:

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

Section 3 — Non-Exclusive; Continuation

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

Section 4 — Insurance or Other Arrangement

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

Section 5 — Exclusion of Certain Acts from Indemnification

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

COLLEGE MANUAL

Revised October 2020

College Manual

Table of Contents

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.

COLLEGE MANUAL

Revised October 2020

College Manual

Table of Contents

College Manual

Revised October 2020

I. Applications for Membership

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

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

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

A. Definitions

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

B. Complaint Received

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

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

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

C. Executive Director

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

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

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

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

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

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

F. Right of Respondent to Request a Hearing

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

G. Hearing Procedures

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

H. Notice to the Board of Directors

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

I. Possible Disciplinary Action and Disclosure to ACEP Members

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

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

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

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

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

2. Scope and Manner of Disclosure

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

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

J. Ground Rules

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

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

III. Chartering Chapters

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

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

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

IV. Charter Suspension-Revocation

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

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

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

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

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

V. Filling Board Vacancies Created by Other Than Removal

General Provisions

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

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

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

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

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

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

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

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

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

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

meet, the following criteria:

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

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

VII. Amendments

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

Council Meeting
October 24-25, 2020
Virtual Meeting

Minutes

The 49th annual meeting of the Council of the American College of Emergency Physicians was called to order at 10:08 am Central time on Saturday, October 24, 2020, by Speaker Gary R. Katz, MD, MBA, FACEP.

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

Dr. Katz provided a meeting dedication and then led the Council in reciting the Pledge of Allegiance and singing the National Anthem. He then provided an introduction and explanation of the virtual meeting format.

Robert Hancock, DO, FACEP, president of the Texas Chapter, welcomed councillors and other meeting attendees.

James D. Thompson, MD, FACEP, serving as chair of the Tellers, Credentials, & Elections Committee, reported that 374 councillors of the 443 eligible for seating had been credentialed in the LUMI virtual meeting platform. A roll call was not conducted because unique credentials were provided to each councillor and were verified through the electronic platform.

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

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

The following members were credentialed in the LUMI virtual meeting platform for the 2020 virtual Council meeting:

ALABAMA CHAPTER	Neil L Christen, MD, FACEP Michael Raphael Salomon, MD, FACEP Annalise Sorrentino, MD, FACEP
ALASKA CHAPTER	Nicholas Papacostas, MD, FACEP David James Scordino, MD, FACEP
ARIZONA CHAPTER	Patricia A Bayless, DO, FACEP Bradley A Dreifuss, MD, FACEP Nicole R Hodgson, MD Paul Andrew Kozak, MD, FACEP Wendy Ann Lucid, MD, FACEP Steven Maher, MD, FACEP Nicholas F Vasquez, MD, FACEP Dale P Woolridge, MD, PhD, FACEP
ARKANSAS CHAPTER	J Shane Hardin, MD, PhD, FACEP Brian L Hohertz, MD, FACEP Robert Thomas VanHook, MD, FACEP

AACEM	Theodore A Christopher, MD, FACEP
CALIFORNIA CHAPTER	Zahir I Basrai, DO Andrea M Brault, MD, FACEP Reb JH Close, MD, FACEP John Dirk Coburn, MD, FACEP Adam P Dougherty, MD Carrieann E Drenten, DO, FACEP Andrew N Fenton, MD, FACEP Jorge A Fernandez, MD, FACEP William E Franklin, DO, FACEP Marc Allan Futernick, MD, FACEP Michael Gertz, MD, FACEP Douglas Everett Gibson, MD, FACEP Vikant Gulati, MD, FACEP Omar Guzman, MD, FACEP Aimee K Moulin, MD, FACEP Taylor S Nichols, MD Valerie C Norton, MD, FACEP Bing S Pao, MD, FACEP Hunter M Pattison, MD Chi Lee Perlroth, MD, FACEP Vikram Raj, MD Vivian Reyes, MD, FACEP Susanne J Spano, MD, FACEP Melanie T Stanzer, DO, FACEP Lawrence M Stock, MD, FACEP Thomas Jerome Sugarman, MD, FACEP Gary William Tamkin, MD, FACEP David Terca, MD Patrick Um, MD, FACEP Andrea M Wagner, MD, FACEP Lori D Winston, MD, FACEP Anna L Yap, MD Randall J Young, MD, FACEP
COLORADO CHAPTER	Ramnik S Dhaliwal, MD, JD Nathaniel T Hibbs, DO, FACEP Douglas M Hill, DO, FACEP Christopher David Johnston, MD, FACEP Rebecca L Kornas, MD, FACEP Carla Elizabeth Murphy, DO, FACEP Donald E Stader, MD, FACEP
CONNECTICUT CHAPTER	Thomas A Brunell, MD, FACEP Michael L Carius, MD, FACEP Daniel Freess, MD, FACEP Elizabeth Schiller, MD, FACEP David E Wilcox, MD, FACEP
CORD	Maria E Moreira, MD, FACEP
DELAWARE CHAPTER	Emily M Granitto, MD, FACEP John T Powell, MD, MHCDS, FACEP
DISTRICT OF COLUMBIA CHAPTER	Marisa Karina Dowling, MD, MPP James M Gaylor, MD James D Maloy, MD

	Rita A Manfredi-Shutler, MD, FACEP
EMRA	Erik Blutinger, MD, MSc Angela Cai, MD, MBA Hannah R Hughes, MD, MBA Omar Z Maniya, MD, MBA Tracy Marko, MD, PhD, MS Karina Sanchez, MD George RJ Sontag, MD Sophia Spadafore, DO
FLORIDA CHAPTER	Andrew I Bern, MD, FACEP Ashley Booth-Norse, MD, FACEP Jordan GR Celeste, MD, FACEP Eliot Goldner, MD, FACEP Shayne M Gue, MD Omar Hammad, MD, FACEP Steven B Kailes, MD, FACEP Mike Lozano, Jr, MD, MSHI, FACEP Kristin McCabe-Kline, MD, FACEP Ryan T McKenna, DO, FACEP Ryan D Nesselroade, MD David J Orban, MD, FACEP Sanjay Pattani, MD, FACEP Russell D Radtke, MD Danyelle Redden, MD, FACEP David Charles Seaberg, MD, CPE, FACEP Todd L Slesinger, MD, FACEP John Caleist Soud, DO L Kendall Webb, MD, FACEP Christian C Zuver, MD, FACEP
GEORGIA CHAPTER	Brett H Cannon, MD, FACEP James Joseph Dugal, MD(E), FACEP(E) Matthew Taylor Keadey, MD, FACEP Jeffrey F Linzer, Sr, MD, FACEP Matthew Lyon, MD, FACEP DW “Chip” Pettigrew, III, MD, FACEP James L Smith, Jr, MD, FACEP Johnny L Sy, DO, FACEP Matthew J Watson, MD, FACEP
GOVT SERVICES CHAPTER	Andrea Austin, MD, FACEP Joshua S da Silva, DO William T Davis, MD Roderick Fontenette, MD, FACEP Alan Jeffrey Hirshberg, MD, MPH, FACEP Julio Rafael Lairet, DO, FACEP Grace Landers, MD Linda L Lawrence, MD, CPE, FACEP Torree M McGowan, MD, FACEP Nadia M Pearson, DO, FACEP Paul James Diggins Roszko, MD, FACEP
HAWAII CHAPTER	Mark Baker, MD, FACEP Daniel Cheng, MD
IDAHO CHAPTER	Ken John Gramyk, MD, FACEP

ILLINOIS CHAPTER	Amit D Arwindekar, MD, FACEP Christine Babcock, MD, FACEP E Bradshaw Bunney, MD, FACEP Shu Boung Chan, MD, FACEP Cai Glushak, MD, FACEP Scott A Heinrich, MD, FACEP George Z Hevesy, MD, FACEP Jason A Kegg, MD, FACEP Janet Lin, MD, FACEP Christopher M McDowell, MD, FACEP Henry Pitzele, MD, FACEP Yanina Purim-Shem-Tov, MD, FACEP Ernest Enjen Wang, MD, FACEP Deborah E Weber, MD, FACEP
INDIANA CHAPTER	Michael D Bishop, MD, FACEP(E) Bart S Brown, MD, FACEP Timothy A Burrell, MD, MBA, FACEP Daniel W Elliott, MD Tyler G Johnson, DO, FACEP James L Shoemaker, Jr, MD, FACEP Lauren Stanley, MD, FACEP
IOWA CHAPTER	Kelly M Douglas, MD Stacey Marie Marlow, MD, JD, FACEP Rachael Sokol, DO, FACEP
KANSAS CHAPTER	Howard Chang, MD, FACEP John M Gallagher, MD, FACEP John F McMaster, MD, FACEP Jeffrey G Norvell, MD, MBA, RDMS, FACEP
KENTUCKY CHAPTER	David Wesley Brewer, MD, FACEP Christopher W Pergrem, MD, FACEP Melissa Platt, MD, FACEP Hugh W Shoff, MD, FACEP
LOUISIANA CHAPTER	James B Aiken, MD, FACEP Deborah D Fletcher, MD, FACEP Phillip Luke LeBas, MD, FACEP Randy L Pilgrim, MD, FACEP Mark Rice, MD, FACEP
MAINE CHAPTER	Thomas C Dancoes, DO, FACEP Garreth C Debiegun, MD, FACEP Charles F Pattavina, MD, FACEP
MARYLAND CHAPTER	Michael C Bond, MD, FACEP Arjun S Chanmugam, MD, FACEP Timothy P Chizmar, MD, FACEP Jonathan Lewis Hansen, MD, FACEP Kyle Fischer, MD, MPH, FACEP Michelle Pyka, MD, FACEP Theresa E Tassey, MD
MASSACHUSETTS CHAPTER	Brien Alfred Barnewolt, MD, FACEP Stephen K Epstein, MD, MPP, FACEP Laura Janneck, MD, FACEP Kathleen Kerrigan, MD, FACEP

	Matthew B Mostofi, DO, FACEP
	Mark Notash, MD, FACEP
	Mark D Pearlmutter, MD, FACEP
	Jesse Rideout, MD, FACEP
	Brian Sutton, MD, FACEP
	Joseph C Tennyson, MD, FACEP
MICHIGAN CHAPTER	Michael J Baker, MD, FACEP
	Sara S Chakel, MD, FACEP
	Nicholas Dyc, MD, FACEP
	Gregory Gafni-Pappas, DO, FACEP
	Michael Vincent Gratson, MD, FACEP
	Zachary Joseph Jarou, MD, MBA
	Rami R Khoury, MD, FACEP
	Warren F Lanphear, 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
	Paul R Pomeroy, Jr, MD, FACEP
	Jacob Henry Price, MD
	Luke Christopher Saski, MD, FACEP
	Jennifer B Stevenson, DO, FACEP
	Larisa May Traill, MD, FACEP
	Bradley J Uren, MD, FACEP
	Bradford L Walters, MD, FACEP
	Mildred J Willy, MD, FACEP
MINNESOTA CHAPTER	Heather Ann Heaton, MD, FACEP
	Timothy James Johnson, MD, FACEP
	Donald L Lum, MD, FACEP
	David A Milbrandt, MD, FACEP
	David Nestler, MD, MS, FACEP
	Lane Patten, MD, FACEP
	Thomas E Wyatt, MD, FACEP
	Andrew R Zinkel, MD, MBA, FACEP
MISSISSIPPI CHAPTER	Fred E Kency, Jr, MD
	Sherry D Turner, DO
MISSOURI CHAPTER	Sabina A Braithwaite, MD, FACEP
	Douglas Mark Char, MD, FACEP
	Jonathan Heidt, MD, MHA, FACEP
	Louis D Jamtgaard, MD, FACEP
	Kevin A Journagan, MD, FACEP
	Marc Mendelsohn, MD, MPH
	Evan Schwarz, MD, FACEP
MONTANA CHAPTER	Harry Eugene Sibold, MD, FACEP
NEBRASKA CHAPTER	Renee Engler, MD, FACEP
	Benjamin L Fago, MD, FACEP
NEVADA CHAPTER	John Dietrich Anderson, MD, FACEP
	Bret Frey, MD, FACEP
	Graham Stephen Ingalsbe, MD
	Gregory Alan Juhl, MD, FACEP

NEW HAMPSHIRE CHAPTER	Reed Brozen, MD, FACEP Sarah Garlan Johansen, MD, FACEP
NEW JERSEY CHAPTER	Jenice Baker, MD, FACEP Thomas A Brabson, DO, FACEP William Basil Felegi, DO, FACEP Rachelle Ann Greenman, MD, FACEP Steven M Hochman, MD, FACEP Marjory E Langer, MD, FACEP Jessica M Maye, DO, FACEP J Mark Meredith, MD, FACEP Nilesh Patel, DO Michael Ruzek, DO, FACEP
NEW MEXICO CHAPTER	Melissa Beth Fleegler, MD, FACEP Margaret Greenwood-Ericksen, DO Tatsuya Norii, MD, FACEP
NEW YORK CHAPTER	Joseph Basile, MD, FACEP Nicole Berwald, MD, FACEP Robert M Bramante, MD, FACEP Kirby Black, MD, FACEP Jay Miller Brenner, MD, FACEP Bernard P. Chang, MD, PhD, FACEP Mark Curato, DO, FACEP Mathew Foley, MD, FACEP Keith Grams, MD, FACEP Sanjey Gupta, DO, FACEP Abbas Husain, MD, FACEP Marc P Kanter, DO, FACEP Stuart Gary Kessler, MD, FACEP Daniel Lakoff, MD, FACEP Penelope Chun Lema, MD, FACEP Robert McCormack, MD, FACEP Dhaval Mehta, MD Laura D Melville, MD Joshua B Moskovitz, MD, MBA, MPH, FACEP Nestor B Nestor, MD, FACEP William F Paolo, MD, FACEP Louise A Prince, MD, FACEP Jennifer Pugh, MD, FACEP Jeffrey S Rabrich, DO, FACEP James Gerard Ryan, MD, FACEP Livia M Santiago-Rosado, MD, FACEP Virgil W Smaltz, MD, FACEP Asa Viccellio, MD, FACEP Luis Carlos Zapata, MD, FACEP
NORTH CAROLINA CHAPTER	Thomas N Bernard, III, MD Scott W Brown, MD, FACEP Jennifer Casaletto, MD, FACEP Gregory J Cannon, MD, FACEP Charles W Henrichs, III, MD, FACEP Thomas Lee Mason, MD, FACEP Eric E Maur, MD, FACEP Abhishek Mehrotra, MD, MBA, FACEP Bret Nicks, MD, MHA, FACEP

	Sankalp Puri, MD, FACEP
	Stephen A Small, MD, FACEP
NORTH DAKOTA CHAPTER	K J Temple, MD, FACEP
OHIO CHAPTER	Eileen F Baker, MD, PhD, FACEP
	Dan Charles Breece, DO, FACEP
	Christina Campana, DO, FACEP
	B Bryan Graham, DO, FACEP
	Tyler Hill, DO, FACEP
	Erika Charlotte Kube, MD, FACEP
	Thomas W Lukens, MD, PhD, FACEP
	Michael McCrea, MD, FACEP
	Catherine Anna Marco, MD, FACEP
	Daniel R Martin, MD, MBA, FACEP
	Jordan Miller, DO
	John R Queen, MD, FACEP
	Matthew J Sanders, DO, FACEP
	Imran Shaikh, MD, FACEP
	Ryan Squier, MD, FACEP
	Nicole Ann Veitinger, DO, FACEP
OKLAHOMA CHAPTER	Cecilia Guthrie, MD, FACEP
	Jeffrey Johnson, MD, FACEP
	George-Thomas M Pugh, MD
	Carolyn Kay Synovitz, MD, MPH, FACEP
OREGON CHAPTER	Michael Henstrom, MD, FACEP
	Michael F McCaskill, MD, FACEP
	John C Moorhead, MD, FACEP
	Evangeline Sokol, MD, FACEP
	Christopher Strear, MD, FACEP
PENNSYLVANIA CHAPTER	Michelle Appel, MD
	Eleanor Dunham, MD, FACEP
	Todd Fijewski, MD, FACEP
	Maria Koenig Guyette, MD, MPPM, FACEP
	Taylor Haas, DO
	Ronald V Hall, MD, FACEP
	F Richard Heath, MD, FACEP
	Annahieta Kalantari, DO, FACEP
	Erik Ian Kochert, MD, FACEP
	Chadd K Kraus, DO, PhD, CPE, FACEP
	Michael J Lynch, MD
	Dhimitri Nikolla, DO
	Shawn M Quinn, DO, FACEP
	Meaghan L Reid, DO
	Thomas Douglas Sallade, DO
	Jennifer L Savino, DO, FACEP
	Daniel Tannenholtz, DO
	Arvind Venkat, MD, FACEP
	Elizabeth Barrall Werley, MD, FACEP
PUERTO RICO CHAPTER	Angelisse M Almodovar Bernier, MD
	Edwin J Garcia La Torre, MD, FACEP
RHODE ISLAND CHAPTER	Nadine T Himelfarb, MD, FACEP
	Achyut B Kamat, MD, FACEP

	Jessica Smith, MD, FACEP
SAEM	Kathleen J Clem, MD, FACEP
SOUTH CAROLINA CHAPTER	Matthew D Bitner, MD, FACEP Allison Leigh Harvey, MD, FACEP Kelly M Johnson, MD, FACEP Christina Millhouse, MD, FACEP Angel Lee Rochester, MD, FACEP Stewart Oliver Sanford, MD
SOUTH DAKOTA	Donald Neilson, MD
TENNESSEE CHAPTER	Shannon Anjelica Markus, MD MPH Thomas R Mitchell, MD, FACEP Matthew Neal, MD John H Proctor, MD, MBA, FACEP Sullivan K Smith, MD, FACEP
TEXAS CHAPTER	Sara Andrabi, MD Carrie de Moor, MD, FACEP Angela Siler Fisher, MD, FACEP Diana L Fite, MD, FACEP Andrea L Green, MD, FACEP Robert D Greenberg, FACEP, FACEP Robert Hancock, Jr, DO, FACEP Doug Jeffrey, MD, FACEP Alexander J Kirk, MD, FACEP Heidi C Knowles, MD, FACEP Laura N Medford-Davis, MD, FACEP Anant Patel, DO, FACEP Sterling Evan Overstreet, MD, FACEP Heather S Owen, MD, FACEP Daniel Eugene Peckenpaugh, MD, FACEP R Lynn Rea, MD, FACEP Richard Dean Robinson, MD, FACEP Marcus Lynn Sims, II, DO, FACEP Theresa Tran, MD, FACEP Gerad A Troutman, MD, FACEP James M Williams, DO, FACEP Sandra Williams, DO, MPH, FACEP
UTAH CHAPTER	Jim V Antinori, MD, FACEP Stephen Carl Hartsell, MD, FACEP Kathleen Marie Lawliss, MD, FACEP Alison L Smith, MD, MPH, FACEP
VERMONT CHAPTER	Ryan Sexton, MD, FACEP Alexandra Nicole Thran, MD, FACEP
VIRGINIA CHAPTER	Trisha Danielle Anest, MDM, MPH, FACEP Caroline Hollis Cox, MD Kenneth Hickey, MD, FACEP Sarah Klemencic, MD, FACEP Joseph Mason, MD, FACEP Cameron K Olderog, MD, FACEP Todd Parker, MD, FACEP Joran Sequeira, DO, FACEP

	Robert Solberg, MD Jesse Duane Spangler, MD
WASHINGTON CHAPTER	Cameron Ross Buck, MD, FACEP Justin Matthew Fuehrer, DO Carlton E Heine, MD, PhD, FACEP Gregg A Miller, MD, FACEP Karolyn K Moody, DO, MPH, FACEP Lola Mudgistratova, MD Nathaniel R Schlicher, MD, JD, MBA, FACEP Susan Amy Stern, MD Liam Yore, MD, FACEP
WEST VIRGINIA CHAPTER	Adam Thomas Crawford, DO, FACEP David Benjamin Deuell, DO, FACEP Christopher S Goode, MD, FACEP
WISCONSIN CHAPTER	Bradley Burmeister, MD Jeffrey J Pothof, MD, FACEP Michael Dean Repplinger, MD, PhD, FACEP Jamie Schneider, MD Brian Sharp, MD, FACEP Christopher Torkilsen, DO
WYOMING CHAPTER	Carol Lea Wright Becker, MD, FACEP
<u>Sections of Membership</u> AIR MEDICAL	Not represented.
AMER ASSOC OF WOMEN EMER PHYSICIANS	Elizabeth Dubey, MD, FACEP
CAREERS IN EMERGENCY MEDICINE	Sanford H Herman, MD, FACEP
CRITICAL CARE MEDICINE	Nicholas M Mohr, MD, FACEP
CRUISE SHIP MEICINE	Not represented.
DEMOCRATIC GROUP PRACTICE	James B Mullen, III, MD, FACEP
DISASTER MEDICINE	Justin W Fairless, DO, FAEMS, FACEP
DIVERSITY, INCLUSION, & HEALTH EQUITY	Ugo A. Ezenkwele, MD, FACEP
DUAL TRAINING	De Benjamin Winter, III, MD
EMERGENCY MEDICAL INFORMATICS	John D. Manning, DO, FACEP
EMS-PREHOSPITAL CARE	Michael O'Brien, MD, FACEP
EMERGENCY MED LOCUM TENENS	Pamela Andrea Ross, MD, FACEP
EMER MED PRAC MGMT & HEALTH POLICY	Richard Lee Austin, Jr, MD
EMERGENCY MEDICINE RESEARCH	James Ross Miner, MD, FACEP
EMERGENCY MEDICINE WORKFORCE	Leslie Mukau, MD, FACEP
EMERGENCY ULTRASOUND	Lisa M. Bundy, MD, FACEP

EVENT MEDICINE	Melissa D Kohn, MD, FACEP
FORENSIC MEDICINE	Ralph James Riviello, MD, FACEP
FREESTANDING EMERGENCY CENTERS	Edward A. Shaheen, MD, FACEP
GERIATRIC EMERGENCY MEDICINE	Maura Kennedy, MD
INTERNATIONAL EMERGENCY MEDICINE	Jeffrey A. Nielson, MD, FACEP
MEDICAL DIRECTORS	C Ryan Keay, MD, FACEP
MEDICAL HUMANITIES	Zayir Malik, MD
OBSERVATION SERVICES	Kristi Ziontz, DO, FACEP
PAIN MANAGEMENT	Eric Michael Ketcham, MD, MBA, FACEP
PALLIATIVE MEDICINE	David Wang, MD
PEDIATRIC EMERGENCY MEDICINE	Eric R Schmitt, MD, MPH, FACEP
QUALITY IMPROVEMENT & PATIENT SAFETY	William Colwell Dalsey, MD, FACEP
RURAL EMERGENCY MEDICINE	Stephen J. Jameson, MD, FACEP
SOCIAL EMERGENCY MEDICINE	Aislinn D. Black, DO, FACEP
SPORTS MEDICINE	William Denq, MD
TACTICAL EMERGENCY MEDICINE	Howard K. Mell, MD, MPH, CPE, FACEP
TELEHEALTH	David C Ernst, MD, FACEP
TOXICOLOGY	Jennifer Hannum, MD, FACEP
TRAUMA & INJURY PREVENTION	Gregory Luke Larkin, MD, MPH, FACEP
UNDERSEA & HYPERBARIC MEDICINE	Stephen Hendriksen, MD, FACEP
WELLNESS	Susan T. Haney, MD, FACEP
WILDERNESS MEDICINE	Brendan H. Milliner, MD
YOUNG PHYSICIANS	Benjamin Karfunkle, MD

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

Past Presidents

Nancy J. Auer, MD, FACEP (WA)
Larry Bedard, MD, FACEP (CA)
Brooks F. Bock, MD, FACEP (CO)
Angela F. Gardner, MD, FACEP (TX)
Nicholas J. Jouriles, MD, FACEP (OH)
Brian F. Keaton, MD, FACEP OH)
John McCabe, MD, FACEP (NY)
George Molzen, MD, FACEP (NM)
Rebecca B. Parker, MD, FACEP (IL)
Michael T. Rapp, MD, FACEP (VA)
Alex M. Rosenau, DO, CPE, FACEP (PA)
Andrew Sama, MD, FACEP (NY)
Robert W. Schafermeyer, MD, FACEP(NC)
Sandra M. Schneider, MD, FACEP (TX)

Richard L. Stennes, MD, FACEP (CA)
Robert E. Suter, DO, MPH, FACEP (TX)

Past Speakers
Louise Andrew, MD
Michael Bresler, MD, FACEP (CA)
Marco Coppola, DO, FACEP (GS)
Mark L. DeBard, MD, FACEP (OH)
Peter M. Fahrney, MD, FACEP (VA)
Peter J. Jacoby, MD, FACEP (CT)
Bruce MacLeod, MD, FACEP (PA)
John G. McManus, Jr., MD, MBA, FACEP (GS)
Todd Taylor, MD, FACEP (AZ)
Arlo F. Weltge, MD, MPH, FACEP (TX)

Past Chairs of the Board
John D. Bibb, MD, FACEP (CA)
Ramon W. Johnson, MD, FACEP (CA)
Debra G. Perina, MD, FACEP (VA)
Robert E. O'Connor, MD, MPH, FACEP (VA)
David P. Sklar, MD, FACEP (NM)

****

The Temporary 2020 Virtual Council Meeting Standing Rules were distributed to the councillors prior to the meeting and were not read aloud.

TEMPORARY 2020 VIRTUAL COUNCIL MEETING STANDING RULES

Due to emergency declarations, Stay at Home Orders, and the impossibility of holding an in-person 2020 Council meeting, the following Rules governing the virtual 2020 Council meeting were recommended for adoption, upon advice of ACEP's General Counsel and Parliamentarian:

Rule 1. The Council meeting shall be conducted using the LUMI platform.

Rule 2. Participation during the Council meeting shall be limited to councillors, alternate councillors, members of the Board of Directors, past presidents, past speakers, past chairs of the Board, ACEP members, and authorized ACEP staff or guests.

Rule 3. Reference Committee hearings shall be held virtually in succession and limited to one hour each. Reference Committees shall include within their consideration asynchronous comments made prior to the virtual hearing on the ACEP platform.

Rule 4. Following any Reference Committee hearing, the Reference Committee may propose amendments to resolutions and Bylaws proposals and shall determine resolutions to be placed on a consent agenda. Any councillor may remove an item from the consent agenda using the LUMI platform.

Rule 5. During Council debate on any matter, anyone wishing to speak shall use the recognition feature of the LUMI platform and shall be recognized in order.

Rule 6. Upon recognition by the Council speaker, anyone wishing to speak shall identify themselves by stating their name, affiliation, and whether they are speaking "for" or "against" the motion.

Rule 7. No individual shall speak more than once on the same item, nor longer than one (1) minute.

Rule 8. No seconds to motions shall be necessary, and there shall be no amendments to resolutions or Bylaws proposals from the floor.

Rule 9. Total debate time allotted for each Bylaws amendment or resolution shall be ten (10) minutes. If there are speakers in the queue when the debate time expires, a vote shall be taken on whether to extend debate for an additional five (5) minutes.

Rule 10. Each candidate for president-elect shall be given an opportunity to speak for five (5) minutes. Each candidate for the Board of Directors shall be given the opportunity to speak for two (2) minutes. Candidate

speeches may be live or prerecorded.

Rule 11. Except as expressly provided in these Temporary Rules, all other Council Standing Rules shall remain in effect.

The Temporary 202 Virtual Council Meeting Standing Rules were adopted without objection.

****

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

Council Standing Rules

Preamble

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

Alternate Councillors

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

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

Amendments to Council Standing Rules

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

Announcements

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

Appeals of Decisions from the Chair

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

Board of Directors Seating

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

Campaign Rules

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

Conflict of Interest Disclosure

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

Councillor Allocation for Sections of Membership

To be eligible to seat a credentialed councillor, a section must have 100 dues-paying members, or the minimum number established by the Board of Directors, on December 31 preceding the annual meeting. Section

councillors must be certified by the section by notifying the Council secretary at least 60 days before the annual meeting.

Councillor Seating

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

Credentialing and Proper Identification

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

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

Debate

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

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

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

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

Distribution of Printed or Other Material During the Annual Meeting

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

Election Procedures

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

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

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

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

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

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

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

Electronic Devices

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

Leadership Development Advisory Committee

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

Limiting Debate

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

Nominating Committee

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

Nominations

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

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

Parliamentary Procedure

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

Any councillor may call for a "point of personal privilege," "point of order," or "parliamentary inquiry" at any time even if it interrupts the current person speaking. This procedure is intended for uses such as asking a

question for clarification, asking the person speaking to talk louder, or to make a request for personal comfort. Use of "personal privilege," etc. to interject debate is out of order.

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

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

Policy Review

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

Reference Committees

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

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

A Reference Committee may recommend that a resolution:

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

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

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

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

Reports

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

Resolutions

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

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

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

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

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

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

  Regular resolutions may be modified or withdrawn by the author(s) up to 45 days prior to the annual meeting. After such time, revisions will follow the usual amendment process and may be withdrawn only with consent of the Council at the annual meeting. As determined by the speaker, extensive revisions during the 90

to 45 day window that appear to alter the original intent of a regular resolution or that would render the background information meaningless will be considered as "Late Resolutions."

- ***Bylaws Resolutions***

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

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

- ***Late Resolutions***

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

- ***Emergency Resolutions***

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

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

Smoking Policy

Smoking is not permitted in any College venue.

Unanimous Consent Agenda

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

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

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

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

Voting Immediately

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

Voting on Resolutions and Motions

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

****

The councillors reviewed and accepted the minutes of the October 25-26, 2019, Council meeting and approved the actions of the Steering Committee taken at their January 22, 2020; April 26, 2020; June 9, 2020; and August 25, 2020, meetings.

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

Dr. Katz reported that eight late resolutions were received and reviewed by the Steering Committee. One resolution was withdrawn. Six memorial resolutions were accepted by the Steering Committee. Memorial resolutions are not assigned to a Reference Committee for testimony. One late resolution was not accepted for submission to the Council. Dr. Katz stated the reasons the late resolution was rejected.

Dr. Katz presented the Nominating Committee report.

Five members were nominated for four positions on the Board of Directors: Michael J. Baker, MD, FACEP; Alison J. Haddock, MD, FACEP; James L. Shoemaker, Jr., MD, FACEP; Aisha T. Terry, MD, MPH, FACEP; and Arvind Venkat, MD, FACEP. Dr. Katz called for floor nominations. There were no floor nominees. The nominations were then closed.

Two members were nominated for President-Elect: Christopher S. Kang, MD, FACEP, and Gillian R. Schmitz, MD, FACEP. Dr. Katz called for floor nominations. There were no floor nominees. The nominations were then closed.

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

Dr. Katz announced that the Reference Committee hearings would be held in succession, Reference Committee A, Reference Committee B, and Reference Committee C. The resolutions considered by the 2020 Council appear below as submitted.

2020 Council Resolutions

RESOLUTION 1

RESOLVED, That the American College of Emergency Physicians commends and thanks Stephen H.

Anderson, MD, FACEP, for his exemplary service, leadership, and commitment to the College and the specialty of emergency medicine.

RESOLUTION 2

RESOLVED, That the American College of Emergency Physicians extends heartfelt appreciation and gratitude and commends James J. Augustine, MD, FACEP, for his dedication as an emergency physician and his outstanding service and leadership to the College and the specialty of emergency medicine.

RESOLUTION 3

RESOLVED, That the American College of Emergency Physicians commends Jon Mark Hirshon, MD, MPH, PhD, FACEP, for his devotion as an emergency physician, educator, and leader in emergency medicine.

RESOLUTION 4

RESOLVED, That the American College of Emergency Physicians commends Janyce M. Sanford, MD, MBA, FACEP, for her service as Chair and Chief of Service for the Department of Emergency Medicine at the University of Alabama at Birmingham.

RESOLUTION 5

RESOLVED, That the American College of Emergency Physicians commends Dean Wilkerson, JD, MBA, CAE, for his outstanding contributions to ACEP and the specialty of emergency medicine.

RESOLUTION 6

RESOLVED, That the American College of Emergency Physicians (ACEP) cherishes the memory of Walter J. Bradley, III, MD, MBA, FACEP, whose philosophy and approach to patient care was "Whatever the hour you may come, you will find light, hope, and human kindness," and be it further

RESOLVED, That national ACEP and the Illinois Chapter extends to his wife Meme, son Ryan, and the extended Bradley and Wood families gratitude for his tremendous service to emergency medicine and EMS.

RESOLUTION 7

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

RESOLUTION 8

RESOLVED, That the American College of Emergency Physicians remembers with gratitude and honors the many contributions made by Colonel (ret) Christopher G Scharenbrock, MD, CPE, FACEP, as one of the leaders in emergency medicine and military medicine; and be it further

RESOLVED; That the American College of Emergency Physicians extends to his wife Mary, his daughters Emily and Anna, his extended family, colleagues, and friends our condolences and gratitude for his tremendous service to the specialty of emergency medicine, military medicine, and to the countless patients and physicians across the world whom he selflessly served.

RESOLUTION 9

RESOLVED, That the ACEP Bylaws Article XI – Committees, Section 1 – General Committees, be amended to read:

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

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

RESOLUTION 10

RESOLVED, That the Council Standing Rules, "Reference Committees" section, paragraph one, be amended to read:

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

and invited guests."; and be it further

RESOLVED, That the Council Standing Rules, "Resolutions" section, be amended to read:

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

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

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

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

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

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

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

- ***Bylaws Resolutions***

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

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

- ***Late Resolutions***

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

- ***Emergency Resolutions***

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

  Emergency resolutions must be submitted in writing, signed by at least two members, and presented to

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

RESOLUTION 11

RESOLVED, That the ACEP Bylaws, Article VIII – Council, Section 6 – Resolutions, paragraph one, be amended to read:

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. **All resolution sponsors and cosponsors must be confirmed at the time the resolution is submitted**.

RESOLUTION 12

RESOLVED, That the Council Standing Rules, "Resolutions" section, be amended to read:

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

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

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

RESOLUTION 13

RESOLVED, That the ACEP Bylaws, Article V – ACEP Fellows, Section 1 - Eligibility, be amended to read:

ARTICLE V — ACEP FELLOWS
Section 1 — Eligibility

Fellows of the College shall meet the following criteria:

1. Be **candidate physician,** regular**,** or international members for three continuous years immediately prior to election.
2. Be certified in emergency medicine at the time of election by the American Board of Emergency Medicine, the American Osteopathic Board of Emergency Medicine, or in pediatric emergency medicine by the American Board of Pediatrics.
3. Meet the following requirements demonstrating evidence of high professional standing at some time during their professional career prior to application.
   A. At least three years of active involvement in emergency medicine as the physician's chief professional activity, exclusive of residency training, and;
   B. Satisfaction of at least three of the following individual criteria during their professional career:
      1. active involvement, beyond holding membership, in voluntary health organizations, organized medical societies, or voluntary community health planning activities or service as an elected or appointed public official;
      2. active involvement in hospital affairs, such as medical staff committees, as attested by the emergency department director or chief of staff;

3. active involvement in the formal teaching of emergency medicine to physicians, nurses, medical students, out-of-hospital care personnel, or the public;
4. active involvement in emergency medicine administration or departmental affairs;
5. active involvement in an emergency medical services system;
6. research in emergency medicine;
7. active involvement in ACEP chapter activities as attested by the chapter president or chapter executive director;
8. member of a national ACEP committee, the ACEP Council, or national Board of Directors;
9. examiner for, director of, or involvement in test development and/or administration for the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine;
10. reviewer for or editor or listed author of a published scientific article or reference material in the field of emergency medicine in a recognized journal or book.

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

RESOLUTION 14

RESOLVED, That the ACEP Bylaws Article IV – Membership, Section 3 – Agreement, and Section 4 – Disciplinary Action, be amended to read:

Section 3 — Agreement

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

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

Section 4 — Disciplinary Action

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

RESOLUTION 15

RESOLVED, That the College Manual be amended by substitution of the *Procedures for Addressing Charges of Ethical Violations and Other Misconduct* to read:

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

A. Definitions

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

~~A.~~ B. Complaint Received

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

1. Must be in writing and signed by the complainant;
2. Must specify in reasonable detail an alleged violation by an ACEP member of **an ACEP policy as it existed at the time of the alleged violation, including** ACEP Bylaws, ~~current~~ ACEP ~~"Principles~~ ***Code of Ethics***, ~~for Emergency Physicians,"~~ other ~~current~~ ACEP ethics policies, or other conduct believed by the complainant to warrant censure, suspension, or expulsion;
3. Must allege a violation that occurred within ~~twelve (12)~~ **ten (10)** years prior to the submission of the complaint**, is not the subject of pending litigation, and any rights of appeal have been exhausted or have expired**;
4. Must state that the complainant has personal, first-hand knowledge or actual documentation of the alleged violation; substantiating documentation must accompany the complaint. Complainant is responsible for ensuring that the documentation does not provide information that can be used to identify a particular patient, including but not limited to, the patient's name, address, social security number, patient identification number, or any identifying information related to members of the patient's family;
5. Must state that the complainant is willing to have his or her name disclosed to the ACEP Executive Director~~, the Ethics Committee, the Bylaws Committee, the Board of Directors,~~ **any additional ACEP review body listed in these *Procedures***, and ~~to~~ the respondent should the complaint be forwarded to the respondent; **and**
6. Must be submitted to the ACEP Executive Director.

~~B.~~ C. Executive Director

1. **a. If any elements of the complaint have not been met, returns the complaint and supporting documentation to complainant, identifying the elements that must be addressed in an ethics complaint.**

   b. If all elements of the complaint have been met, sends ~~1. Sends~~ a written acknowledgement to the complainant confirming ~~the~~ complainant's intent to file a complaint**. Includes a copy of ACEP's *Procedures* providing** ~~and identifying~~ the ~~elements~~ **guidelines and timetables** that ~~must~~ **will** be ~~addressed~~ **followed** in **this matter. Requests complainant sign acknowledgement specifying intent to file** an ethics complaint **and to be bound by the *Procedures***.
2. Confirms receipt of an acknowledgement signed by the complainant specifying intent to file an ethics complaint and to be bound by the ~~"Procedures for Addressing Charges of Ethical Violations and Other Misconduct" ("Procedures")~~ ***Procedures.***
3. Notifies the ACEP President and the ~~e~~**C**hair of the Ethics Committee or the Bylaws Committee, as appropriate, that a complaint has been filed and forwards to each of them a copy of the complaint.
   4. a. Determines, in consultation with the ACEP President and the ~~e~~**C**hair of the Ethics ~~and/or~~ **Committee, the** Bylaws Committee**, or other committee designee,** that the complaint is frivolous, inconsequential, or does not allege an actionable violation of a policy or principle included in the *Code of Ethics* ~~*for Emergency Physicians*~~ or ~~of~~ ACEP Bylaws, or other conduct warranting censure, suspension, or expulsion. If so, the Executive Director dismisses the complaint and will notify the complainant of this determination, or
   b. Determines, in consultation with the **ACEP President and the Chair of the** Ethics Committee ~~chair~~**, or other committee designee,** that the complaint alleges conduct that may constitute a violation of a policy or principle included in the *Code of Ethics* ~~*for Emergency Physicians*~~, and if so, forwards the complaint and the response together, ~~as soon as~~ **after** both are received, to each member of the Ethics ~~Committee, or, at the discretion of the chair of the Ethics Committee, to members of a subcommittee of the Ethics Committee appointed for that purpose~~ **Complaint Review Panel**, or
   c. Determines, in consultation with the **ACEP President and the Chair of the** Bylaws Committee ~~chair~~**, or other committee designee,** that the complaint alleges conduct that may constitute a violation of ACEP Bylaws or other conduct justifying censure, suspension, or expulsion, and forwards the complaint and response together, ~~as soon as~~ **after** both are received, to each member of the Bylaws Committee, or at the discretion of the ~~e~~**C**hair of the Bylaws Committee, to members of a subcommittee of the Bylaws Committee appointed for that purpose, or

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

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

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

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

1. Reviews the written record of any complaint that alleges a violation of ~~current~~ **the** ACEP ~~"Principles~~ ***Code*** *of Ethics* ~~for Emergency Physicians"~~ or other ~~current~~ ACEP ethics policies **as they existed at the time of the alleged violation and the accompanying response**.
2. Discusses the complaint and response by telephone conference call~~;~~**.**
3. Determines the need to solicit in writing additional information or documentation from the parties, third parties, or experts regarding the complaint.
4. Considers whether:
   a. ~~Current~~ **Applicable version of the** ACEP ~~"Principles~~ ***Code*** *of Ethics* ~~for Emergency Physicians"~~ or other ~~current~~ ACEP ethics policies apply.
   b. Alleged behavior constitutes a violation of ~~current~~ **the applicable version of the** ACEP ~~"*Principles*~~ ***Code*** *of Ethics* ~~*for Emergency Physicians*"~~ or other ~~current~~ ACEP ethics policies.
   c. Alleged conduct warrants censure, suspension, or expulsion.

~~5. Proceeds to develop its recommendation based solely on the written record.~~

~~6. Develops a report regarding the complaint~~ **and recommendation for action**~~.~~ ~~Minority reports may also be presented.~~

~~7.~~**5.** ~~The Ethics Committee will deliver its report and minority reports, if any, to the Board of Directors. In its report, the Ethics Committee shall recommend that the Board of Directors~~ **Decides to**:

   a. Dismiss the complaint; or
   b. ~~Take~~ **Ethics Complaint Review Panel renders a decision to impose** disciplinary action~~, the specifics of which shall be included in the committee's report.~~ **based on the written record.**

~~8. At the discretion of the chair of the Ethics Committee, these functions may be carried out by a subcommittee of five or more members of the Ethics Committee. The Ethics Committee chair shall appoint this subcommittee and designate one of its members to chair the subcommittee. The subcommittee may seek counsel from other consultants with particular expertise relevant to the matter~~

~~under consideration. In the event that a subcommittee is appointed, it shall deliver its report and recommendations to the Board of Directors.~~

6. **If the Ethics Complaint Review Panel determines to impose disciplinary action pursuant to Section D.5.b., the respondent will be provided with notification of the Ethics Complaint Review Panel's determination and the option of:**
   a. **A hearing; or**
   b. **The imposition of the Ethics Complaint Review Panel decision based solely on the written record.**
7. **If the respondent chooses the option described in Section D.6.b., that is, an Ethics Complaint Review Panel decision based solely on the written record, the Ethics Complaint Review Panel will implement its decision to impose disciplinary action based on the written record.**

~~C~~ **E. Bylaws** ~~Committee~~**Complaint Review Process [within sixty (60) days of the forwarding of the complaint/response specified in Section** ~~B~~**C.4.**~~b~~**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. ~~Current~~ **Applicable version of the** ACEP Bylaws apply.
   b. Alleged behavior constitutes a violation of ~~current~~ **the applicable version of the** ACEP Bylaws.
   c. Alleged conduct warrants censure, suspension, or expulsion.

~~5. Proceeds to develop its recommendation based solely on the written record.~~

~~6. Develops a report regarding the complaint and recommendation for action. A minority reports may also be presented.~~

~~7.~~**5.** ~~The Bylaws Committee will deliver its report and minority reports, if any, to the Board of Directors. In its report, the Bylaws Committee shall recommend that the Board of Directors~~ **Decides to**:
   a. Dismiss the complaint; or
   b. ~~Take~~ **Bylaws Committee renders a decision to impose** disciplinary action~~, the specifics of which shall be included in the committee's report~~ **based solely on the written record.**

~~8. At the discretion of the chair of the Bylaws Committee, these functions may be carried out by a subcommittee of five or more members of the Bylaws Committee. The Bylaws Committee chair shall appoint this subcommittee and designate one of its members to chair the subcommittee. The subcommittee may seek counsel from other consultants with particular expertise relevant to the matter under consideration. In the event that a subcommittee is appointed, it shall deliver its report and recommendations to the Board of Directors.~~

6. **If the Bylaws Committee determines to impose disciplinary action pursuant to Section E.5.b., the respondent will be provided with notification of the Bylaws Committee's determination and the option of:**
   a. A hearing; or
   b. The imposition of the Bylaws Committee's decision based solely on the written record.
7. **If the respondent chooses the option described in Section E.6.b., that is, a Bylaws Committee decision based solely on the written record, the Bylaws Committee will implement its decision to impose disciplinary action based on the written record.**

~~E. Board of Directors~~

~~1. Receives the report of the Ethics Committee or Bylaws Committee, including minority reports, if any, and receives the complaint and response.~~

~~2. May request further information in writing from the complainant and/or respondent.~~

~~3. Decides to:~~
   ~~a. Dismiss the complaint; or~~
   ~~b. Render a decision to impose disciplinary action based on the written record.~~

~~4. If the Board determines to impose disciplinary action pursuant to Section E.3.b., the respondent will be provided with notification of the Board's determination and the option of:~~
   ~~a. A hearing; or~~
   ~~b. The imposition of the Board decision based solely on the written record.~~

5. The decision to impose disciplinary action shall require a two-thirds vote of Directors voting at a meeting in which a quorum is present pursuant to ACEP Bylaws. Directors entitled to vote include members of the Board who have been present for the entire discussion of the complaint, either in person or by conference call, with no conflict of interest or other reason to recuse themselves from participation.
6. If the respondent chooses the option described in Section E.4.b., that is, a Board decision based solely on the written record, the Board will implement its decision to impose disciplinary action based on the written record.

F. Ad Hoc Committee

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

    e. If the respondent requests a hearing, the Ad Hoc Committee shall follow the hearing procedures described in Section H below.

    f. An affirmative vote of two-thirds of the Ad Hoc Committee shall be required to take disciplinary action against the respondent. If the Ad Hoc Committee does not achieve a two-thirds vote of its members, the respondent shall be exonerated.

    g. If the respondent does not request a hearing, the Ad Hoc Committee will report to the Board its decision to impose disciplinary action based on the written record. This decision will be final and will be implemented by the Board.

G. F. Right of Respondent to Request a Hearing

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

H. G. Hearing Procedures

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

~~**10.**~~**9.** The decision of the Board ~~or Ad Hoc Committee~~ **Hearing Panel** will be expressed in a resolution that will be included in the minutes of the meeting at which the decision occurs. Written notice of the ~~Board's or Ad Hoc Committee~~ **Board Hearing Panel's** decision will be sent by ~~certified U.S. mail~~ **USPS Certified Mail** to the respondent and complainant within sixty (60) days of the decision. This written

notice will include the ~~Board's or Ad Hoc Committee's~~ **Board Hearing Panel's** decision and a statement of the basis for that decision.

H. Notice to the Board of Directors

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

I. Possible Disciplinary Action~~: Censure, Suspension, or Expulsion~~ and Disclosure to ACEP Members

1. **Nature of Disciplinary Action**
   a. **Censure**
   ~~a.~~ **i.** Private Censure: a private letter of censure informs a member that his or her conduct ~~is~~ **does** not ~~in conformity~~ **conform** with the College's ethical standards; it may detail the manner in which ~~the Board~~ **ACEP** expects the member to behave in the future and may explain that, while the conduct does not, at present, warrant public censure or more severe disciplinary action, the same or similar conduct in the future may warrant a more severe action. ~~The content~~ **Upon written request by a member** of **ACEP, ACEP may confirm the censure; however, contents of the** ~~a private~~ letter ~~of censure shall~~ **will** not be ~~disclosed~~ **provided.** ~~but the fact that such a letter has been issued shall be disclosed.~~
   ~~b.~~ **ii.** Public Censure: a public letter of censure shall detail the manner in which the censured member has been found to violate the College's ethical standards set forth in Section ~~A.~~**B.**2. above. **The censure shall be announced in an appropriate ACEP publication. The published announcement shall also state which ACEP policy or Bylaws provision was violated by the member and shall inform ACEP members that they may request further information about the disciplinary action.**
   ~~2.~~ **b.** Suspension from ACEP membership shall be for a period of twelve **(12)** months; the dates of commencement and completion of the suspension shall be determined by the ~~Board of Directors~~ **ACEP President**. At the end of the twelve~~-~~ **(12)** month period of suspension, the suspended member ~~shall be offered~~ **may request** reinstatement. Request for reinstatement shall be processed in the same manner as that of any member whose membership has lapsed (i.e., has been cancelled for non-payment of dues). **The suspension shall be announced in an appropriate ACEP publication. The published announcement shall also state which ACEP policy or Bylaws provision was violated by the member and shall inform ACEP members that they may request further information about the disciplinary action. ACEP is also required to report the suspension from membership and a description of the conduct that led to the suspension to the Board of Medical Examiners in the states in which the physician is licensed which may result in a report of such action to the National Practitioner Data Bank.**
   ~~3.~~ **c.** Expulsion from ACEP membership shall be for a period of five **(5)** years, after which the expelled member may petition the Board of Directors for readmission to membership. The decision regarding such a petition shall be entirely at the discretion of the Board of Directors. **The expulsion**

~~J. Disclosure~~

~~1. Nature of Disciplinary Action~~

~~a. Private censure: the content of a private letter of censure~~ shall ~~not~~ be ~~disclosed, but the fact that such a letter has been issued~~ **announced in an appropriate ACEP publication. The published announcement** shall ~~be disclosed. The name of the respondent shall be disclosed, but the conduct that resulted in censure shall not be disclosed.~~**also state which ACEP policy or Bylaws provision was violated by**

~~b. Public censure: both the fact of issuance, and the content, of a public letter of censure shall be disclosed.~~

~~c. Suspension: the dates of suspension, including whether or not~~ the member ~~was reinstated at the end of the period of suspension, along with a statement of the basis for the suspension, shall be disclosed. ACEP is also required to report the suspension of membership and a description of the conduct that led to suspension to the Boards of Medical Examiners in the states in which the physician is licensed, which~~ **and shall inform ACEP members that they** may ~~result in a report of~~

~~such~~ **request further information about the disciplinary** action. ~~to the National Practitioner Data Bank.~~

~~d. Expulsion: the date of expulsion, along with a statement of the basis for the expulsion, shall be disclosed. If the five-year period has elapsed, the disclosure shall indicate whether the former member petitioned for reinstatement and, if so, the Board's decision on such petition~~. ACEP is also required to report the expulsion from membership and a description of the conduct that led to expulsion to the Boards of Medical Examiners in the states in which the physician is licensed which may result in a report of such action to the National Practitioner Data Bank.

2. Scope and Manner of Disclosure
   a. Disclosure to ACEP ~~members~~ **Members**: Any ACEP member may transmit ~~to the Executive Director~~ a request for information **to the Executive Director** regarding disciplinary actions taken by the College. Such letter shall specify the name of the member or former member who is the subject of the request. The Executive Director shall disclose, in writing, the relevant information as described in Section ~~J~~ **I**.1.
   b. ~~Public~~ Disclosure **to Non-Members**: **If a non-member** ~~The Board of Directors shall publicize in an appropriate ACEP publication the names of members receiving public censure, suspension, or expulsion. This published announcement shall also state which ACEP bylaw or policy was violated by the member and shall inform ACEP members that they may request further information about the disciplinary action. If any person~~ makes a request for information about disciplinary actions against a member who has received public censure, suspension, or expulsion, the Executive Director shall refer that person to the published announcement of that disciplinary action in an ACEP publication. **No further information shall be provided.**

~~K.~~**J.** Ground Rules

1. All proceedings are confidential until a final decision on the complaint is rendered by the ~~Board of Directors or an Ad Hoc Committee pursuant to Section F.~~ **applicable ACEP review body**, at which time the decision will be available upon request by ACEP members, to the extent specified in Section ~~J.~~ **I.** Files of these proceedings, including written submissions and hearing record will be kept confidential.
2. Timetable guidelines are counted by calendar days unless otherwise specified.
3. The Ethics ~~Committee~~ **Complaint Review Panel**, the Bylaws Committee, **or** the Board ~~of Directors, their appointed subcommittees, as appropriate, or an Ad Hoc Committee~~ **Hearing Panel**, may request further written documentation from either party to the complaint; a time to satisfy any request will be specified in the notice of such request, and these times will not count against the ~~committee's, Board's, subcommittee's, or Ad Hoc Committee's overall time to complete its task. However, such requests and the responses thereto shall not extend the time to deliver a recommendation or a decision to the Board beyond ninety (90) days from the date the complaint is forwarded to the appropriate committee, subcommittee, or Ad Hoc Committee.~~ **ACEP review body's overall time to complete its task.**
4. All parties to the complaint are responsible for their own costs; ACEP will pay its own administrative and committee costs.
5. If a participant in this process (such as a member of the Ethics ~~Committee~~ **Complaint Review Panel**, the Bylaws Committee, or **the** Board ~~of Directors~~ **Hearing Panel**) is a party to the complaint, has a material reason for bias, subjectivity, or conflicts of interest in the matter, or is in direct economic competition with the respondent, that person shall recuse himself or herself from the process except as a complaining party or respondent. ~~Any committee member who recuses himself or herself shall report this recusal promptly to the committee chair, and any Board member who recuses himself or herself shall report this recusal promptly to the chair of the Board.~~ **at which time the ACEP President will appoint a replacement.**
6. Once the ~~Board~~ **Ethics Complaint Review Panel or the Bylaws Committee** has made a decision ~~or implemented a decision of an Ad Hoc Committee pursuant to Section F.~~ on a complaint, it will not consider additional allegations against the same respondent based on the same or similar facts.
7. The ~~Board's~~ **Ethics Complaint Review Panel or the Bylaws Committee's** decision ~~or the decision of an Ad Hoc Committee pursuant to Section F.~~ to impose an adverse action must be based on a reasonable belief that the action is warranted by the facts presented or discovered in the course of the disciplinary process.
8. If a respondent fails to respond to a complaint, to **a** notice of the right to request a hearing, or to a request for information, the ~~Board or an Ad Hoc~~ **Ethics Complaint Review Panel, the Bylaws**

Committee, ~~pursuant to Section F.~~ **or the Board Hearing Panel** may make a decision on the complaint solely on the basis of the information it has received.

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

~~10.~~**9.** If a respondent seeks to voluntarily resign his/her ACEP membership after ACEP has received a complaint against that respondent, that request for resignation will not be accepted by ACEP until the complaint has been resolved. For the purposes of this provision, non-payment of ACEP member dues will be interpreted as a request for resignation.

RESOLUTION 16

RESOLVED, That the ACEP Bylaws Article IX – Board of Directors, Section 3 – Meetings be amended to read:

Section 3 — Meetings

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

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

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

Special meetings of the Board of Directors may be called by the president **or the chair of the Board** with not less than ~~10~~ **48 hours** ~~nor more than 50 days~~ notice to each director, either personally or by other appropriate means of communication. Special meetings also may be called by one-third of the current members of the Board in like manner and on like notice. Such notice of a special meeting of the Board of Directors shall specify the business to be transacted at, and the purpose of, such special meeting.

RESOLUTION 17

RESOLVED, That the Council Standing Rules, "Unanimous Consent Agenda" section, be amended to read as follows with the proviso that the changes will become effective after the 2020 Council meeting:

Unanimous Consent Agenda

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

~~4. Non-controversial in nature~~

~~5. Generated little or no debate during the Reference Committee~~

~~6. Clear consensus of opinion (either pro or con) was expressed at Reference Committee~~

All resolutions assigned to a Reference Committee, except for Bylaws resolutions, ~~and resolutions that require substantive amendments~~ shall ~~not~~ be placed on a Unanimous Consent Agenda.

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

RESOLUTION 18

RESOLVED, That ACEP set benchmarks for improving racial/ethnic and gender diversity of its members, committee members, councillors, Council Officers, and Board of Directors; and be it further

RESOLVED, That ACEP encourage community and academic emergency medicine groups to collect and publish demographic data about its members and set benchmarks for improving racial/ethnicity and gender diversity among its members.

RESOLUTION 19

RESOLVED, That ACEP create or select a framework to assess the work of the College (position statements, adopted resolutions, task forces) through the lens of health equity; and be it further

RESOLVED, That ACEP provide to members a biannual assessment of the work of the College as it pertains to health equity.

RESOLUTION 20

RESOLVED, That ACEP honor emergency physicians with an annual award named in memory of Kayce Anderson who have led the way in improving the care of patients with substance use and behavioral health issues.

RESOLUTION 21

RESOLVED, That ACEP become an official member of the Medical Society Consortium on Climate & Health; and be it further

RESOLVED, That ACEP support one ACEP member representative by paying registration and travel expenses to attend the Medical Society Consortium on Climate & Health annual meeting starting in 2021.

RESOLUTION 22

RESOLVED, That ACEP develop a dedicated media training course for emergency physicians to respond to requests from state or local media outlets via ACEP constituent chapters and sections with an emphasis on specific talking points pertinent to the key issues affecting those physicians at that level; and be it further

RESOLVED, That ACEP develop a media training course specifically focused on effective, unbiased, fact-based social media delivery; and be it further

RESOLVED, That ACEP partner with state chapters and sections to effectively market a media training course for chapter and section leaders and encourage that chapter and section officers are offered the opportunity to enroll in such training in conjunction with ACEP *Scientific Assembly* or other ACEP meetings.

RESOLUTION 23

RESOLVED, That ACEP develop a process to collaborate with ACEP **s**ections to identify and retain subspecialty content expert lecturers based on training, extensive experience, and subspecialty-certification (when applicable) for in-person and virtual education as well as publications; and be it further

RESOLVED, That priority be given to subject matter experts when selecting faculty lecturers at the *Scientific Assembly* to include in the following order:

1. Board certified emergency physicians who are recognized as national or international leaders in the subspecialty field, typically by their scientific contributions and unique experiences, and/or those who have received the formal endorsement of the ACEP section of greatest interest; or
2. Fellowship trained board diplomates in the subspecialty subject matter area with authorship of subject matter peer reviewed publications; or
3. Fellowship trained board diplomates in the subspecialty subject matter area; or
4. Fellowship trained board certified or board eligible diplomates in the subspecialty subject matter area; or

Board certified emergency physicians who can demonstrate subject matter expertise in the area in question, such as a regional or national reputation, extensive experience and/or with authorship of subject matter peer-reviewed publications.

RESOLUTION 24

RESOLVED, That ACEP promote awareness that healthcare providers are calling 911 on behalf of patients who cannot call 911 themselves, will not call 911 themselves, or have inadequate communication when speaking to 911 dispatchers themselves; and be it further

RESOLVED, That ACEP promote awareness that medical directors of Public Safety Access Points and EMS may need to build policies to take into strong consideration the patients' medical information and patients' medical needs provided by the treating doctor who activates the 911 emergency on behalf of a patient.

RESOLUTION 25

RESOLVED, That ACEP create a task force and commission an independent study on the extraordinary financial influence health insurers have asserted over emergency physicians by leveraging EMTALA mandates and

withholding appropriate reimbursement against emergency physicians; and be it further

RESOLVED, That ACEP engage an independent healthcare economist to analyze the reimbursement challenges and adverse financial impacts of the healthcare financing system on emergency medicine and the effect of commercial health insurance and reimbursement policies on emergency care; and be it further

RESOLVED, That ACEP advocate for higher standards and additional scrutiny of health insurer spending, including the Medical Loss Ratio (MLR) standards, to ensure more resources are dedicated to the patient health services and not diverted for other business pursuits without clear benefit to their patient population; and be it further

RESOLVED, That ACEP work with other similarly affected professional organizations, consumer advocacy groups, and the American Medical Association (AMA) to further understand the contribution of health insurers on the increased financial burden of patient access to emergency services and on the physician delivery of emergency care.

RESOLUTION 26

RESOLVED, That ACEP reaffirm the importance of recognizing and addressing the social determinants of health, including systemic racism; and be it further

RESOLVED, That ACEP continue to explore models of health care that would make equitable health care accessible to all; and be it further

RESOLVED, That ACEP continue to use its voice as an organization and support its members who seek to dismantle systems of discrimination and advocate for polices promoting the social determinants of health within historically disenfranchised communities at an institutional, local, state, and national level.

RESOLUTION 27

RESOLVED, That ACEP advocate for the use of the unqualified terms "resident" and "residency" and "fellow" and "fellowship" when used in the emergency medicine clinical setting to connote a physician with acceptance, enrollment, and participation in an approved allopathic, osteopathic, dentistry, or podiatry residency (or fellowship) program; and be it further

RESOLVED, That ACEP recognizes the gold standard for emergency medicine training is, and must remain, the completion of an American Board of Emergency Medicine or American Osteopathic Board of Emergency Medicine accredited physician residency program.

RESOLUTION 28

RESOLVED, That the American College of Emergency Physicians endorse a national ban on the use of choke holds; and be it further

RESOLVED, That ACEP educate its members and relevant stakeholders about the hazard of choke holds and the availability of non-lethal alternatives and promote these alternatives when appropriate.

RESOLUTION 29

RESOLVED, That ACEP modify the existing policy statement "Emergency Physician Contractual Relationships" through deletion and substitution as follows: "The emergency physician ~~should~~ **shall receive detailed itemized reports on** ~~have the right to review~~ what is billed and collected for his or her service **on at least a monthly basis** regardless of whether or not billing and collection is assigned to another entity within the limits of state and federal law. **The emergency physician shall not be asked to waive access to this information**."; and be it further

RESOLVED, That ACEP modify the existing policy statement "Emergency Physician Rights and Responsibilities" through deletion and substitution as follows: "5. Emergency physicians ~~should~~ **shall** be provided ~~periodic~~ **detailed itemized** reports of billings and collections in their name **on at least a monthly basis** and have the right to audit such billings, without retribution. **The emergency physician shall not be asked to waive access to this information**."; and be it further

RESOLVED, That ACEP adopt as policy that: "No member of ACEP will, directly or indirectly, deny another emergency physician the ability to receive detailed itemized billing and remittance information for medical services they provide."; and be it further

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

RESOLVED, That ACEP adopt this policy: "Any entity that wishes to advertise in ACEP vehicles, exhibit at its meetings, provide sponsorship, other support or otherwise be associated with ACEP will as of January 1, 2021, provide every emergency physician associated with that entity, at a minimum, a monthly statement with detailed information on what has been billed and collected in the physician's name. This information must be provided without the need for the physician to request it. Physicians cannot be asked to waive access to this information. The entities

affected include but is not limited to revenue cycle management companies, physician groups, hospitals, and staffing companies."

RESOLUTION 30

RESOLVED, That ACEP establish policy that requires all employers, persons, or entities who contract for emergency physician services (whether in-person or via telehealth) to provide itemized billing and collection information on a monthly basis to the emergency physician for all charges billed and all collections made under the physician's name, license number, or other identifying information without the physician having to request it; and be it further

RESOLVED, That ACEP establish policy that requires all employers, persons or entities who contract for emergency physician services to provide information on a monthly basis to physicians for any and all compensation or benefit, cash, and payment-in-kind, received by the employer or Contract Management Group (CMG) as a result of the physician providing his or her services without any requirement of the physician requesting it.

RESOLUTION 31

RESOLVED, ACEP establish policy that advocates for legislation requiring Policy Weakness Disclosures *(PWD) be provided by health insurers to potential customers before and at the time of sale of any healthcare policy that specifically explains the policy that they are selling with specific examples of "worse case scenarios" (including hypothetical emergency department visits resulting in $10,000 outpatient visit and $200,000 hospitalization with out-of-network emergency physicians, anesthesiologists, radiologists, telehealth physician and non-physician providers, excluded services, co-pays, deductibles, etc., to help the public understand the potential risks of buying a particular insurance policy that actually can and do occur; and be it further

RESOLVED, That ACEP support legislation imposing penalties on insurers who do not provide Policy Weakness Disclosures to policyholders as required, i.e., before they purchase the policy that include requiring the insurer to cover 100% of all charges without deductible, co-pay, exclusions, etc.

RESOLUTION 32

RESOLVED, That ACEP support adoption of Medicare-for-All as an alternative to employment-based insurance – but only if such a program provides universal access, fosters competition, preserves patient choice of provider and physician autonomy, and recognizes the essential value of emergency medicine; and be it further

RESOLVED, That ACEP explore opportunities to partner with other like-minded organizations that favor the Medicare-for-All approach to providing universal health care to all Americans.

RESOLUTION 33

RESOLVED, That the College seek the decoupling of clinical documentation from billing, regulatory, and administrative compliance requirements; and be it further

RESOLVED, That the College seek the end of pay-for-performance programs in emergency medicine; and be it further

RESOLVED, That the College encourage the Emergency Medicine Foundation Board of Trustees to offer funding for research into the effects of scientific management and pay-for-performance programs on patient care and emergency physicians.

RESOLUTION 34

RESOLVED, That ACEP support access to bleeding control kits in all schools and public venues nationwide akin to the automated external defibrillators (AED) access programs; and be it further

RESOLVED, That ACEP support the expansion of bleeding control training in schools and communities to support educated use of these kits in the event of an emergency until help arrives.

RESOLUTION 35

RESOLVED, That ACEP take a leadership role to ensure the inclusion of prehospital care (e.g., emergency medical services) as a seamless component of health care delivery rather than merely a transport mechanism; and be it further

RESOLVED, That ACEP advocate for bidirectional data integration between hospitals and EMS; and be it further

RESOLVED, That ACEP advocate for appropriate payment of EMS services to include all clinical services separate from transport; and be it further

RESOLVED, That ACEP advocate for the development of a payment structure for EMS medical direction and oversight including physician field response; and be it further

RESOLVED, That ACEP advocate for additional support to the National Highway Traffic Safety Administration Office of EMS to allow for further federal leadership of EMS systems development and evolution and expansion of the National EMS Information System; and be it further

RESOLVED, That ACEP collaborate with other stakeholder organizations to promote legislation that will allow for the integration of reimbursed prehospital care into a seamless patient-centered system of healthcare delivery.

RESOLUTION 36

RESOLVED, That ACEP support legislation to make the CMS waivers that were allowed during the COVID-19-declared emergency related to telehealth permanent, i.e., allow patient to be at any location, allow provider to be at any location, same or different than the patient, allow waiving of cost sharing, allow coding using any code that reflects the service provided; and be it further

RESOLVED, That ACEP support legislation mandating all payers to allow patients to select the physician of their choice, whether employed, within the health insurer's network, or outside of insurer's network, without restriction, to provide telehealth services for acute unscheduled care to any or all their insured patients; and be it further

RESOLVED, That ACEP support legislation requiring all payers to pay parity to physician and non-physician health providers for telehealth services as would be paid for in-person services for appropriate or equivalent care; and be it further

RESOLVED, That ACEP support penalties to insurers for intentional actions, rules or policy that limit, restrict, delay, deny or prevent access to necessary acute unscheduled care or services from the physician or non-physician provider of the patient's choice in an appropriate time period as determined by physicians in that region, or national determined standard or in the payment to the practitioner for the care or services provided.

RESOLUTION 37

RESOLVED, That ACEP advance the responsible implementation of telehealth practice consistent with policies and guidelines previously developed by ACEP, the American Medical Association, and specialty-specific best practices as well as ongoing assessment of patient outcomes, physician-patient relationship, and cost; and be it further

RESOLVED, That ACEP, in collaboration with other medical organizations, advocate for state and federal legislation that supports Medicaid, Medicare, and private payer reimbursement and coverage parity for live video physician telehealth visits as well as fair reimbursement of ancillary telehealth services such as remote patient monitoring, eConsults, and store and forward technology; and be it further

RESOLVED, That ACEP oppose restrictions to telehealth care unless those restrictions are consistent with established best practices, confidentiality, or patient safety protections.

RESOLUTION 38

RESOLVED, That ACEP, in collaboration with other medical organizations, advocate for universal access to telehealth care through expanded broadband infrastructure and wireless connectivity to all rural and underserved areas of the United States as well as supporting innovative strategies to improve individual access to broadband and cellular technology.

RESOLUTION 39

RESOLVED, That ACEP join the American Academy of Ophthalmology in condemning the use of rubber bullets (and similar projectiles) and tear gas to control or disperse crowds and calling on all law enforcement officials to permanently and immediately end these practices.

RESOLUTION 40

RESOLVED, That ACEP develop a stockpile of airborne and contact level personal protection equipment that would include five N95 respirators, five surgical masks, five gowns, and one face shield available to members on request during a pandemic to mitigate delays from normal supply chains; and be it further

RESOLVED, That ACEP partner with hospitals or other organizations to donate or sell personal protection equipment stockpiled for members when the expiration dates are near to prevent waste and automatically replenish the stockpile to maintain adequate volumes for our membership.

RESOLUTION 41

RESOLVED, That ACEP establish a new policy that hospitals must maintain adequate supply of personal protection equipment to supply all emergency and other workers that may be necessary during an infectious, radioactive, chemical, or biologic disaster for at least a 60-day minimum when used as directed by the manufacturer;

and be it further

RESOLVED, That ACEP establish a new policy that in the event any hospital fails to provide adequate personal protection equipment in terms of quantity, particular type. and quality, to its emergency workers the employer or staffing company is responsible and will immediately supply appropriate and adequate personal protection equipment for the physicians and non-physicians staffing the emergency department and other sites; and be it further

RESOLVED, That ACEP establish a new policy supporting emergency physicians and other emergency workers providing their own personal protection equipment without any penalty of any kind if the hospital or other "employer" (staffing company) fails to provide adequate and sufficient personal protection equipment to be used as intended by the manufacturer of the personal protection equipment.

RESOLUTION 42

RESOLVED, That ACEP develop policy statements to address:

) the implications for emergency physicians of inadequate personal protective equipment;
2) conflicts with hospitals and practice organizations on the use of self-purchased personal protective equipment;
3) crisis treatment standards; and
4) the proportionality of responses by hospitals and practice organizations toward emergency physicians' compensation or benefits during times of pandemic illness or other similar events.

RESOLUTION 43

RESOLVED, That ACEP promote transparency in institutional data to better identify disparities and biases in medical care; and be it further

RESOLVED, That ACEP continue to encourage compliance with training to combat discrimination for all clinicians; and be it further

RESOLVED, That ACEP continue to explore frameworks for integrating anti-discrimination into our emergency departments and institutions at all levels including, but not limited to, patients, families, medical students, staff, trainees, staff physicians, administration, and other stakeholders.

RESOLUTION 44

RESOLVED, That ACEP adopt this policy; "No member of ACEP will, directly or indirectly, deny another emergency physician the right to due process regarding their medical staff privileges and ability to see patients in an emergency department. No member of ACEP will hold a management position with any entity that denies an emergency physician of this right."; and be it further

RESOLVED, That ACEP modify the existing policy statement "Emergency Physician Rights and Responsibilities" through deletion and substitution as follows: "6. Emergency physicians ~~should~~ **shall** be accorded due process before any adverse final action with respect to employment or contract status, the effect of which would be the loss or limitation of medical staff privileges. Emergency physicians' medical and/or clinical staff privileges ~~should~~ **shall** not be reduced, terminated, or otherwise restricted except for grounds related to their competency, health status, limits placed by professional practice boards or state law. 7. Emergency physicians who practice pursuant to an exclusive contract arrangement ~~should~~ **shall** not be required to waive their individual medical staff due process rights as a condition of practice opportunity or privileges."; and be it further

RESOLVED, That ACEP adopt this policy: "Any entity that wishes to advertise in ACEP vehicles, exhibit at its meetings, provide sponsorship, other support or otherwise be associated with the ACEP will as of January 1, 2021 shall remove all restrictions on due process for emergency physicians. Physicians cannot be asked to waive this right as it can be detrimental to the quality and safety of patient care. The entities affected include but is not limited to physician groups, hospitals, and staffing companies."

RESOLUTION 45

RESOLVED, That ACEP create new or reaffirm policy that supports that all states and U.S. territories waive standard licensing requirements including fees for emergency physicians to provide their services, whether in person or not, in any state or territory once a disaster has been declared by a state or federal entity, agency or official and afterwards until services related to the disaster are no longer needed, so long as emergency physician holds a license in good standing in any U.S. state or territory, does not charge for his/her services and practices within his/her area of knowledge and expertise; and be it further

RESOLVED, That ACEP create new policy that supports legislation protecting any/all emergency physicians who provide their services, in person or otherwise, at no charge during disasters and their aftermath, and granting these emergency physicians immunity and holding them harmless for any services, that they provide to patients

during disasters and aftermath so long as the emergency physician(s) practices within his/their area of knowledge or expertise.

RESOLUTION 46

RESOLVED, That ACEP create new policy to establish a confidential "Job Database" or direct such a database to be created and controlled by an emergency physician controlled entity with the top priority of what is best for emergency physicians, that allows emergency physicians to provide their ratings, and/or opinions regarding employers and contract management groups (CMGs) for only those employers and CMGs that they have worked for or been contracted in an anonymous manner that is not accessible by or can be influenced by employers or contract management groups that is only accessible by other emergency physicians; and be it further

RESOLVED, That ACEP establish new policy that opposes employers or contract management groups from discouraging, obstructing, preventing or otherwise preventing any emergency physician from providing information or obtaining information from a confidential Job Database developed by ACEP; and be it further

RESOLVED, That ACEP establish new policy opposing penalty or punishment of any kind, actual or the withholding of benefit, to any emergency physician who provides information to, or receives information from, a confidential Job Database developed by ACEP.

RESOLUTION 47

RESOLVED, That ACEP partner with the Emergency Medicine Residents' Association to encourage all employers to honor their employment contracts with graduating emergency medicine resident physicians.

RESOLUTION 48

RESOLVED, That ACEP engage the Accreditation Council for Graduate Medical Education and other relevant stakeholders to construct objective criteria for new residency accreditation that takes into account emergency medicine workforce needs, competitive advantages and disadvantages, geographical distribution of workforce, and expected shortages and/or excess of emergency physicians to adequately steward needs for newly accredited emergency medicine residency programs.

RESOLUTION 49

RESOLVED, That ACEP create a policy statement acknowledging the seriousness of strangulation in intimate partner and sexual violence and denouncing the use of choke hold/carotid restraint by law enforcement; and be it further

RESOLVED, That ACEP work with the Emergency Nurses Association, International Association of Forensic Nurses, Training Institute on Strangulation Prevention, and other related organizations and stakeholders to create an information paper on the emergency department evaluation, treatment, and management of strangulation and available resources.

RESOLUTION 50

RESOLVED, That ACEP develop a clinical policy supporting the use of expedited partner therapy; and be it further

RESOLVED, That ACEP develop model legislation that removes legal obstacles to expedited partner therapy, promotes legal clarity where the laws are ambiguous, and provides legal protection for health care professionals that choose to prescribe expedited partner therapy; and be it further

RESOLVED, That ACEP work with state and local health departments and key stakeholders to develop expedited partner therapy protocols.

RESOLUTION 51

RESOLVED, That ACEP create new policy that promotes federal, state, and private funding for pilot projects and studies to help provide care, once a disaster is officially declared by a state or federal agency, entity or official, to disaster victims and rescue workers using telehealth and other technology as tools and to study the effectiveness of using telehealth as a vehicle for the evaluation and treatment of disaster victims and patients; and be it further

RESOLVED, That ACEP create new policy that encourages federal, state, and private funding to develop and implement telehealth and other technology educational programs and training of first responders and disaster workers to become more familiar with such tools to improve access, evaluation of, and the care delivered to victims of natural and man-made disasters.

RESOLUTION 52

RESOLVED, That ACEP will prepare a comprehensive review of the legal and regulatory matters related to

the corporate practice of medicine and fee splitting in each state and the results of this review will be compiled into a resource and announced to members as an available electronic download; and be it further

RESOLVED, That ACEP adopt as policy: "The ACEP, in concert with its relevant component state chapter, in those states where there are existing prohibitions on the corporate practice of medicine, will provide assistance to physician owned groups who are threatened with contract loss to a corporate entity or to hospital employed physicians whose site will be taken over by a corporate entity by providing, upon request, a written review of the legality of the corporation obtaining the contract for emergency services."; and be it further

RESOLVED, That ACEP, in those states that are found to have existing prohibitions on the corporate practice of medicine, along with the relevant state chapter, will petition the appropriate authorities in that state to examine the corporate practice of emergency medicine if such is believed to occur within that state and ACEP will reach out to the state professional societies of anesthesia and radiology in this effort and solicit the support of the state medical society; and be it further

RESOLVED, That ACEP will convene a meeting with representatives of physician professional associations representing anesthesiologists, radiologists, hospitalists, dermatologists, and other specialties affected by private equity involvement to examine joint efforts to combat the corporate control of medicine by lay entities.

RESOLUTION 53 *(This late resolution was accepted by the Council.)*

RESOLVED, That the American College of Emergency Physicians remembers with honor and gratitude the accomplishments and contributions of a gifted emergency physician Lindsey Jo Myers, MD and extends condolences and gratitude to her family and friends for her service to the specialty of emergency medicine and to patient care.

RESOLUTION 54 *(This late resolution was accepted by the Council.)*

RESOLVED, That the American College of Emergency Physicians cherishes the memory and expresses its appreciation for the professional accomplishments and personal influence of "Arn," a consummate gentleman and emergency medicine pioneer, and be it further

RESOLVED, That the American College of Emergency Physicians and the Pennsylvania College of Emergency Physicians extends to his wife Anne, daughters Janice and Sarah, and sons Carl "Gus," Peter, and Paul, and the extended Muller family gratitude for his tremendous service to public health and to the specialty of emergency medicine as one of its founding fathers.

RESOLUTION 55 *(This late resolution was accepted by the Council.)*

RESOLVED, That the American College of Emergency Physicians cherishes the memory and legacy of J. Ward Donovan, MD, FACEP, FACMT, who dedicated himself to his patients, to his profession, and to his family, and be it further

RESOLVED, That the American College of Emergency Physicians and the Pennsylvania College of Emergency Physicians extends to his wife Joan, daughter Erin, son-in-law, Greg, and grandchildren, Seamus and Aoife, and to the extended Donovan family gratitude for his tremendous service to the specialty of emergency medicine and to his leadership, vision, and commitment in the development of emergency medicine and medical toxicology.

RESOLUTION 56 *(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 magnanimous life of Craig Manifold, DO, FACEP, FAAEM, FAEMS, on the State of Texas, the Texas College of Emergency Physicians, and the Government Services Chapter of ACEP; and be it further

RESOLVED, That the aforementioned groups acknowledge the substantial loss to the medical community and bereavement of his many colleagues and friends, but above all extend condolences to his beloved wife of 31 years, Denise L. Moore, and their precious children Hanna Moore Manifold Cappadonna, her husband, Barrett; Della Caroline Manifold-Stolle, and her husband, Steven; and his son, Caleb Andrew Manifold.

RESOLUTION 57 *(This late resolution was accepted by the Council.)*

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

RESOLVED, That the American College of Emergency Physicians extends to the family of Douglas W. Lowery-North, MD FACEP, his friends, and his colleagues our condolences and gratitude for his tremendous service to his country, the specialty of emergency medicine, and to the patients and physicians of California, Georgia, Oregon, and the United States.

RESOLUTION 58 *(This late resolution was accepted by the Council.)*

RESOLVED, That the American College of Emergency Physicians and the Hawaii Chapter recognizes Debra Sanders for her Aloha and her outstanding contributions to the chapter.

****

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

Resolutions 9-23, were referred to Reference Committee A. Andrea L. Green, MD, FACEP, chaired Reference Committee A and other members were: Bradley Burmeister, MD; Angela P. Cornelius, MD, FACEP; Douglas M. Char, MD, FACEP; Kurtis Mayz, JD, MD, MBA, FACEP; Michael Ruzek, DO, FACEP; Leslie Moore, JD; Maude Surprenant Hancock; and Shari Purpura.

Resolutions 24-39 (except #28), were referred to Reference Committee B. Ashley Booth-Norse, MD, FACEP, chaired Reference Committee B and other members were: Sara A. Brown, MD, FACEP, John M. Gallagher, MD, FACEP, William D. Falco, MD, FACEP, Heidi C. Knowles, MD, FACEP, Jay Mullen, MD, FACEP, Ryan McBride, MPP, Jeff Davis, and Brad Gruehn.

Resolutions 40-52 and Resolution 28 were referred to Reference Committee C. Hilary Fairbrother, MD, FACEP, chaired Reference Committee C and other members were: Shamie Das, MD, FACEP; Heather M. Heaton, MD, FACEP; Todd Slesinger, MD, FACEP; Alison Smith, MD, MPH; Nicole A. Veitinger, DO, FACEP; Margaret Montgomery, RN, MSN; Paul Krawietz; Mandie Mims, MLS; and Travis Schulz, MLS, AHIP.

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

At 3:48 pm Dr. Katz addressed the Council and then reviewed the procedure for the adoption of the 2020 memorial resolutions. The Council reviewed the list of members who have passed away since the last Council meeting. Dr. Katz then read the resolveds of the memorial resolutions for Walter J. Bradley, III, MD, MBA, FACEP; Lorna Breen, MD, FACEP; Christopher Scharenbrock, MD, CPE, FACEP; Lindsey J. Myers, MD; Herbert Arnold (Arn) Muller, MD, FACEP; J. Ward Donovan, MD, FACEP, FACMT; Craig A. Manifold, DO, FACEP, FAAEM, FAEMS; Douglas W. Lowery-North, MD, MSPH, FACEP; and Debra Sanders. 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.

Christopher S. Kang, MD, FACEP, presented the secretary-treasurer's report.

Video reports from the American Board of Emergency Medicine, American Osteopathic Board of Emergency Medicine, Emergency Medicine Residents' Association, the Emergency Medicine Foundation (EMF) , and the National Emergency Medicine Political Action Committee were recorded prior to the Council meeting and the recorded sessions were made available to councillors for viewing on demand

Dr. Katz provided updates on the EMF and NEMPAC Council Challenges.

ACEP President William P. Jaquis, MD, FACEP, addressed the Council.

The Council recessed at 4:33 pm and reconvened at 10:01 am on Sunday, October 25, 2020.

Dr. Thompson reported that 335 councillors of the 443 eligible for seating had been credentialed in the LUMI virtual meeting platform. A series of demographic questions were displayed for the Council and responses were submitted through the LUMI platform.

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

Dr. Katz announced that the Reference Committee reports would be discussed in succession: Reference Committee A, Reference Committee B, and Reference Committee C.

At 10:49 am, Dr. Thompson reported that 414 councillors of the 443 eligible for seating had been credentialed in the LUMI virtual meeting platform.

REFERENCE COMMITTEE A

Dr. Green 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 10, Resolution 17, Amended Resolution 18, Amended Resolution 19, Amended Resolution 20, Resolution 21, and Resolution 22.

Not for adoption: Resolution 23.

Resolution 17, Amended Resolution 20, Resolution 21, and Resolution 23 were extracted. The Council adopted the remaining resolutions as recommended for unanimous consent without objection.

AMENDED RESOLUTION 18

RESOLVED, THAT ACEP ~~SET BENCHMARKS~~ **WILL STUDY AND CREATE A PLAN** FOR IMPROVING RACIAL/ETHNIC**,** ~~AND~~ GENDER**, AND OTHER FORMS OF** DIVERSITY OF ITS MEMBERS, COMMITTEE MEMBERS, COUNCILLORS, COUNCIL OFFICERS, AND BOARD OF DIRECTORS; AND BE IT FURTHER

RESOLVED, THAT ACEP **COLLECT AND PUBLISH DEMOGRAPHIC DATA ABOUT ITS MEMBERS, COUNCIL, AND LEADERS** AND ENCOURAGE COMMUNITY AND ACADEMIC EMERGENCY MEDICINE GROUPS ~~TO COLLECT AND~~ **ALIKE TO** PUBLISH DEMOGRAPHIC DATA ABOUT ITS MEMBERS AND**,** ~~SET BENCHMARKS~~ **LIKEWISE, TO CREATE A PLAN FOR** IMPROVING RACIAL/ETHNIC~~ITY~~**,** ~~AND~~ GENDER **AND OTHER FORMS OF** DIVERSITY AMONG ITS MEMBERS~~.~~**; AND BE IT FURTHER**

RESOLVED, THAT ACEP CREATE AN ANNUAL DIVERSITY REPORT TO BE PRESENTED TO COUNCIL FOR THE NEXT 5 YEARS.

AMENDED RESOLUTION 19

RESOLVED, THAT ACEP CREATE OR SELECT A FRAMEWORK TO ASSESS THE **FUTURE** WORK OF THE COLLEGE (POSITION STATEMENTS, ADOPTED RESOLUTIONS, TASK FORCES) THROUGH THE LENS OF HEALTH EQUITY; AND BE IT FURTHER

RESOLVED, THAT ACEP PROVIDE TO MEMBERS A ~~BIANNUAL~~ **BIENNIAL** ASSESSMENT OF THE WORK OF THE COLLEGE AS IT PERTAINS TO HEALTH EQUITY.

The committee recommended that Resolution 9 be adopted.

It was moved THAT RESOLUTION 9 BE ADOPTED. The motion was adopted.

The committee recommended that Amended Resolution 11 be adopted.

It was moved THAT AMENDED RESOLUTION 11 BE ADOPTED:

RESOLVED, THAT THE ACEP BYLAWS, ARTICLE VIII – COUNCIL, SECTION 6 – RESOLUTIONS, PARAGRAPH ONE, BE AMENDED TO READ:

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.

ALL RESOLUTION SPONSORS AND COSPONSORS MUST BE CONFIRMED ~~**AT THE TIME THE RESOLUTION IS SUBMITTED**~~ **AT LEAST 45 DAYS IN ADVANCE OF THE COUNCIL MEETING.** The motion was not adopted.

The committee recommended that Amended Resolution 12 be adopted.

It was moved THAT AMENDED RESOLUTION 12 BE ADOPTED:

RESOLVED, That the Council Standing Rules, "Resolutions" section, be amended to read:

"RESOLUTIONS" ARE CONSIDERED FORMAL MOTIONS THAT IF ADOPTED BY A MAJORITY VOTE OF THE COUNCIL AND RATIFIED BY THE BOARD OF DIRECTORS BECOME OFFICIAL COLLEGE POLICY. RESOLUTIONS PERTAINING ONLY TO THE COUNCIL STANDING RULES DO NOT REQUIRE BOARD RATIFICATION AND BECOME EFFECTIVE IMMEDIATELY UPON ADOPTION. RESOLUTIONS PERTAINING TO THE COLLEGE BYLAWS (BYLAWS RESOLUTIONS) REQUIRE ADOPTION BY A TWO-THIRDS VOTE OF CREDENTIALED COUNCILLORS AND SUBSEQUENTLY A TWO-THIRDS VOTE OF THE BOARD OF DIRECTORS.

RESOLUTIONS MUST BE SUBMITTED IN WRITING BY AT LEAST TWO MEMBERS OR BY COMPONENT BODIES, COLLEGE COMMITTEES, OR THE BOARD OF DIRECTORS. A LETTER OF ENDORSEMENT IS REQUIRED FROM THE SUBMITTING BODY IF SUBMITTED BY A COMPONENT BODY. **ALL RESOLUTION SPONSORS AND COSPONSORS MUST BE CONFIRMED ~~AT THE TIME THE RESOLUTION IS SUBMITTED.~~ 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. The motion was adopted.

The committee recommended that Resolution 13 be adopted.

It was moved THAT RESOLUTION 13 BE ADOPTED. The motion was adopted.

The committee recommended that Resolution 14 be adopted.

It was moved THAT RESOLUTION 14 BE ADOPTED. The motion was adopted.

The committee recommended that Resolution 15 be adopted.

It was moved THAT RESOLUTION 15 BE ADOPTED. The motion was adopted.

The committee recommended that Resolution 16 be adopted.

It was moved THAT RESOLUTION 16 BE ADOPTED. The motion was adopted.

The committee recommended that Resolution 17 be adopted:

It was moved THAT RESOLUTION 17 BE ADOPTED. The motion was adopted.

The committee recommended that Amended Resolution 20 be adopted with a revised title ~~Kayce Anderson~~ ACEP Award for Excellence in Innovations in the ED Care of Patients with ~~Substance Use &~~ Behavioral Health and Substance Use ~~Issues~~ Disorder.

It was moved THAT AMENDED RESOLUTION 20 BE ADOPTED:

RESOLVED, THAT ACEP **WILL** HONOR EMERGENCY PHYSICIANS WITH ~~AN~~ **THIS** ANNUAL AWARD, ~~NAMED IN MEMORY OF KAYCE ANDERSON~~ WHO HAVE LED THE WAY IN

IMPROVING THE CARE OF PATIENTS WITH ~~SUBSTANCE USE AND~~ BEHAVIORAL HEALTH **AND SUBSTANCE USE** ~~ISSUES~~ **DISORDER**. The motion was adopted.

The committee recommended that Resolution 21 be adopted:

It was moved THAT RESOLUTION 21 BE ADOPTED.

It was moved THAT RESOLUTION 21 BE REFERRED TO THE BOARD OF DIRECTORS. The motion was not adopted.

The main motion was then voted on and adopted.

The committee recommended that Resolution 23 not be adopted.

It was moved THAT THE FIRST RESOVLED OF RESOLUTION 23 BE ADOPTED. The motion was not adopted.

It was moved THAT THE SECOND RESOLVED OF RESOLUTION 23 BE ADOPTED. The motion was not adopted.

REFERENCE COMMITTEE B

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

The committee recommended the following resolutions by unanimous consent:

For adoption: Amended Resolution 24, Resolution 25, Amended Resolution 26, Amended Resolution 27, Amended Resolution 29 (first two resolveds) Amended Resolution 30, Amended Resolution 31, Resolution 34, Resolution 35, and Resolution 38.

Not for adoption: Resolution 32, Resolution 33, and Resolution 39.

For referral: Amended Resolution 29 (last 3 resolveds) and Substitute Resolution 36 (in lieu of Resolutions 36 and 37).

Amended Resolution 27, Amended Resolution 29, Resolution 32, Resolution 33, and Substitute Resolution 36 were extracted. The Council adopted the remaining resolutions as recommended for unanimous consent without objection.

AMENDED RESOLUTION 24

RESOLVED, THAT ACEP PROMOTE AWARENESS THAT HEALTHCARE ~~PROVIDERS~~ **PROFESSIONALS** ARE ~~CALLING~~ **INCREASINGLY ACCESSING** 911 ON BEHALF OF PATIENTS WHO CANNOT CALL 911 THEMSELVES, WILL NOT CALL 911 THEMSELVES, OR HAVE INADEQUATE COMMUNICATION WHEN SPEAKING TO 911 DISPATCHERS THEMSELVES; AND BE IT FURTHER

RESOLVED, THAT ACEP PROMOTE AWARENESS THAT MEDICAL DIRECTORS OF PUBLIC SAFETY ACCESS POINTS AND EMS MAY NEED TO BUILD POLICIES TO TAKE INTO STRONG CONSIDERATION THE PATIENTS' MEDICAL INFORMATION AND PATIENTS' MEDICAL NEEDS PROVIDED BY THE TREATING DOCTOR WHO ACTIVATES THE 911 EMERGENCY ON BEHALF OF A PATIENT**; AND BE IT FURTHER**

RESOLVED, THAT ACEP WORK WITH RELEVANT STAKEHOLDERS TO FACILITATE THE PROCESS OF EMERGENCY MEDICAL DISPATCHER PROCESSING OF CALLS ORIGINATED BY MEDICAL PROFESSIONALS – ESPECIALLY BY THOSE UTILIZING TELEHEALTH TECHNOLOGIES.

AMENDED RESOLUTION 26

RESOLVED, THAT ACEP REAFFIRM THE IMPORTANCE OF RECOGNIZING AND ADDRESSING THE SOCIAL DETERMINANTS OF HEALTH, INCLUDING SYSTEMIC RACISM **AS IT PERTAINS TO EMERGENCY CARE**; AND BE IT FURTHER

RESOLVED, THAT ACEP CONTINUE TO EXPLORE MODELS OF HEALTH CARE THAT WOULD MAKE EQUITABLE HEALTH CARE ACCESSIBLE TO ALL; AND BE IT FURTHER

RESOLVED, THAT ACEP CONTINUE TO USE ITS VOICE AS AN ORGANIZATION AND SUPPORT ITS MEMBERS WHO SEEK TO ~~DISMANTLE~~ **REFORM DISCRIMINATORY** SYSTEMS ~~OF DISCRIMINATION~~ AND ADVOCATE FOR POLICES PROMOTING THE SOCIAL DETERMINANTS OF HEALTH WITHIN HISTORICALLY DISENFRANCHISED COMMUNITIES AT AN INSTITUTIONAL, LOCAL, STATE, AND NATIONAL LEVEL.

AMENDED RESOLUTION 30

~~RESOLVED, THAT ACEP ESTABLISH POLICY THAT REQUIRES ALL EMPLOYERS, PERSONS, OR ENTITIES WHO CONTRACT FOR EMERGENCY PHYSICIAN SERVICES (WHETHER IN-PERSON OR VIA TELEHEALTH) TO PROVIDE ITEMIZED BILLING AND COLLECTION INFORMATION ON A MONTHLY BASIS TO THE EMERGENCY PHYSICIAN FOR ALL CHARGES BILLED AND ALL COLLECTIONS MADE UNDER THE PHYSICIAN'S NAME, LICENSE NUMBER, OR OTHER IDENTIFYING INFORMATION WITHOUT THE PHYSICIAN HAVING TO REQUEST IT; AND BE IT FURTHER~~

RESOLVED, THAT ACEP ESTABLISH POLICY THAT ~~REQUIRES~~ **ENCOURAGES** ALL EMPLOYERS, PERSONS OR ENTITIES WHO CONTRACT FOR EMERGENCY PHYSICIAN SERVICES TO PROVIDE INFORMATION ON A ~~MONTHLY~~ **SEMI-ANNUAL** BASIS TO **NON-FEDERAL** PHYSICIANS FOR ANY AND ALL COMPENSATION OR BENEFIT, CASH, AND PAYMENT-IN-KIND, RECEIVED BY THE EMPLOYER OR CONTRACT MANAGEMENT GROUP (CMG) AS A RESULT OF THE PHYSICIAN PROVIDING HIS OR HER SERVICES WITHOUT ANY REQUIREMENT OF THE PHYSICIAN REQUESTING IT.

AMENDED RESOLUTION 31

RESOLVED, **THAT** ACEP ESTABLISH POLICY ~~THAT~~ ADVOCAT~~ES~~**ING** FOR LEGISLATION REQUIRING ~~POLICY WEAKNESS DISCLOSURES *(PWD) BE PROVIDED BY~~ HEALTH INSURERS TO **PROVIDE WRITTEN DISCLOSURES TO** POTENTIAL CUSTOMERS **EXPLAINING THE POLICY AND POTENTIAL SHORTFALLS WHERE CUSTOMERS WOULD BE FINANCIALLY RESPONSIBLE,** BEFORE THEY COULD RECEIVE ANY BENEFIT AND AT THE TIME OF SALE OF ANY HEALTHCARE POLICY ~~THAT SPECIFICALLY EXPLAINS THE POLICY THAT THEY ARE SELLING WITH SPECIFIC EXAMPLES OF "WORSE CASE SCENARIOS" (INCLUDING HYPOTHETICAL EMERGENCY DEPARTMENT VISITS RESULTING IN $10,000 OUTPATIENT VISIT AND $200,000 HOSPITALIZATION WITH OUT-OF-NETWORK EMERGENCY PHYSICIANS, ANESTHESIOLOGISTS, RADIOLOGISTS, TELEHEALTH PHYSICIAN AND NON-PHYSICIAN PROVIDERS, EXCLUDED SERVICES, CO-PAYS, DEDUCTIBLES, ETC., TO HELP THE PUBLIC UNDERSTAND THE POTENTIAL RISKS OF BUYING A PARTICULAR INSURANCE POLICY THAT ACTUALLY CAN AND DO OCCUR~~; AND BE IT FURTHER

RESOLVED, THAT ACEP SUPPORT LEGISLATION IMPOSING PENALTIES ON INSURERS WHO DO NOT PROVIDE ~~POLICY WEAKNESS DISCLOSURES~~ **WRITTEN DISCLOSURES EXPLAINING THE POLICY AND POTENTIAL SHORTFALLS WHERE CUSTOMERS WOULD BE FINANCIALLY RESPONSIBLE** TO POLICYHOLDERS AS REQUIRED, I.E., BEFORE THEY PURCHASE THE POLICY THAT INCLUDE REQUIRING THE INSURER TO COVER 100% OF ALL CHARGES WITHOUT DEDUCTIBLE, CO-PAY, EXCLUSIONS, ETC.

The committee recommended that Amended Resolution 27 be adopted.

It was moved THAT AMENDED RESOLUTION 27 BE ADOPTED:

RESOLVED, THAT ACEP REAFFIRM THE GOLD STANDARD FOR EMERGENCY MEDICINE TRAINING IS, AND MUST REMAIN, THE COMPLETION OF AN ACGME ACCREDITED EMERGENCY MEDICINE RESIDENCY TRAINING PROGRAM AND BOARD CERTIFICATION BY ABEM OR ABOEM; AND BE IT FURTHER

RESOLVED, THAT ACEP RECOGNIZE THE VALUABLE CONTRIBUTION OF NPS AND PAS WITHIN A PHYSICIAN-LED TEAM IN THE EMERGENCY DEPARTMENT AND THAT ANY DEVELOPMENT OF NP/PA POST-GRADUATE TRAINING PROGRAMS MUST BE DONE WITH APPROVAL OF THE EMERGENCY DEPARTMENT LEADERSHIP; AND BE IT FURTHER

RESOLVED, THAT ACEP **WORK WITH RELEVANT STAKEHOLDERS TO CLARIFY NON-PHYSICIAN POST-GRADUATE TITLE TERMINOLOGY, AND** ADVOCATE **FOR ALTERNATIVE TERMINOLOGY** ~~AGAINST THE USE OF~~ **REPLACING** THE ~~UNQUALIFIED~~ TERMS "RESIDENT" AND "RESIDENCY" AND "FELLOW" AND "FELLOWSHIP" IN CONJUNCTION WITH**, BUT NOT LIMITED, TO** NURSE PRACTITIONER**S** (NP) AND PHYSICIAN ASSISTANT**S** (PA) ~~POSTGRADUATE TRAINING PROGRAMS TITLES AS THEY ARE~~ **AS THEIR TRAINING IS** NOT EQUIVALENT TO THE TRAINING UNDERTAKEN BY PHYSICIANS IN AN ACGME ACCREDITED EMERGENCY MEDICINE RESIDENCY AND FELLOWSHIP PROGRAMS; ~~WHEN USED IN THE EMERGENCY MEDICINE CLINICAL SETTING TO CONNOTE A PHYSICIAN WITH ACCEPTANCE, ENROLLMENT, AND PARTICIPATION IN AN APPROVED ALLOPATHIC, OSTEOPATHIC, DENTISTRY, OR PODIATRY RESIDENCY (OR FELLOWSHIP) PROGRAM~~; AND BE IT FURTHER

~~RESOLVED, THAT ACEP RECOGNIZES THE GOLD STANDARD FOR EMERGENCY MEDICINE TRAINING IS, AND MUST REMAIN, THE COMPLETION OF AN AMERICAN BOARD OF EMERGENCY MEDICINE OR AMERICAN OSTEOPATHIC BOARD OF EMERGENCY MEDICINE ACCREDITED PHYSICIAN RESIDENCY PROGRAM.~~

RESOLVED, THAT ACEP CREATE A "DEFINITION OF EMERGENCY MEDICINE RESIDENCY" POLICY STATEMENT.

It was moved THAT AMENDED RESOLUTION 27 BE REFERRED TO THE BOARD OF DIRECTORS. The motion was not adopted.

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

It was moved THAT RESOLVEDS TWO THROUGH 4 OF AMENDED RESOLUTION 27 BE REFERRED TO THE BOARD OF DIRECTORS. The motion was not adopted.

It was moved THAT RESOLVEDS TWO THROUGH 4 OF AMENDED RESOLUTION 27 BE ADOPTED. The motion was adopted.

The committee recommended that the first two resolveds of Amended Resolution 29 be adopted.

It was moved THAT FIRST TWO RESOLVEDS OF AMENDED RESOLUTION 29 BE ADOPTED:

RESOLVED, THAT ACEP MODIFY THE EXISTING POLICY STATEMENT "EMERGENCY PHYSICIAN CONTRACTUAL RELATIONSHIPS" THROUGH DELETION AND SUBSTITUTION AS FOLLOWS: "THE EMERGENCY PHYSICIAN ~~SHALL~~ **IS ENTITLED TO** ~~RECEIVE~~ **DETAILED ITEMIZED REPORTS ON** ~~HAVE THE RIGHT TO REVIEW~~ WHAT IS BILLED AND COLLECTED FOR HIS OR HER SERVICE **ON A SEMI-ANNUAL BASIS** ~~AT LEAST A MONTHLY BASIS~~ REGARDLESS OF WHETHER OR NOT BILLING AND COLLECTION IS ASSIGNED TO ANOTHER ENTITY WITHIN THE LIMITS OF STATE AND FEDERAL LAW. **THE EMERGENCY PHYSICIAN SHALL NOT BE ASKED TO WAIVE ACCESS TO THIS INFORMATION**."; AND BE IT FURTHER

RESOLVED, THAT ACEP MODIFY THE EXISTING POLICY STATEMENT "EMERGENCY PHYSICIAN RIGHTS AND RESPONSIBILITIES" THROUGH DELETION AND SUBSTITUTION AS FOLLOWS: "5. EMERGENCY PHYSICIANS ~~SHALL~~ **ARE ENTITLED TO** ~~BE PROVIDED~~ ~~PERIODIC~~ **DETAILED ITEMIZED** REPORTS OF BILLINGS AND COLLECTIONS IN THEIR NAME ~~ON AT LEAST A MONTHLY BASIS~~ **ON A SEMI-ANNUAL BASIS** AND HAVE THE RIGHT TO AUDIT SUCH BILLINGS **AT ANY TIME**, WITHOUT RETRIBUTION. **THE EMERGENCY PHYSICIAN SHALL NOT BE ASKED TO WAIVE ACCESS TO THIS INFORMATION**."; AND BE IT FURTHER

It was moved THAT THE FIRST TWO RESOLVEDS OF AMENDED RESOLUTION 29 BE REFERRED TO THE BOARD OF DIRECTORS. The motion was not adopted.

The main motion was then voted on and adopted.

It was moved THAT THE LAST THREE RESOLVEDS OF AMENDED RESOLUTION 29 BE REFERRED TO THE BOARD OF DIRECTORS:

RESOLVED, THAT ACEP ADOPT AS POLICY THAT: "NO MEMBER OF ACEP WILL, DIRECTLY OR INDIRECTLY, DENY ANOTHER EMERGENCY PHYSICIAN THE ABILITY TO RECEIVE DETAILED ITEMIZED BILLING AND REMITTANCE INFORMATION FOR MEDICAL SERVICES THEY PROVIDE."; AND BE IT FURTHER

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

RESOLVED, THAT ACEP ADOPT THIS POLICY: "ANY ENTITY THAT WISHES TO ADVERTISE IN ACEP VEHICLES, EXHIBIT AT ITS MEETINGS, PROVIDE SPONSORSHIP, OTHER SUPPORT OR OTHERWISE BE ASSOCIATED WITH ACEP WILL AS OF JANUARY 1, 2021, PROVIDE EVERY EMERGENCY PHYSICIAN ASSOCIATED WITH THAT ENTITY, AT A MINIMUM, A MONTHLY STATEMENT WITH DETAILED INFORMATION ON WHAT HAS BEEN BILLED AND COLLECTED IN THE PHYSICIAN'S NAME. THIS INFORMATION MUST BE PROVIDED WITHOUT THE NEED FOR THE PHYSICIAN TO REQUEST IT. PHYSICIANS CANNOT BE ASKED TO WAIVE ACCESS TO THIS INFORMATION. THE ENTITIES AFFECTED INCLUDE BUT IS NOT LIMITED TO REVENUE CYCLE MANAGEMENT COMPANIES, PHYSICIAN GROUPS, HOSPITALS, AND STAFFING COMPANIES." The motion was adopted.

The committee recommended that Resolution 32 not be adopted.

It was moved THAT RESOLUTION 32 BE ADOPTED. The motion was not adopted.

The committee recommended that Resolution 33 not be adopted.

It was moved THAT THE FIRST RESOLVED OF RESOLUTION 33 BE ADOPTED. The motion was not adopted.

It was moved THAT THE SECOND AND THIRD RESOLVEDS OF RESOLUTION 33 BE ADOPTED. The motion was not adopted.

The committee recommended that Substitute Resolution 36 be referred to the Board of Directors in lieu of Resolutions 36 and 37.

It was moved THAT SUBSTITUTE RESOLUTION 36 BE ADOPTED IN LIEU OF RESOLUTIONS 36 AND 37:

RESOLVED, THAT ACEP SUPPORT LEGISLATION TO ~~MAKE THE CMS WAIVERS THAT WERE ALLOWED DURING THE COVID-19 DECLARED EMERGENCY RELATED TO TELEHEALTH PERMANENT, I.E.,~~ ALLOW PATIENTS TO BE AT ANY LOCATION, ALLOW EMERGENCY MEDICINE PHYSICIANS OR OTHER CLINICIANS THAT ARE SUPERVISED BY EMERGENCY MEDICINE PHYSICIANS, TO BE AT ANY LOCATION, SAME OR DIFFERENT THAN THE PATIENT, ALLOW WAIVING OF COST SHARING, ALLOW CODING USING ANY CODE THAT REFLECTS THE SERVICE PROVIDED; AND BE IT FURTHER,

RESOLVED, THAT ACEP SUPPORT LEGISLATION MANDATING ALL PAYERS TO ALLOW PATIENTS TO SELECT THE PHYSICIAN OF THEIR CHOICE, WHETHER EMPLOYED, WITHIN THE HEALTH INSURER'S NETWORK, OR OUTSIDE OF INSURER'S NETWORK, WITHOUT RESTRICTION, TO PROVIDE TELEHEALTH SERVICES FOR ACUTE UNSCHEDULED CARE TO ANY OR ALL THEIR INSURED PATIENTS; AND BE IT FURTHER

~~RESOLVED, THAT ACEP SUPPORT LEGISLATION REQUIRING ALL PAYERS TO PAY PARITY TO PHYSICIAN AND NON-PHYSICIAN HEALTH PROVIDERS FOR TELEHEALTH SERVICES AS~~

~~WOULD BE PAID FOR IN-PERSON SERVICES FOR APPROPRIATE OR EQUIVALENT CARE; AND BE IT FURTHER~~

~~RESOLVED, THAT ACEP SUPPORT PENALTIES TO INSURERS FOR INTENTIONAL ACTIONS, RULES OR POLICY THAT LIMIT, RESTRICT, DELAY, DENY OR PREVENT ACCESS TO NECESSARY ACUTE UNSCHEDULED CARE OR SERVICES FROM THE PHYSICIAN OR NON-PHYSICIAN PROVIDER OF THE PATIENT'S CHOICE IN AN APPROPRIATE TIME PERIOD AS DETERMINED BY PHYSICIANS IN THAT REGION, OR NATIONAL DETERMINED STANDARD OR IN THE PAYMENT TO THE PRACTITIONER FOR THE CARE OR SERVICES PROVIDED.~~

RESOLVED, THAT ACEP ADVANCE THE RESPONSIBLE IMPLEMENTATION OF TELEHEALTH PRACTICE CONSISTENT WITH POLICIES AND GUIDELINES PREVIOUSLY DEVELOPED BY ACEP, THE AMERICAN MEDICAL ASSOCIATION, AND SPECIALTY-SPECIFIC BEST PRACTICES AS WELL AS ONGOING ASSESSMENT OF PATIENT OUTCOMES, PHYSICIAN-PATIENT RELATIONSHIP, AND COST; AND BE IT FURTHER

RESOLVED, THAT ACEP, IN COLLABORATION WITH OTHER MEDICAL ORGANIZATIONS, ADVOCATE FOR STATE AND FEDERAL LEGISLATION THAT SUPPORTS MEDICAID, MEDICARE, AND PRIVATE PAYER REIMBURSEMENT AND COVERAGE PARITY FOR LIVE VIDEO PHYSICIAN TELEHEALTH VISITS AS WELL AS FAIR REIMBURSEMENT OF ANCILLARY TELEHEALTH SERVICES SUCH AS REMOTE PATIENT MONITORING, ECONSULTS, AND STORE AND FORWARD TECHNOLOGY; AND BE IT FURTHER

RESOLVED, THAT ACEP OPPOSE RESTRICTIONS TO TELE-HEALTH CARE UNLESS THOSE RESTRICTIONS ARE CONSISTENT WITH ESTABLISHED BEST PRACTICES, CONFIDENTIALITY, OR PATIENT SAFETY PROTECTIONS.

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

The committee recommended that Resolution 39 not be adopted.

It was moved THAT RESOLUTION 39 BE ADOPTED.

It was moved THAT RESOLUTION 39 BE REFERRED TO THE BOARD OF DIRECTORS. The motion was not adopted.

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

REFERENCE COMMITTEE C

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

The committee recommended the following resolutions by unanimous consent:

For adoption: Amended Resolution 41, Amended Resolution 42, Amended Resolution 43, Amended Resolution 44 (first and second resolveds), Amended Resolution 47, Substitute Resolution 49 (in lieu of Resolutions 28 and 49), Resolution 50, Resolution 51, and Amended Resolution 52.

Not for adoption: Resolution 40 and Resolution 46.

For referral: Amended Resolution 44 (third resolved), Amended Resolution 45, and Resolution 48.

Amended Resolution 41, Amended Resolution 44, Amended Resolution 45, Resolution 46, Amended Resolution 47, Amended Resolution 48, Substitute Resolution 49, and Amended Resolution 52 were extracted.

<u>AMENDED RESOLUTION 42</u>

RESOLVED, THAT ACEP DEVELOP POLICY STATEMENTS TO ADDRESS:

1) THE IMPLICATIONS ~~FOR EMERGENCY PHYSICIANS~~ OF INADEQUATE PERSONAL PROTECTIVE EQUIPMENT **<u>FOR EMERGENCY PHYSICIANS</u>**;
2) ~~CONFLICTS WITH HOSPITALS AND PRACTICE ORGANIZATIONS ON THE USE OF SELF-~~

~~PURCHASED PERSONAL PROTECTIVE EQUIPMENT;~~

3) **THE CARE OF PATIENTS UNDER** CRISIS TREATMENT STANDARDS; AND
4) THE PROPORTIONALITY OF RESPONSES BY HOSPITALS AND PRACTICE ORGANIZATIONS TOWARD EMERGENCY PHYSICIANS' compensation or benefits during times of pandemic illness or other similar events.

AMENDED RESOLUTION 43

RESOLVED, THAT ACEP PROMOTE TRANSPARENCY IN INSTITUTIONAL DATA TO BETTER IDENTIFY DISPARITIES AND BIASES IN MEDICAL CARE; AND BE IT FURTHER

RESOLVED, THAT ACEP CONTINUE TO ENCOURAGE COMPLIANCE WITH TRAINING TO COMBAT DISCRIMINATION FOR ALL CLINICIANS; AND BE IT FURTHER

RESOLVED, THAT ACEP CONTINUE TO EXPLORE FRAMEWORKS FOR INTEGRATING ANTI-DISCRIMINATION INTO OUR EMERGENCY DEPARTMENTS AND INSTITUTIONS AT ALL LEVELS INCLUDING, BUT NOT LIMITED TO, PATIENTS, FAMILIES, MEDICAL STUDENTS, STAFF, TRAINEES, STAFF PHYSICIANS, ADMINISTRATION, AND OTHER STAKEHOLDERS.

The committee recommended that Amended Resolution 41 be adopted.

It was moved THAT AMENDED RESOLUTION 41 BE ADOPTED:

RESOLVED, THAT ACEP ~~ESTABLISH A NEW POLICY THAT IN THE EVENT ANY HOSPITAL FAILS TO PROVIDE ADEQUATE PERSONAL PROTECTION EQUIPMENT IN TERMS OF QUANTITY, PARTICULAR TYPE. AND QUALITY, TO ITS EMERGENCY WORKERS THE EMPLOYER OR STAFFING COMPANY IS RESPONSIBLE AND WILL IMMEDIATELY SUPPLY APPROPRIATE AND ADEQUATE PERSONAL PROTECTION EQUIPMENT FOR THE PHYSICIANS AND NON-PHYSICIANS STAFFING THE EMERGENCY DEPARTMENT AND OTHER SITES;~~ **WORK WITH RELEVANT STAKEHOLDER ORGANIZATIONS TO ESTABLISH APPROPRIATE MINIMUM STANDARDS AND REGULATIONS APPLICABLE TO HOSPITALS FOR THE READILY ACCESSIBLE STORAGE OF APPROPRIATE LEVELS OF PERSONAL PROTECTIONS EQUIPMENT FOR ALL WORKERS AT THE FACILITY, AND TO STRENGTHEN PENALTIES FOR VIOLATION FOR SUCH REGULATIONS**; AND BE IT FURTHER

RESOLVED, THAT ACEP WORK WITH RELEVANT STAKEHOLDERS TO ESTABLISH OR STRENGTHEN WHISTLEBLOWER PROTECTIONS WHO IN GOOD FAITH REPORT DEFICIENCIES IN THE QUANTITY OR QUALITY OF PERSONAL PROTECTIVE EQUIPMENT (PPE) MADE AVAILABLE TO THEM FOR THE PURPOSES OF CARING FOR PATIENTS; AND BE IT FURTHER

RESOLVED, THAT ACEP ESTABLISH A NEW POLICY SUPPORTING EMERGENCY PHYSICIANS AND OTHER EMERGENCY WORKERS PROVIDING THEIR OWN PERSONAL PROTECTION EQUIPMENT WITHOUT ANY PENALTY OF ANY KIND IF ~~THE HOSPITAL OR OTHER "EMPLOYER" (STAFFING COMPANY) FAILS TO PROVIDE~~ ADEQUATE AND SUFFICIENT PERSONAL PROTECTION EQUIPMENT TO BE USED AS INTENDED BY THE MANUFACTURER OF THE PERSONAL PROTECTION EQUIPMENT **IS NOT PROVIDED**.

It was moved THAT AMENDED RESOLUTION 41 BE REFERRED TO THE BOARD OF DIRECTORS. The motion was not adopted.

The main motion was then voted on and adopted.

The committee recommended that the first resolved of Amended Resolution 44 be adopted.

It was moved THAT THE FIRST RESOLVED OF AMENDED RESOLUTION 44 BE ADOPTED:

RESOLVED, THAT ACEP ADOPT THIS POLICY; "NO MEMBER OF ACEP WILL, DIRECTLY OR INDIRECTLY, DENY ANOTHER EMERGENCY PHYSICIAN THE RIGHT TO DUE PROCESS REGARDING THEIR MEDICAL STAFF PRIVILEGES AND ABILITY TO SEE PATIENTS IN AN EMERGENCY DEPARTMENT. NO MEMBER OF ACEP WILL HOLD A MANAGEMENT POSITION

WITH ANY ENTITY THAT DENIES AN EMERGENCY PHYSICIAN OF THIS RIGHT."; AND BE IT FURTHER

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

The committee recommended that the second resolved of Amended Resolution 44 be adopted.

It was moved THAT THE SECOND RESOLVED OF AMENDED RESOLUTION 44 BE ADOPTED:

RESOLVED, THAT ACEP MODIFY THE EXISTING POLICY STATEMENT "EMERGENCY PHYSICIAN RIGHTS AND RESPONSIBILITIES" THROUGH DELETION AND SUBSTITUTION AS FOLLOWS: "6. EMERGENCY PHYSICIANS ~~SHOULD BE ACCORDED~~ **ARE ENTITLED TO** DUE PROCESS BEFORE ANY ADVERSE FINAL ACTION WITH RESPECT TO EMPLOYMENT OR CONTRACT STATUS, THE EFFECT OF WHICH WOULD BE THE LOSS OR LIMITATION OF MEDICAL STAFF PRIVILEGES. EMERGENCY PHYSICIANS' MEDICAL AND/OR CLINICAL STAFF PRIVILEGES SHOULD NOT BE REDUCED, TERMINATED, OR OTHERWISE RESTRICTED EXCEPT FOR GROUNDS RELATED TO THEIR COMPETENCY, HEALTH STATUS, LIMITS PLACED BY PROFESSIONAL PRACTICE BOARDS OR STATE LAW. 7. EMERGENCY PHYSICIANS WHO PRACTICE PURSUANT TO AN EXCLUSIVE CONTRACT ARRANGEMENT SHOULD NOT BE REQUIRED TO WAIVE THEIR INDIVIDUAL MEDICAL STAFF DUE PROCESS RIGHTS AS A CONDITION OF PRACTICE OPPORTUNITY OR PRIVILEGES."; AND BE IT FURTHER

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

The committee recommended that the third resolved of Amended Resolution 44 be referred to the Board of Directors.

It was moved THAT THE THIRD RESOLVED OF AMENDED RESOLUTION 44 BE ADOPTED:

RESOLVED, THAT ACEP ADOPT THIS POLICY: "ANY ENTITY THAT WISHES TO ADVERTISE IN ACEP VEHICLES, EXHIBIT AT ITS MEETINGS, PROVIDE SPONSORSHIP, OTHER SUPPORT OR OTHERWISE BE ASSOCIATED WITH THE ACEP WILL AS OF JANUARY 1, 2021 SHALL REMOVE ALL RESTRICTIONS ON DUE PROCESS FOR EMERGENCY PHYSICIANS. PHYSICIANS CANNOT BE ASKED TO WAIVE THIS RIGHT AS IT CAN BE DETRIMENTAL TO THE QUALITY AND SAFETY OF PATIENT CARE. THE ENTITIES AFFECTED INCLUDE BUT IS NOT LIMITED TO PHYSICIAN GROUPS, HOSPITALS, AND STAFFING COMPANIES."

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

It was moved THAT THE COUNCIL RECONSIDER RESOLUTION 39. The motion was not adopted.

The committee recommended that Amended Resolution 45 be referred to the Board of Directors.

It was moved THAT AMENDED RESOLUTION 45 BE ADOPTED.

It was moved THAT AMENDED RESOLUTION 45 BE REFERRED TO THE BOARD OF DIRECTORS. The motion was adopted.

The committee recommended that Resolution 46 not be adopted.

It was moved THAT RESOLUTION 46 BE ADOPTED. The motion was not adopted.

The committee recommended that Amended Resolution 47 be adopted.

It was moved THAT AMENDED RESOLUTION 47 BE ADOPTED:

RESOLVED, THAT ACEP PARTNER WITH THE EMERGENCY MEDICINE RESIDENTS' ASSOCIATION TO ENCOURAGE ALL EMPLOYERS TO HONOR THEIR EMPLOYMENT CONTRACTS WITH GRADUATING EMERGENCY MEDICINE RESIDENT **AND FELLOW** PHYSICIANS. The motion was adopted.

The committee recommended that Resolution 48 be referred to the Board of Directors.

It was moved THAT RESOLUTION 48 BE ADOPTED.

It was moved THAT RESOLUTION 48 BE REFERRED TO THE BOARD OF DIRECTORS. The motion was adopted.

It was moved THAT THE COUNCIL RECONSIDER AMENDED RESOLUTION 41. The motion was not adopted.

The committee recommended that Substitute Resolution 49 be adopted in lieu of Resolutions 28 and 49.

It was moved THAT SUBSTITUTE RESOLUTION 49 BE ADOPTED IN LIEU OF RESOLUTIONS 28 AND 49:

RESOLVED, THAT THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS (ACEP) ACKNOWLEDGES THE HAZARD ASSOCIATED WITH AIR-CHOKE HOLDS, STRANGULATION AND CAROTID RESTRAINT; AND BE IT FURTHER

RESOLVED, THAT ACEP EDUCATE ITS MEMBERS AND RELEVANT STAKEHOLDERS ON THE HAZARDS AND THE RECOGNITION AND APPROPRIATE MANAGEMENT OF PATIENTS WHO PRESENT TO THE EMERGENCY DEPARTMENT WITH INJURIES ASSOCIATED WITH AIR-CHOKE HOLDS, STRANGULATION AND CAROTID RESTRAINT MANEUVERS IN VARIOUS SETTINGS. The motion was adopted.

The committee recommended that Amended Resolution 52 be adopted.

It was moved THAT AMENDED RESOLTUION 52 BE ADOPTED:

RESOLVED, THAT ACEP WILL PREPARE A COMPREHENSIVE REVIEW OF THE LEGAL AND REGULATORY MATTERS RELATED TO THE CORPORATE PRACTICE OF MEDICINE AND FEE SPLITTING IN EACH STATE AND THE RESULTS OF THIS REVIEW WILL BE COMPILED INTO A RESOURCE AND ANNOUNCED TO MEMBERS AS AN AVAILABLE ELECTRONIC DOWNLOAD; AND BE IT FURTHER

RESOLVED, THAT ACEP ADOPT AS POLICY: "~~THE~~ ACEP, IN CONCERT WITH ITS RELEVANT COMPONENT STATE CHAPTER, IN THOSE STATES WHERE THERE ARE EXISTING PROHIBITIONS ON THE CORPORATE PRACTICE OF MEDICINE, WILL PROVIDE ASSISTANCE TO PHYSICIAN OWNED GROUPS WHO ARE THREATENED WITH CONTRACT LOSS TO A CORPORATE ENTITY OR TO HOSPITAL EMPLOYED PHYSICIANS WHOSE SITE WILL BE TAKEN OVER BY A CORPORATE ENTITY BY PROVIDING, UPON REQUEST, A WRITTEN REVIEW OF THE LEGALITY OF THE CORPORATION OBTAINING THE CONTRACT FOR EMERGENCY SERVICES."; AND BE IT FURTHER

RESOLVED, THAT ACEP, IN THOSE STATES THAT ARE FOUND TO HAVE EXISTING PROHIBITIONS ON THE CORPORATE PRACTICE OF MEDICINE, ALONG WITH THE RELEVANT STATE CHAPTER, WILL PETITION THE APPROPRIATE AUTHORITIES IN THAT STATE TO EXAMINE THE CORPORATE PRACTICE OF EMERGENCY MEDICINE IF SUCH IS BELIEVED TO OCCUR WITHIN THAT STATE AND ACEP WILL REACH OUT TO THE STATE PROFESSIONAL SOCIETIES ~~OF ANESTHESIA AND RADIOLOGY~~ **AS APPROPRIATE** IN THIS EFFORT AND SOLICIT THE SUPPORT OF THE STATE MEDICAL SOCIETY; AND BE IT FURTHER

RESOLVED, THAT ACEP WILL **WORK WITH THE AMERICAN MEDICAL ASSOCIATION TO** CONVENE A MEETING WITH REPRESENTATIVES OF PHYSICIAN PROFESSIONAL ASSOCIATIONS REPRESENTING SPECIALTIES **AND OTHER STAKEHOLDERS** AFFECTED BY ~~PRIVATE EQUITY AND OTHER LAY INFLUENCE INVOLVEMENT TO EXAMINE JOINT EFFORTS TO COMBAT~~ THE CORPORATE ~~CONTROL~~ **PRACTICE** OF MEDICINE ~~BY LAY~~

~~ENTITIES~~, **TO ENSURE THE AUTONOMY OF PHYSICIAN OWNED GROUPS OR HOSPITAL EMPLOYED PHYSICIANS CONTRACTING WITH CORPORATELY-OWNED MANAGEMENT SERVICE ORGANIZATIONS**.

It was moved THAT AMENDED RESOLTUION 52 BE REFERRED TO THE BOARD OF DIRECTORS. The motion was adopted.

****

Dr. Katz reviewed the procedure for the adoption of the 2020 commendation resolutions. He then read the resolveds of the commendation resolutions for Stephen H. Anderson, MD, FACEP; James J. Augustine, MD, FACEP; Jon Mark Hirshon, MD, MPH, PhD, FACEP; Janyce M. Sanford, MD, MBA, FACEP; and Dean Wilkerson, JD, MBA, CAE. The Council adopted the commendation resolutions by acclamation.

ACEP President Mark S. Rosenberg, DO, FACEP, addressed the Council.

Dr. Thompson reported that 434 councillors of the 443 eligible for seating had been credentialed in the LUMI virtual meeting platform.

The Board of Directors elections were conducted through the LUMI platform. Dr. Shoemaker and Dr. Venkat were elected to a three-year term. Dr. Haddock and Dr. Terry were re-elected to a three-year term each.

The president-elect elections were conducted through the LUMI platform. Dr. Schmitz was elected.

There being no further business, Dr. Katz adjourned the 2020 Council meeting at 4:47 pm on Sunday, October 25, 2020. The next meeting of the ACEP Council is scheduled for October 23-24, 2020, at the Westin Boston Waterfront Hotel in Boston, MA.

Respectfully submitted,

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

Approved by,

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

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Steering Committee Conference Call
January 26, 2021

Minutes

Speaker Gary Katz, MD, FACEP, called to order a conference call meeting of the Council Steering Committee of the American College of Emergency Physicians at 8:05 am Central time on Tuesday, January 26, 2021.

Steering Committee members present for all or portions of the meeting were: Eileen Baker, MD, FACEP; Lisa Bundy, MD, FACEP; Angela Cornelius, MD, FACEP; Carrie de Moor, MD, FACEP; Hilary Fairbrother, MD, FACEP; Kelly Gray-Eurom, MD, FACEP, vice speaker; William Falco, MD, FACEP; Gary Katz, MD, FACEP, speaker; Steven Kailes, MD, FACEP; Rami Khoury, MD, FACEP; Kurtis Mayz, MD, FACEP; Kristin McCabe-Kline, MD, FACEP; Christina Millhouse, MD, FACEP; James Mullen, MD, FACEP; Randy Pilgrim, MD, FACEP; Larisa Traill, MD, FACEP; and Ashley Tarchione, MD.

Other members and guests present for all or portions of the meeting were: L. Anthony Cirillo, MD, FACEP; Melissa Costello, MD, FACEP; J.T. Finnell, MD, FACEP; Alison Haddock, MD, FACEP, vice president; Christopher Kang, MD, FACEP, chair of the Board; Gabor Kelen, MD, FACEP; Mark Rosenberg, DO, FACEP, president; Gillian Schmitz, MD, FACEP, president-elect; James Shoemaker, MD, FACEP; Ryan Stanton, MD, FACEP; and Arvind Venkat, MD, FACEP.

Staff present for all or portions of the meeting were: Mary Ellen Fletcher, CPC, CEDC; Pawan Goyal, MD, MHA, FHIMSS; Maude Suprenant Hancock; Robert Heard, MBA, CAE; Mari Houlihan; David McKenzie, CAE; Harry Monroe; Margaret Montgomery, RN; Sonja Montgomery, CAE; Leslie Moore, JD; Sandy Schneider, MD, FACEP; Susan Sedory, MA, CAE; Carole Wollard; and Laura Wooster, MPH.

Officer and Staff Reports
Speaker

Dr. Katz welcomed everyone and thanked them for their participation and commitment to the College. He reminded everyone of the "Conflict of Interest" policy statement and to declare any potential conflicts of interest as necessary.

Vice Speaker

Dr. Gray-Eurom reported that she and Dr. Katz have attended the virtual Board of Directors meetings and continue to monitor social media activity for any issues that may be related to Council business and that may need to be addressed by the Steering Committee.

President

Dr. Rosenberg reported on his activities since taking office as president. He and Ms. Sedory have met virtually with 13 chapters to date and plan to meet with all 53 chapters by *ACEP21.* He discussed the committee objectives he has assigned related to COVID-19/Future Pandemics and Health Care Disparities/Health Equity and provided updates on the work of several task forces.

President-Elect

Dr. Schmitz reported on her activities since being elected as president-elect, ACEP's work on the surprise medical billing legislation, her goal to improve communications with members, and combating negative comments about ACEP on social media. She also reported on ACEP's membership models testing.

Executive Director

Ms. Sedory reported on several key initiatives for ACEP: continuing to update COVID-19 resources for members, ACEP's partnership with Pfizer to distribute PSAs on supporting COVID-19 vaccinations; regulatory advocacy work related to surprise medical billing legislation; ACEP held 81 webinars in 2020 that resulted in almost 16,000 registrations; all ACEP in-person meetings have been suspended until July; the Leadership & Advocacy Conference is now scheduled for July 25-27, 2021; plans are underway for *ACEP21* to be held in person and staff are making plans for all possibilities including virtual participation; and 13 chapters are now managed by ACEP.

Steering Committee Expectations

Dr. Katz reminded the Steering Committee of their expectation to attend the April 25, 2021,virtual Steering Committee meeting and the Leadership & Advocacy Conference that has been rescheduled to July 25-27, 2021, in Washington, DC. The Steering Committee will also meet at 6:00 pm on Friday, October 22, 2021, in Boston, the evening prior to the Council meeting. He encouraged communications using the Steering Committee's engagED community.

Councillor Allocation

Dr. Katz reported that councillor allocation for 2021 is 446, which is an increase of three councillors than were allocated for the 2020 meeting. AZ, FL, GS, and NY each gained one councillor. CO and DC each lost one councillor. The new Aerospace Medicine Section has not yet met the minimum membership requirement of 100 members and was not allocated a councillor for the 2021 meeting. All other sections met the minimum membership requirement and will have a councillor for the 20220 Council meeting.

Tellers, Credentials, & Elections Committee Report

Dr. Gray-Eurom presented the report from the Tellers, Credentials, & Elections Committee from the 2020 Council meeting. James M. Thompson, MD, FACEP, served as Chair of the committee. Dr. Thompson worked with staff to verify the number of councillors credentialled in the LUMI platform and to confirm the election results. The entire committee was not needed because the meeting was held virtually. There were 443 councillors allocated for the 2020 meeting and 434 were credentialed. The Air Medical Section and the Cruise Ship Medicine Section were unrepresented. AL, CO, ID, MS, and NY were underrepresented by one councillor and FL was underrepresented by two councillors. Electronic voting was conducted using the LUMI virtual meeting platform. Following the elections, five councillors questioned whether their votes were received and tabulated. Upon investigation it was verified that their votes were received and this confirmation was provided to the councillors. The summary of responses to the demographic questions were provided to the Steering Committee.

2020 Virtual Council Meeting

Dr. Katz and Dr. Gray-Eurom discussed various aspects of the 2020 virtual Council meeting. There were more than 600 participants logged into the LUMI platform and more than 200 watched the live streaming through the platform used for *ACEP20.* There was consensus from the Steering Committee to continue utilizing asynchronous testimony on resolutions submitted for the 2021 Council meeting and to use that testimony in developing preliminary Reference Committee reports prior to the Council meeting. It was noted that changes to the Council Standing Rules will be needed if there is a desire by the Council to continue asynchronous testimony and using preliminary Reference Committee reports as the foundation for the live Reference Committee process.

There were mixed reactions to continuing video reports for the 2021 Council meeting and it was suggested that those invited to give reports be provided the option of presenting in person or in video format. The Steering Committee also discussed the possibility of providing live streaming options for members who would like to participate virtually. It was noted that the costs for live camera feed may be prohibitive and there may be potential legal implications if consent is not given by everyone who appears on camera.

Several topics were suggested for the 2021 Town Hall meeting: emergency medicine workforce, rural emergency medicine, and use of non-physicians in the emergency department. It was also suggested that the demographic survey include a question about emergency medicine group ownership.

The Annual Meeting Subcommittee will review the Council meeting agenda, discuss additional suggestions for the Town Hall meeting topic, review the demographic survey questions, and provide recommendations for the Steering Committee to consider at the April meeting.

Elections Process

Dr. Katz and Dr. Gray-Eurom discussed the campaign and elections process used for the 2020 virtual meeting and the plans to return to the usual in-person format for the 2021 Candidate Forum. Several changes to the Candidate Campaign Rules were identified:

- delete Rule #1 since Board members and Council officers no longer submit written activity reports
- revise Rule #11 to limit campaign messages to text only without graphics or photos
- revise Rule #13b to clarify that video or audio conferencing with sections is permitted
- prohibit active campaigning prior to the official announcement of the slate of candidates by the Nominating Committee
- add the ability for candidates to hold their own virtual town hall meetings
- prohibit chapters and sections from requesting additional written campaign materials from candidate
- specify that all candidates for a particular office are provided the same opportunity to participate.in a section or chapter leadership meeting

The Candidate Forum Subcommittee will review the Candidate Campaign Rules and provide their recommendations for the Steering Committee to consider at the April meeting.

Potential Council Standing Rules Amendments

The Steering Committee did not identify any Council Standing Rules amendments that need to be submitted to the 2021 Council.

Action on Resolutions

Reports summarizing actions taken by the Board of Directors on resolutions adopted at the 2020, 2019, and 2018 Council meetings were provided for review. The reports were assigned to the Annual Meeting Subcommittee for further review.

Subcommittee Appointments

Dr. Katz asked Steering Committee members to notify Ms. Montgomery of their interest in serving on the Annual Meeting Subcommittee and/or the Candidate Forum Subcommittee. Ms. Montgomery will email the objectives and deadlines both subcommittees. The subcommittee reports will be discussed at the April 25, 2021, Steering Committee meeting.

Next Meeting

The next meeting of the Council Steering Committee is scheduled for Sunday, April 25, 2021.

With no further business, the meeting was adjourned at 10:53 am Central time on Tuesday, January 26, 2021.

Respectfully submitted,

Gary R. Katz, MD, MBA, FACEP
Council Speaker and Chair

Kelly Gray-Eurom, MD, MMM, FACEP

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

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Steering Committee Conference Call
April 25, 2021

Minutes

Speaker Gary Katz, MD, FACEP, called to order a conference call meeting of the Council Steering Committee of the American College of Emergency Physicians at 8:05 am Central time on Sunday, April 25, 2021.

Steering Committee members present for all or portions of the meeting were: Eileen Baker, MD, FACEP; Lisa Bundy, MD, FACEP; Angela Cornelius, MD, FACEP; Carrie de Moor, MD, FACEP; Kelly Gray-Eurom, MD, FACEP, vice speaker; William Falco, MD, FACEP; Gary Katz, MD, FACEP, speaker; Rami Khoury, MD, FACEP; Kurtis Mayz, MD, FACEP; Kristin McCabe-Kline, MD, FACEP; Christina Millhouse, MD, FACEP; Michael Ruzek, MD, FACEP; Larisa Traill, MD, FACEP; and Tracy Marko, MD, PhD, MS.

Other members and guests present for all or portions of the meeting were: L. Anthony Cirillo, MD, FACEP; Melissa Costello, MD, FACEP; Jeffrey Goodloe, MD, FACEP; Christopher Kang, MD, FACEP, chair of the Board; Mark Rosenberg, DO, FACEP, president; Gillian Schmitz, MD, FACEP, president-elect; James Shoemaker, MD, FACEP; and Arvind Venkat, MD, FACEP.

Staff present for all or portions of the meeting were: Mary Ellen Fletcher, CPC, CEDC; Sonja Montgomery, CAE; Leslie Moore, JD; Sandy Schneider, MD, FACEP; and Susan Sedory, MA, CAE.

Minutes

The minutes of the January 26, 2021, Steering Committee meeting were approved as written.

Officer and Staff Reports
Speaker

Dr. Katz welcomed everyone and thanked them for their participation and commitment to the College. He reminded everyone of the "Conflict of Interest" policy statement and to declare any potential conflicts of interest as necessary.

Dr. Katz announced the 2021 Council awards recipients:

Council Meritorious Service Award – Sanford Herman, MD, FACEP
Council Teamwork Award – John Bibb, MD, FACEP; Fred Dennis, MD, MBA, FACEP; Eric Ketcham, MD, MBA, FACEP; Alexis LaPietra, DO, FACEP; and Donald Stader, III, MD, FACEP
Council Horizon Award – Hilary Fairbrother, MD, FACEP
Council Champion in Diversity & Inclusion Award – Rebecca Parker, MD, FACEP
Council Curmudgeon Award – David Overton, MD, FACEP

Dr. Katz announced that a Council Forum will be held on July 25, 2021, 1:00 – 3:00 pm, during the Leadership & Advocacy Conference (LAC) in Washington, DC. The Council Forum is an opportunity to learn about the Council and to help members refine any resolutions they are developing and to seek cosponsors. The session occurs the day before the July 26, 2021, submission deadline for resolutions.

Ms. Montgomery reminded everyone that a Steering Committee meeting will not be held during LAC this year.

Vice Speaker

Dr. Gray-Eurom reported that she and Dr. Katz have attended the virtual Board of Directors meetings and continue to monitor issues related to the Council and any that may need to be addressed by the Steering Committee.

President

Dr. Rosenberg provided an update on key initiatives underway and the work of several task forces. He and Ms. Sedory have held virtual meetings with 28 chapters to date and plan to meet with all 53 chapters by *ACEP21.* The structure of these meetings is a Town Hall Forum to discuss issues that are important to each chapter and how national ACEP might be able to provide assistance. The major issues that have emerged are workforce, the future of emergency medicine (expanding the role of emergency medicine, such as telehealth), physician well-being, and nurse staffing. He reported on the committee objectives he has assigned related to COVID-19/Future Pandemics and Health Care Disparities/Health Equity and the Workforce Summit that was held on April 9, 2021. He also reported on the Board's discussions regarding Amended Resolution 58(19) The Role of Private Equity in Emergency Medicine and the consultant's inability to obtain the data that is requested in the resolution. The Board and staff are trying to identify other options to address the resolution.

President-Elect

Dr. Schmitz reported on the Board's approval of the revised policy statements "Emergency Physician Contractual Relationships" and "Emergency Physicians Rights and Responsibilities" based on the language in Amended Resolution 29(20) Billing and Collections Transparency (first two resolveds) and Referred Amended Resolution 44(20) Due Process in Emergency Medicine (second resolved). ACEP has always supported due process and transparency in billing. There are other initiatives in progress to support transparency and to meet the intent of Referred Amended Resolution 52(20) The Corporate Practice of Medicine. She provided additional information regarding the Board's discussion of Amended Resolution 58(19) The Role of Private Equity in Emergency Medicine and difficulty in obtaining the data requested in the resolution. ACEP is looking for other ways to obtain the data.

Executive Director

Ms. Sedory discussed plans for LAC in July and *ACEP21* in Boston. Staff are diligently working to transform education needs to meet the ABEM My EMCert requirements. COVID-19 resources are still being updated; however, the primary focus is now on the Workforce Task Force and follow up initiatives. The workforce report has shown where there are opportunities within emergency medicine. Staff are reviewing all of ACEP's programs to ensure we are focused on the primary needs of members. This process will help guide the budget being prepared for FY 21-22. She reiterated the Board's disappointment in the inability to obtain the data requested in Amended Resolution 58(19) The Role of Private Equity in Emergency Medicine and ACEP's goal of finding other ways to obtain the data.

Annual Meeting Subcommittee

Dr. Mayz presented the subcommittee's report on their assigned objectives. The subcommittee supports the current format of the Town Hall meeting that includes a pro/con debate of various aspects of an issue by high-level speakers/content experts followed by a period of Q & A. The topics suggested at the January Steering Committee meeting were reviewed and the subcommittee recommends the following topics for consideration: emergency medicine workforce (including rural, physician assistants and nurse practitioners in the ED, and the effect of telemedicine) and private equity in emergency medicine. The Council officers will make the final determination about the format, topic, and speakers for this year's Town Hall meeting during the summer.

The subcommittee reviewed the Board's actions on 2018, 2019, and 2020 resolutions and concurred that the actions taken to date are appropriate. The Actions on Resolutions reports will be updated this summer to reflect any additional activity that may have occurred since January 2021. The updated reports will be provided to the Council and will also be available in the Council section of the ACEP Website. Dr. Katz will highlight actions on some of the resolutions during his report to the Council.

The subcommittee reviewed the demographic questions from prior years and concurred that certain demographic questions should be asked every year to analyze changes within the Council. The subcommittee provided suggestions for questions related to COVID-19 and future pandemic response. The final questions will be developed this summer for approval by the Council officers.

The subcommittee reviewed the Council meeting agenda and recommended that video reports be utilized as much as possible, although some reports, such as reports from the president and president-elect, should always be given live. Some members of the subcommittee supported continuing to record the candidate speeches and making them available on demand. It was noted that the Candidate Forum Subcommittee is responsible for recommendations regarding the Candidate Forum and other requirements for candidates. The subcommittee supports continuing the asynchronous testimony process for the 2021 resolutions. Dr. Gray-Eurom explained the enhancements that are in progress for developing a better asynchronous testimony process for this year.

Ms. Sedory updated the committee on the searchable resolution database that is on the website. She explained that additional enhancements have been identified, including a global search function in addition to the ability to search by year.

Ms. Sedory addressed a question about safety protocols for the Council meeting and *ACEP21*. ACEP will follow all guidelines and enhanced safety protocols.

Candidate Forum Subcommittee Report

Dr. Katz presented the subcommittee's report on their assigned objectives. The majority of the subcommittee's objectives will be completed this summer and during the 2021 Council meeting.

The subcommittee provided recommendations for several changes to the Candidate Campaign Rules for the Steering Committee to consider.

It was moved THAT THE STEERING COMMITTEE APPROVE THE REVISED CANDIDATE CAMPAIGN RULES. The motion was adopted.

The subcommittee will hold a call immediately following this meeting to finalize the candidate written questions and to review the assignments for moderators, coordinators, and door monitors. The subcommittee will also meet in Boston on October 22, 2021, 4:30 – 6:00 pm to review the format for the Candidate Forum and to meet with the candidates.

Next Meeting

The next meeting of the Council Steering Committee is scheduled for Friday, October 22, 2021, in Boston, MA.

With no further business, the meeting was adjourned at 9:40 am Central time on Sunday, April 25, 2021.

Respectfully submitted,

Gary R. Katz, MD, MBA, FACEP
Council Speaker and Chair

Kelly Gray-Eurom, MD, MMM, 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.

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

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

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2021 Council Meeting
Reference Committees

Reference Committee A – Governance & Membership
Resolutions 10-24

Michael McCrea, MD, FACEP (OH), Chair
Kathleen Clem, MD, FACEP (FL)
Debra Fletcher, MD, FACEP (LA)
John M. Gallagher, MD, FACEP (KS)
Ken Holbert, MD, FACEP (TN)
Thom Mitchell, MD, FACEP (TN)

Maude Surprenant Hancock
Laura Lang, JD

Reference Committee B – Advocacy & Public Policy
Resolutions 25-41

Ashley Booth-Norse, MD, FACEP (FL), Chair
Erik Blutinger, MD, MSc, (NY)
Paul Kozak, MD, FACEP (AZ)
Catherine Marco, MD, FACEP (OH)
Howard K. Mell, MD, CPE, FACEP (IL)
Thomas J. Sugarman, MD, FACEP (CA)

Jeff Davis
Ryan McBride, MPP

Reference Committee C – Emergency Medicine Practice
Resolutions 42-59

L. Carlos Zapata, MD, FACEP (NY) Chair
Purva Grover, MD, FACEP (OH)
Jonathan Hansen, MD, FACEP (MD)
Jeffrey Linzer, MD, FACEP (GA)
Eric Maur, MD, FACEP (NC)
Sandra Williams, DO, FACEP (TX)

Travis Schulz, MLS, AHIP
Kaeli Vandertulip, MBA, MSLS, AHIP

Reference Committee D – Scope of Practice & Workforce
Resolutions 60-77

Abhi Mehrotra, MD, FACEP (NC) Chair
William Falco, MD, FACEP (WI)
Daniel Freess, MD, FACEP (CT)
Todd Slesinger, MD, FACEP (FL)
Odetolu Odufuye, MD, FACEP (D&I Section)
Scott Pasichow, MD, MPH (YPS)

Adam Krushinskie, MPA
Harry Monroe

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

INTRODUCTION

2021 Annual Council Meeting
Friday Evening, October 22 through Sunday, October 24, 2021
Westin Boston Seaport District Hotel and Boston Convention & Exhibition Center (BCEC)

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 and are for information only.

Only resolutions subsequently adopted by both the Council and the Board of Directors (except for Council Standing Rules resolutions) become official. For those of you who may be new to the Council resolution process, only the RESOLVED sections of the resolutions are considered by the Council. The WHEREAS statements are informational or explanatory only.

Asynchronous testimony on all resolutions assigned to a Reference Committee will open no later than September 23. An announcement with the link to the 2021 resolutions will be posted on the Council engagED as soon as testimony is open. Asynchronous testimony is open to all members. After clicking on the link provided:

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

When commenting please include the following:

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.
4. Please keep your comments 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 Thursday, October 14. Comments from the online testimony will be used to develop the preliminary Reference Committee reports. The preliminary report will be distributed to the Council on Monday, October 18 and will be the starting point for the live Reference Committee debate during the Council meeting in Boston on Saturday, October 23.

Visit the Council Meeting Web site: https://acep.elevate.commpartners.com/ to access all materials and information for the Council meeting. The resolutions and other resource documents for the meeting are located under the "Document Library" tab. You may download and print the entire Council notebook compendium, or individual section tabs from the Table of Contents. You will also find separate compendiums of the Council officer candidates, President-Elect candidates, Board of Directors candidates, and the resolutions. Additional documents may be added to the Council Meeting Web site over the next several days, so please check back if what you need is not currently available.

We are looking forward to seeing everyone in Boston!

Your Council officers,

Gary R. Katz, MD, MBA, FACEP
Speaker

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

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2021 Council Resolutions

Resolution #	Subject/Submitted by	Reference Committee
1	Commendation for Vidor E. Friedman, MD, FACEP *Florida College of Emergency Physicians*	
2	Commendation for William P. Jaquis, MD, MSHQS, FACEP *Maryland Chapter*	
3	Commendation for Gary R. Katz, MD, MBA, FACEP *Ohio Chapter*	
4	Commendation for Margaret M. Montgomery, RN, MSN *Isabel Barata, MD, FACEP* *Robert De Lorenzo, MD, FACEP* *Dan Freess, MD, FACEP* *Alan Heins, MD, FACEP* *Antony Hsu, MD, FACEP* *Jon Mark Hirshon, MD, FACEP* *Ryan Keay, MD, FACEP* *Robin Polansky, MD, FACEP* *Lynne Richardson, MD, FACEP* *Sandra Schneider, MD, FACEP* *John Sy, MD, FACEP* *Michael Turturro, MD, FACEP* *Bradford Walters, MD, FACEP* *Arlo Weltge, MD, FACEP* *Critical Care Medical Section* *Medical Directors Section* *Pain Management & Addiction Medicine Section* *Undersea & Hyperbaric Medicine Section*	
5	In Memory of Catherine Agustiady-Becker, DO *New York Chapter* *Virginia College of Emergency Physicians*	
6	In Memory of Heide J. Lako-Adamson, MD *North Dakota College*	
7	In Memory of Joseph Litner, MD, PhD, FACEP *Government Services Chapter*	
8	In Memory of Paul S. Auerbach, MD, MS, FACEP *California Chapter*	
9	In Memory of Samuel C. Slimmer, Jr., MD, FACEP *Pennsylvania College of Emergency Physicians*	
10	Board of Directors Action on Council Resolutions - Bylaws Amendment *District of Columbia Chapter* *North Carolina College of Emergency Physicians* *Virginia Chapter* *West Virginia Chapter*	A

Resolution #	Subject/Submitted by	Reference Committee
11	Eligibility for Retired Membership - Bylaws Amendment *Membership Committee* *Board of Directors*	A
12	Permitting Bylaws Amendments on the Unanimous Consent Agenda – Council Standing Rules Amendment *Sara Chakel, MD, FACEP* *Michael McCrea, MD, FACEP* *Scott Pasichow, MD, MPH* *Paul Pomeroy, MD, FACEP* *Todd Slesinger, MD, FACEP, FCCM, FCCP* *James Thompson, MD, FACEP* *Larisa Traill, MD, FACEP* *Nicole Veitinger, DO, FACEP*	A
13	ACEP President-Elect Selected Directly by Members *Louisiana Chapter*	A
14	Establishing a Young Physician Position on the ACEP Nominating Committee *Young Physician Section*	A
15	Member Determined Council Representation *Louisiana Chapter*	A
16	ACEP Group Membership *John C. Moorhead, MD, FACEP* *Christopher Strear, MD, FACEP*	A
17	Fair Emergency Physician Employment Contract Template *Louisiana Chapter*	A
18	Change to ACEP Conflict of Interest Statement *Howard K. Mell, MD, MPH, FACEP* *Phillip Luke LeBas, MD, FACEP*	A
19	Clear and Complete Conflict of Interest Disclosure at the Council Meeting *Louisiana Chapte* *r*	A
20	Creation of the Social Emergency Medicine Association *Howard K. Mell, MD, MPH, FACEP* *Taylor Nichols, MD*	A
21	Diversity, Equity, and Inclusion *Ramon Johnson, MD, FACEP* *Nicholas Jouriles, MD, FACEP* *Marcus Wooten, MD* *Yvette Calderon, MD, FACEP* *Diversity, Inclusion, & Health Equity Section*	A
22	Expanding Diversity & Inclusion in Educational Programs *New York Chapter*	A
23	Media Marketing of Value of Emergency Medicine Board Certification *Louisiana Chapter*	A
24	More Focused College *Louisiana Chapter*	A

Resolution #	Subject/Submitted by	Reference Committee
25	ACEP Report Card *John C. Moorhead, MD, FACEP* *Christopher Strear, MD, FACEP*	B
26	Advocacy for Syringe Services Programs and Fentanyl Test Strips *Ohio Chapter* *Pennsylvania College of Emergency Physicians*	B
27	Conditional Support for Medicare-for-All *Larry Bedard, MD, FACEP* *Gregory Gafni-Pappas, DO, FACEP* *Cai Glushak, MD, FACEP* *Michael Gratson, MD, MHSA, FACEP* *James Maloy, MD* *Jacob Manteuffel, MD, FACEP* *James Mitchiner, MD, MPH, FACEP* *Charles Pattavina, MD, FACEP* *Megan Ranney, MD, MPH, FACEP* *Rachel Solnick, MD, MSc* *Robert Solomon, MD, FACEP* *Peter Viccellio, MD, FACEP* *Bradford Walters, MD, FACEP*	B
28	Consumer Awareness Through Classification of Emergency Departments *Paul Kivela, MD, FACEP* *California Chapter* *Delaware Chapter* *Florida College of Emergency Physicians* *Maryland Chapter*	B
29	Downcoding *Florida College of Emergency Physicians* *Illinois College of Emergency Physicians* *Minnesota College of Emergency Physicians* *Missouri College of Emergency Physicians*	B
30	Unfair Health Plan Payment Policies *Douglas P. Brosnan, MD, JD, FACEP* *Bing S. Pao, MD, FACEP* *Thomas Jerome Sugarman, MD, FACEP* *California Chapter* *Michigan College of Emergency Physicians* *Missouri Chapter*	B
31	Employment-Retaliation, Whistleblower, Wrongful Termination *Olga Gokova, MD, FACEP* *Rebecca B. Parker, MD, FACEP* *Amish Shah, MD, FACEP* *Arizona College of Emergency Physicians*	B
32	Firearm Ban in EDs Excluding Active Duty Law Enforcement *Chris Barsotti, MD, FACEP* *Sarah Hoper, MD, MD, FACEP* *James C. Mitchiner, MD, MPH, FACEP* *Alexandra Nicole Thran, MD, FACEP* *Vermont Chapter* *American Association of Women Emergency Physicians Section* *Diversity Inclusion & Health Equity Section*	B

Resolution #	Subject/Submitted by	Reference Committee
33	Formation of a National Bureau for Firearm Injury Prevention *California Chapter* *DC Chapter* *Maryland Chapter* *Massachusetts College of Emergency Physicians* *New York Chapter* *North Carolina College of Emergency Physicians* *Vermont Chapter*	B
34	Global Budgeting for Emergency Physician Reimbursement in Rural and Underserved Areas *Ohio Chapter* *Pennsylvania College of Emergency Physicians*	B
35	Preserving Rural Emergency Care in Rural Critical Access Hospitals and Rural Emergency Hospitals *Rural Emergency Medicine Section*	B
36	Mitigating the Unintended Consequences of the CURES ACT *New York Chapter*	B
37	Physician Pay Ratio *Louisiana Chapter*	B
38	Prehospital Oversight and Management of Patients Experiencing Hyperactive Delirium with Severe Agitation *Kevin E. McVaney, MD* *Stephen J. Wolf, MD, FACEP* *Colorado Chapter*	B
39	Recommit to Lessening Opioid Deaths in America *Ohio Chapter* *Pennsylvania College of Emergency Physicians*	B
40	Reimbursement for Naloxone Distributed from Emergency Departments *Missouri Chapter* *Ohio Chapter* *Pennsylvania College of Emergency Physicians*	B
41	Take Home Naloxone Programs in Emergency Departments *Donald E. Stader, MD, FACEP* *Nathan M. Novotny* *John Spartz* *Emergency Medicine Residents' Association* *Colorado Chapter* *New Jersey Chapter* *Massachusetts College of Emergency Physicians* *Diversity, Inclusion, & Health Equity Section* *Pain Management & Addiction Medicine Section* *Social Emergency Medicine Section*	B
42	Administration of COVID-19 Vaccines in the Emergency Department *Laura Janneck, MD, FACEP* *Nikkole Turgeon, BS* *International Emergency Medicine Section* *Social Emergency Medicine Section* *Young Physicians Section*	C

Resolution #	Subject/Submitted by	Reference Committee
43	Autonomous "Shared Governance" Due Process *Paul D. Kivela, MD, MBA, FACEP* *California Chapter*	C
44	Caring for Transgender and Gender Diverse Patients in the Emergency Department *Lauren Apgar, DO* *Leslie Gailloud* *Logan Jardine, MD, MPH* *Hannah Janeway, MD* *International Emergency Medicine Section* *Social Emergency Medicine Section* *Young Physicians Section*	C
45	ED Performance Measures Data for Small, Rural, and Critical Access Hospital EDs *Quality Improvement & Patient Safety Section* *Massachusetts College of Emergency Physicians* *Rhode Island Chapter* *Wisconsin Chapter*	C
46	Effects of EM Practice Ownership on the Costs and Quality of Emergency Care *Stephen Epstein, MD, MPP, FACEP* *Jay Mullen, MD, FACEP*	C
47	Family and Medical Leave *Megan Dougherty, MD, FACEP* *Sarah Hoper, MD, JD, FACEP* *Iowa Chapter* *Vermont Chapter* *American Association of Women Emergency Physicians*	C
48	Financial Incentives to Reduce ED Crowding *Stephen Epstein, MD, MPP, FACEP* *Thomas J. Sugarman, MD, FACEP*	C
49	Forced EMS Diversion *New York Chapter*	C
50	Harms of Marijuana *Michael Carius, MD, FACEP* *Roneet Lev, MD, FACEP* *Gregory Shangold, MD, FACEP* *Thomas J. Sugarman, MD, FACEP* *Connecticut College of Emergency Physicians* *Rhode Island Chapter*	C
51	Medical Bill of Rights for Detained and Incarcerated persons While Receiving Emergency Medical Care *Georgia College of Emergency Physicians*	C
52	Standardization of Medical Screening Exams of Arrested Persons Brough to the ED *Utah Chapter*	C
53	Reporting of Injuries Suspected or Reported to be Resulting from Law Enforcement Actions *Taylor Nichols, MD* *Alexander Schmalz, MD, MPH* *Kevin Durgun, MD* *California Chapter* *Young Physicians Section*	C

Resolution #	Subject/Submitted by	Reference Committee
54	Understanding the Effects of Law Enforcement Presence in the ED *Diversity, Inclusion, & Health Equity Section* *International Emergency Medicine Section* *Social Emergency Medicine Section*	C
55	Patient Experience Scores *New York Chapter*	C
56	Race-Based Science and Detrimental Impact on Black, Indigenous, and People of Color Communities *Diversity, Inclusion, & Health Equity Section* *Social Emergency Medicine Section* *District of Columbia Chapter*	C
57	Social Determinants of Health Screening in the Emergency Department *Nikkole J. Turgeon, BS* *Anna G. Wright, MD* *Dominique Gelmann* *Betty Chang, MD, FACEP* *Daniel B. Gingold, MD, MPH* *International Emergency Medicine Section* *Social Emergency Medicine Section*	C
58	Updating and Enhancing ED Buprenorphine Treatment Training and Support *Missouri Chapter* *Pennsylvania College of Emergency Physicians*	C
59	Use of Medical Interpreters in the Emergency Department *Laura Janneck, MD, FACEP* *Nikkole Turgeon, BS* *International Emergency Medicine Section* *Social Emergency Medicine Section*	C
60	Accountable Organizations to Resident and Fellow Trainees *Emergency Medicine Residents' Association (EMRA)*	D
61	Advocating for a Required Emergency Medicine Rotation at All U.S. Medical Schools *Pennsylvania College of Emergency Physicians*	D
62	Support of Telehealth Education in Emergency Medicine Residency *Emergency Medicine Residents' Association* *Pennsylvania College of Emergency Physicians*	D
63	Physician-Led Team Leader Training *Government Services Chapter*	D
64	Rural Emergency Medicine Education and Recruitment *Rural Emergency Medicine Section*	D
65	Rural Providers Support and a Call for Data *Rural Emergency Medicine Section*	D
66	ACEP Promotion of the Role of the Emergency Physician *Howard K. Mell, MD, MPH, CPE, FACEP* *Illinois College of Emergency Physicians*	D

Resolution #	Subject/Submitted by	Reference Committee
67	Patient Informed Consent *Emergency Medicine Workforce Section*	D
68	Patient's Right to Board Certified Emergency Physicians 24/7 (In-person or via Telehealth *Louisiana Chapter* *Emergency Telehealth Section*	D
69	Workforce Transparency *Louisiana Chapter*	D
70	Creation of Specialized Scope Expansion Advocacy Teams for State Level Advocacy *Government Services Chapter*	D
71	Emergency Medicine Workforce by Non-Physician Practitioners *Emergency Medicine Workforce Section*	D
72	Fair Compensation to Emergency Physicians for Collaborative Practice Agreements & Supervision *Louisiana Chapter*	D
73	Offsite Supervision of Nurse Practitioners and Physician Assistants *Emergency Medicine Residents' Association* *Ohio Chapter* *Pennsylvania College of Emergency Physicians* *Young Physicians Section*	D
74	Regulations by state medical Boards of All Who Engage in Practice of Medicine *Emergency Medicine Workforce Section*	D
75	Required Clinical Experience for Emergency Nurses *Pennsylvania College of Emergency Physicians*	D
76	Standards for Non-Residency Trained Physicians and Mid-Levels to Work in Emergency Medicine *District of Columbia Chapter* *Maryland Chapter*	D
77	Workforce Fairness *Louisiana Chapter*	D

Late Resolutions

78	In Memory of Leon L. Haley, Jr., MD, MHSA, CPE, FACEP, FACHE *Florida College of Emergency Physicians* *Diversity, Inclusion, & Health Equity Section*	

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 1(21)

SUBMITTED BY: Florida College of Emergency Physicians

SUBJECT: Commendation for Vidor E. Friedman, MD, FACEP

WHEREAS, Vidor E. Friedman, MD, FACEP, served the College with complete dedication while serving on the Board of Directors 2012-2020 and in his roles as Secretary-Treasurer 2016-17, Vice President 2017-18, President-Elect June-October 2018, President 2018-19, and Immediate Past President 2019-20; and

WHEREAS, Dr. Friedman brought the depth and breadth of his experience to his role on the Board of Directors, facilitated several key initiatives for ACEP, and appointed many task forces to address key issues affecting the practice of emergency medicine; and

WHEREAS, During his tenure on the Board of Directors, Dr. Friedman was committed to improving the practice of emergency medicine and the lives of emergency physicians; and

WHEREAS, Dr. Friedman was instrumental in enhancing ACEP's involvement in international emergency medicine by creating an International Emergency Medicine Committee; and

WHEREAS, Dr. Friedman led ACEP's efforts to hire a new executive director by appointing an Executive Directors Search Committee and served as the Board Liaison to the committee; and

WHEREAS, Dr. Friedman has been an articulate spokesperson for ACEP's advocacy agenda and a champion for the National Emergency Medicine Political Action Committee having served on its Board of Trustees, as well as the Emergency Medicine Action Fund Board of Governors, and working to advance critical advocacy issues for ACEP members; and

WHEREAS, Dr. Friedman served on the Board of Trustees of the Emergency Medicine Foundation 2011-16 and as its chair in 2015, and continues to support his commitment to emergency medicine research through his contributions and participation in the Wiegenstein Legacy Society; and

WHEREAS, Dr. Friedman has served as a member, chair, and Board Liaison to various ACEP committees, task forces, and sections; and

WHEREAS, Dr. Friedman demonstrated leadership through chapter involvement as a member of the Florida College of Emergency Physicians and served on the Board of Directors 2003-19 and as President 2011-12; and

WHEREAS, In all his meetings and travels, Dr. Friedman represented the College with diplomacy, integrity, and honor; and

WHEREAS, Dr. Friedman has been a mentor, friend, and role model to numerous individuals and will continue to serve the College and the specialty of emergency medicine; therefore be it

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

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 2(21)

SUBMITTED BY: Maryland Chapter

SUBJECT: Commendation for William P. Jaquis, MD, MSHQS, FACEP

WHEREAS, William P. Jaquis, MD, MSHQS, FACEP, has been an extraordinary and dedicated leader while serving on the Board of Directors 2012-2021 and in his roles as Secretary-Treasurer 2015-16, Vice President 2016-17, President-Elect 2018-19, President 2019-20, and Immediate Past President 2020-21; and

WHEREAS, Dr. Jaquis, during his tenure on the ACEP Board of Directors and as President, participated in numerous visionary efforts, including the Future of Emergency Medicine Summit, and appointed many task forces to address key issues affecting the practice of emergency physicians; and

WHEREAS, Dr. Jaquis led ACEP during the COVID-19 pandemic and championed the creation of multiple policies and resources to assist in treating patients and for the safety and well-being of emergency physicians and the public; and

WHEREAS, Dr. Jaquis has been a staunch advocate for preserving reimbursement for emergency physicians and ensure that the "No Surprises Act" represents a reasonable and favorable solution for emergency physicians; and

WHEREAS, Dr. Jaquis maintained an active clinical schedule while serving on the ACEP Board of Directors; and

WHEREAS, Dr. Jaquis has shown exemplary leadership and outstanding service with his tireless efforts and expertise on various committees, task forces, sections, the Council, and Board of Directors; and

WHEREAS, Dr. Jaquis has been an articulate spokesperson for ACEP's advocacy agenda and the National Emergency Medicine Political Action Committee having served on its Board of Trustees and working to advance critical advocacy issues on behalf of emergency physicians; and

WHEREAS, Dr. Jaquis has expressed his commitment to the Emergency Medicine Foundation and emergency medicine research through his contributions and participation in the Wiegenstein Legacy Society; and

WHEREAS, Dr. Jaquis demonstrated leadership through chapter involvement and served on the Maryland Chapter Board of Directors 2004-17 and as President 2015-16; and

WHEREAS, Dr. Jaquis has represented the College with honor and distinction and is a role model of commitment and productivity; and

WHEREAS, Dr. Jaquis will continue to be involved and committed to the practice of emergency medicine and to ACEP's mission; therefore be it

RESOLVED, That the American College of Emergency Physicians commends William P. Jaquis, MD, MSHQS, FACEP, for his outstanding service, leadership, commitment to the College and the specialty of emergency medicine, and to the patients we serve.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 3(21)

SUBMITTED BY: Ohio Chapter

SUBJECT: Commendation for Gary R. Katz, MD, MBA, FACEP

WHEREAS, Gary R. Katz, MD, MBA, FACEP, has served the American College of Emergency Physicians with honor, distinction, and dedication as Council Vice Speaker 2017-19 and Council Speaker 2019-21; and

WHEREAS, Dr. Katz represented the Council at Board of Directors' meetings during his terms as Vice Speaker and Speaker; and

WHEREAS, Dr. Katz was a leader in managing the evolving ways of conducting the business of the Council and was instrumental in coordinating efforts and enhancing the productivity within the Council, including creation of the asynchronous testimony process; and

WHEREAS, Dr. Katz expertly and efficiently led the Council by implementing the virtual Council meeting in 2020 to allow the Council to complete its work despite the challenges caused by the COVID-19 pandemic; and

WHEREAS, Dr. Katz expertly and efficiently led the Council by implementing the virtual Council meeting in 2020 to continue to advance the work of the Council despite the challenges caused by the COVID-19 pandemic; and

WHEREAS, Dr. Katz, diligently devoted significant amounts of time, creativity, humor, and enthusiasm to his duties as a Council officer; and

WHEREAS, Dr. Katz is respected for his integrity, objectivity, parliamentary skills, and the mentorship he provided to numerous councillors from across the College; and

WHEREAS, Dr. Katz welcomed and encouraged the participation of new councillors and alternate councillors on Council committees; and

WHEREAS, Dr. Katz has demonstrated a long history of service to the Council including serving as a councillor and alternate councillor and on various Council committees; and

WHEREAS, Dr. Katz was the recipient of the Council's Horizon Award in 2011; and

WHEREAS, Dr. Katz has maintained an active presence in the Ohio Chapter and served on the Board of Directors 2008-15 and 2018-21 and as president 2009-10; and

WHEREAS, Dr. Katz has shown exemplary leadership and outstanding service with his participation on several committees and task forces of the College and is a recognized leader and advocate for the specialty; and

WHEREAS, Dr. Katz 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 Gary R. Katz, MD, MBA, FACEP, for his service as Council Speaker and Council Vice Speaker, and for his enthusiasm and commitment to the specialty of emergency medicine and to the patients we serve.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 4(21)

SUBMITTED BY:

Isabel Barata, MD, FACEP
Robert Delorenzo, MD, FACEP
Dan Freess, MD, FACEP
Alan Heins, MD, FACEP
Antony Hsu, MD, FACEP
Jon Mark Hirshon, MD, FACEP
Ryan Keay, MD, FACEP
Robin Polansky, MD, FACEP
Lynne Richardson, MD, FACEP
Sandra Schneider, MD, FACEP
John Sy, MD, FACEP
Michael Turturro, MD, FACEP
Bradford Walters, MD, FACEP
Arlo Weltge, MD, FACEP
Critical Care Medical Section
Medical Directors Section
Pain Management & Addiction Medicine Section
Undersea & Hyperbaric Medicine Section

SUBJECT: Commendation for Margaret Montgomery, RN, MSN

WHEREAS, Margaret Montgomery, RN, MSN, has served in multiple roles within the American College of Emergency Physicians since joining ACEP in February 2000 including staff liaison for the Public Health & Injury Prevention Committee, the Emergency Medicine Practice Committee, and the following sections: Critical Care Medicine, Medical Directors, Pain Management & Addiction Medicine, and Undersea & Hyperbaric Medicine; and

WHEREAS, Ms. Montgomery has facilitated the development of more than 200 policy statements, Policy Resource and Education Papers (PREPs), and information papers that are reviewed and approved by the Board of Directors and her work not only enhanced the committees and sections but also helped ACEP members provide better care for their patients; and

WHEREAS, Ms. Montgomery has had a positive influence and contributed in ways great and small to the development of dozens of leaders within ACEP including ACEP presidents, Council officers, Board members, committee and section chairs, fellow staff members, ACEP fellows, and emergency medicine residents; and

WHEREAS, Ms. Montgomery has been an infallible resource to ACEP members regarding countless issues related to the administration of emergency care and thus has had a positive impact on the provision of emergency care to our patients; and

WHEREAS, Ms. Montgomery embodies the following attributes: steadfastness, professionalism, energetic nature, diplomacy, passion, productiveness, insightfulness, dedication, trustworthiness, determination, and last but not least a great sense of humor; and

WHEREAS, Ms. Montgomery has served many through the following roles: expert drafter, intellectual, mentor, magical being, leader, true friend, role model, family, and pillar of balance; and

WHEREAS, Ms. Montgomery has been key to the success of the Public Health & Injury Prevention Committee and the Emergency Medicine Practice Committee, her organization and leadership was fundamental, and she provided the framework for the committee chairs to be successful; and

WHEREAS, Ms. Montgomery was the consistent presence and guide that specifically helped the Critical Care Medicine Section maintain perseverance in its goals and humanity in its objectives and she kept this wild and visionary group on track to accomplish so many great things from board certification status to mentoring up and coming young emergency medicine intensivists in their journey and without her, the great ideas from the members of this section would have remained as ideas forever – she helped visions become reality through her historic knowledge, institutional memory, and keen insight as to how to effect change; and

WHEREAS, Ms. Montgomery provided direction, inspiration, and guidance, as well as nurturing the strengths and talents of the committee chair and members to achieve the objectives; and

WHEREAS, Ms. Montgomery retired effective July 1, 2021, after more than 21 years of exemplary service; therefore be it

RESOLVED, That the American College of Emergency Physicians commends Margaret Montgomery, RN, MSN, for her outstanding service and commitment to the College and the specialty of emergency medicine.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 5(21)

SUBMITTED BY: New York Chapter ACEP
Virginia College of Emergency Physicians

SUBJECT: In Memory of Catherine Agustiady-Becker, DO

WHEREAS, The specialty of emergency medicine and the Virginia College of Emergency Physicians (VACEP) lost a rising physician leader, compassionate physician, colleague, and friend in Catherine Agustiady-Becker, DO who passed away tragically and unexpectedly on May 3, 2021, at the age of 37; and

WHEREAS, Dr. Agustiady-Becker was a distinguished graduate of the SUNY at Buffalo and the University of New England College of Osteopathic Medicine and completed her emergency medicine residency at the University of Buffalo; and

WHEREAS, Dr. Agustiady-Becker was respected for her compassionate care of her patients and clinical acumen and she appreciated the diversity of emergency medicine and the unique opportunity she had to care for different patients at the time when they needed it most; and

WHEREAS, Dr. Agustiady-Becker was dedicated to physician leadership and was a rising leader in VACEP and emergency medicine; and

WHEREAS, Dr. Agustiady-Becker was a former VACEP leadership and advocacy fellow where she engaged and worked to develop a mentorship platform within the College; and

WHEREAS, Dr. Agustiady-Becker was not only dedicated to her patients, but to changing the policies and practices of emergency medicine for the greater good; and

WHEREAS, Dr. Agustiady-Becker was devoted to physician wellness and balance between professional development and family life; and

WHEREAS, Dr. Agustiady-Becker wrote with candor about her experiences as an emergency physician and the challenges all physicians face and wrote eloquently of her love of the practice of emergency medicine; and

WHEREAS; Dr. Agustiady-Becker was a world traveler and avid outdoors-woman who loved to hike; and

WHEREAS, Above all, Dr. Agustiady-Becker was a devoted mother and wife to her three boys and her husband, Jacob, and a devoted daughter to her mother who was a role model to her; therefore be it

RESOLVED, That the American College of Emergency Physicians remembers with gratitude and honors the many contributions made by Catherine Agustiady-Becker, DO, as one of the rising stars in emergency medicine; and be it further

RESOLVED; That the American College of Emergency Physicians extends to her husband, Jacob, her sons Wyatt, Theodore, and Quentin, her extended family, colleagues, and friends our condolences and gratitude for her tremendous service to the specialty of emergency medicine and to the countless patients and physicians across the country whom she served selflessly.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 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(21)

SUBMITTED BY: North Dakota Chapter

SUBJECT: In Memory of Heidi J. Lako-Adamson, MD

WHEREAS, Emergency medicine lost a passionate emergency physician and advocate for emergency medical services with the untimely death of Heidi J. Lako-Adamson on March 31, 2021; and

WHEREAS, Dr. Lako-Adamson received her medical degree from the University of North Dakota School of Medicine and Health Sciences and completed her emergency medicine residency at Regions Hospital in St. Paul, Minnesota; and

WHEREAS, Dr. Lako-Adamson became an EMT and paramedic prior to medical school and worked as a paramedic while attending medical school; and

WHEREAS, Dr. Lako-Adamson served as Medical Director for Fargo-Moorhead Ambulance and numerous rural emergency medicine services; and

WHEREAS, Dr. Lako-Adamson served her community for 13-years as emergency medicine physician, volunteer physician for sporting teams, public health officer, and marathon medical director; and

WHEREAS Dr. Lako-Adamson was recognized for her deep passion for rural EMS, which earned her great respect and admiration from EMS providers; and

WHEREAS, Dr. Lako-Adamson will be missed by her friends and colleagues who were privileged to know her and appreciated her strength of character and zeal for emergency medicine; therefore be it

RESOLVED, That the American College of Emergency Physicians remembers with honor and gratitude the accomplishments and contributions of a gifted emergency physician, Heidi J. Lako-Adamson, MD, and extends condolences and gratitude to her husband, Mark, for her service to the specialty of emergency medicine and to patient care.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 7(21)

SUBMITTED BY: Government Services Chapter
Louisiana Chapter
Washington Chapter

SUBJECT: In Memory of Joseph Litner, MD, PhD, FACEP

WHEREAS, The specialty of emergency medicine and the Government Services Chapter of the American College of Emergency Physicians (GSACEP) lost an emergency medicine trailblazer, compassionate physician, government services leader, emergency medicine faculty, colleague, and friend in Joseph Litner MD, PhD, FACEP, who passed away on May 18, 2021, at the age of 75; and

WHEREAS, Dr. Litner received his doctor of philosophy and medical degree from Queen's University in Ontario, Canada and completed his residency in emergency medicine at Charity Hospital in New Orleans, Louisiana; and

WHEREAS, Dr. Litner practiced emergency medicine for more than four decades in Louisiana, Mississippi, and Washington state accumulating more than 100,000 hours of direct emergency patient care; and

WHEREAS, Dr. Litner remained dedicated and committed to the field of EMS leading him to serve as medical director for multiple units throughout the country for more than 40 years; and

WHEREAS, Dr. Litner served his country faithfully, selflessly, and honorably as a federal government employee for more than 15 years, always devoted to the education of military medical officers, advancement of military medicine, and those we serve; and

WHEREAS, Dr. Litner served in numerous teaching positions, educating and mentoring countless medical students, interns, and residents while serving as faculty at Charity Hospital in New Orleans, LA, and Madigan Army Medical Center in Tacoma, WA; and

WHEREAS, With his expertise, Dr. Litner was an appointed Board Examiner by the American Board of Emergency Medicine for 14 years; and

WHEREAS, Above all, Dr. Litner was a devoted family man, pioneer in the field of emergency medicine, astute clinician, and a passionate educator, and to quote his obituary, "He was blessed with a brilliant mind, an insatiable thirst for knowledge...He was kind, loyal and generous to a fault and an outrageously funny raconteur with a larger-than-life personality who filled the room."; and

WHEREAS, Dr. Litner dedicated his life to his family, friends, and patients; therefore be it

RESOLVED, That the American College of Emergency Physicians recognizes the scope, breadth, and lasting impact of the magnanimous life of Joseph Litner, MD, PhD, FACEP, on the states of Washington, Mississippi, Louisiana, and the Government Services Chapter of ACEP; therefore be it

RESOLVED That the American College of Emergency Physicians and the Government Services Chapter acknowledge the huge loss and bereavement of his many colleagues and friends, but above all, extend condolences to his beloved wife of more than 40 years, Maria Hugi, MD, FACEP, and their precious children, David and Jonathan.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 8(21)

SUBMITTED BY: California Chapter

SUBJECT: In Memory of Paul S. Auerbach, MD, MS, FACEP

WHEREAS, The specialty of emergency medicine lost a longtime ACEP member, a beloved leader, and a wilderness medicine pioneer when Paul S. Auerbach, MD, FACEP, passed away on June 23, 2021 at 70 years of age; and

WHEREAS, After graduating from medical school at Duke University, Dr. Auerbach completed his emergency medicine residency at what is now Ronald Reagan UCLA / Olive View UCLA Medical Center; and

WHEREAS, Dr. Auerbach joined ACEP in 1984, and quickly became involved in research and education; and

WHEREAS, Dr. Auerbach was an Editorial Board member for Annals of Emergency Medicine from 1987 to 1991; and

WHEREAS, Wilderness medicine as we know it would not be possible without Dr. Auerbach's groundwork; and

WHEREAS, Dr. Auerbach was a pioneer in the field of wilderness medicine and worked hard to continue paving the way for education and advancement of the specialty; and

WHEREAS, A champion of wilderness medicine as a distinct area of emergency medicine, Dr. Auerbach became the editor for the *Journal of Wilderness Medicine* from 1990 to 1995 and then wrote what is considered by many to be the definitive textbook on the practice, *Wilderness Medicine*; and

WHEREAS, Dr. Auerbach also authored *Medicine for the Outdoors* and was co-author of *Enviromedics: The Impact of Climate Change on Human Health and Field Guide to Wilderness Medicine*; and

WHEREAS, Globally renowned in both emergency medicine and wilderness medicine, Dr. Auerbach worked not only to support educating others for the greater good, but also led many initiatives for relief in remote areas and partnerships around the world, ultimately working to make the world a better place; and

WHEREAS, Dr. Auerbach had a special relationship with Nepal and was part of a team that built a much-needed hospital there; and

WHEREAS, Dr. Auerbach was a strong supporter of the Wilderness Medicine Section, as well as MedWAR (Medical Wilderness Adventure Race) which carried over with his continued support of the EMRA MedWAR since it began in 2016; and

WHEREAS, Dr. Auerbach was always willing to put in the time to help anyone and get his hands dirty if it was going to advance education or help others; and

WHEREAS, Dr. Auerbach's legacy is most obvious in the arena of wilderness medicine, his dedication and commitment to the specialty spanned many arenas; and

WHEREAS, In 1999, Dr. Auerbach was awarded ACEP's Judith E. Tintinalli Award for Outstanding Contribution in Education, one of the College's highest leadership honors; and

WHEREAS, Dr. Auerbach served on several ACEP task forces, including the Sports Related Head Injury Task Force and the High Threat Emergency Care Task Force; and

WHEREAS, Dr. Auerbach was an officer of the Emergency Medicine Foundation's (EMF) Board of Trustees and was EMF's Secretary/Treasurer in 2020; and

WHEREAS, Dr. Auerbach demonstrated his dedication to EM research by joining the EMF Mentor Circle and funding the Climate and Emergency Medicine Research Grant; and

WHEREAS, Dr. Auerbach was most recently the Redlich Family Professor Emeritus in the Department of Emergency Medicine at the Stanford University School of Medicine, and Adjunct Professor of Military/Emergency Medicine at the F. Edward Hébert School of Medicine of the Uniformed Services University of the Health Sciences; and

WHEREAS, Dr. Auerbach was a member of the Council on Foreign Relations, and served on the National Medical Committee for the National Ski Patrol System; and

WHEREAS, Dr. Auerbach was a first responder to the earthquakes in Haiti (2010) and Nepal (2015); and

WHEREAS, Dr. Auerbach was a visiting scholar at the National Center for Disaster Medicine and Public Health and previously Chief of the Divisions of Emergency Medicine at Vanderbilt University and Stanford University; and

WHEREAS, Dr. Auerbach's brilliance, sense of humor, innovation, adventurous spirit, energy, and compassion will be deeply missed but always remembered; and

WHEREAS, Dr. Auerbach is whom many refer to as the "Father of Wilderness Medicine" and he certainly helped make all this possible; we are forever indebted to him and grateful for his hard work; therefore be it

RESOLVED, That the American College of Emergency Physicians and the California Chapter extend to the family of Paul S. Auerbach, MD, MS, FACEP, gratitude for his tremendous service to emergency medicine.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 9(21)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: In Memory of Samuel C. Slimmer, Jr., MD, FACEP

WHEREAS, The specialty of emergency medicine lost a distinguished leader and pioneer when Samuel C. Slimmer Jr., MD, FACEP, passed away December 21st, 2020, at the age of 81; and

WHEREAS, Dr. Slimmer graduated from Reading Central Catholic High School in 1957, St. Joseph's University in 1961, and Temple University School of Medicine in 1965; and

WHEREAS, Dr. Slimmer completed his internship training in 1966 at The Reading Hospital (now Tower Health); and

WHEREAS, Dr. Slimmer helped establish the first emergency medicine physician group at The Reading Hospital in 1967; and

WHEREAS, Dr. Slimmer served as the medical director of the emergency department at The Reading Hospital, The Pottsville Hospital, and Warne Clinic (now Lehigh Valley Schuylkill South) for many years; and

WHEREAS, Dr. Slimmer served as the president of the Schuylkill County Medical Society; and

WHEREAS, Dr. Slimmer was one of the original members of ACEP joining in 1968; and

WHEREAS, Dr. Slimmer was recognized in 2018 as one of the longest tenured members of ACEP; and

WHEREAS, Dr. Slimmer was given the Special Recognition Award by the Pennsylvania College of Emergency Physicians (PACEP) in 2019 for service and contributions to the specialty; and

WHEREAS, Dr. Slimmer retired in 2018, having spent 51 years practicing emergency medicine; and

WHEREAS, We owe a tremendous amount of gratitude to him for his unassailable commitment and dedication to the specialty, particularly in early years when many did not give it the respect it deserved, thus forging a path for all who came after him; and

WHEREAS, Dr. Slimmer was a loving and proud father and grandfather; therefore be it

RESOLVED, That the American College of Emergency Physicians cherishes the memory and legacy of Samuel C. Slimmer, Jr., MD, FACEP, who was a pioneer in the specialty and dedicated himself to his patients, to his profession, and to his family, and be it further

RESOLVED, That the American College of Emergency Physicians and the Pennsylvania College of Emergency Physicians extends to his son Samuel J., daughter-in-law Kelly, daughter Lara, and granddaughters Ellianna and Eily gratitude for his tremendous service as one of the first emergency physicians, as well as for his dedication and commitment to the specialty of emergency medicine.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2021 Council Meeting
Reference Committee Members

Reference Committee A – Governance & Membership
Resolutions 10-24

Michael McCrea, MD, FACEP (OH), Chair
Kathleen Clem, MD, FACEP (FL)
Debra Fletcher, MD, FACEP (LA)
John M. Gallagher, MD, FACEP (KS)
Ken Holbert, MD, FACEP (TN)
Thom Mitchell, MD, FACEP (TN)

Maude Surprenant Hancock
Laura Lang, JD

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 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: 10(21)

SUBMITTED BY: District of Columbia Chapter
North Carolina College of Emergency Physicians
Virginia Chapter
West Virginia Chapter

SUBJECT: Board of Directors Action on Council Resolutions

PURPOSE: Amends the Bylaws to include reporting requirements to the Council regarding the disposition of all resolutions considered by the Council and reporting requirements for all resolutions adopted and referred by the Council.

FISCAL IMPACT: Budgeted staff resources.

WHEREAS, The Council has the right and responsibility to advise and instruct the Board of Directors by means of resolutions; and

WHEREAS, The Board of Directors has a duty to act on resolutions adopted by the Council; and

WHEREAS, The College would benefit from timely updates and increased transparency regarding the Board of Directors' actions on Council resolutions; therefore be it

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

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

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

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

The ACEP Council Speaker and Vice Speaker or their designee shall provide to the College a written summary of the Council meeting within 14 calendar days of the adjournment of the Council meeting. This summary shall include:

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

Thereafter, the Board of Directors shall provide to the College written and comprehensive communication regarding the actions taken and status of each adopted and referred resolution. A summary of the Board of Directors' intent, discussion, and decision for each referred resolution shall be included. These communications shall be provided at 30 calendar day 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.

Background

This resolution amends the Bylaws to include reporting requirements to the Council regarding the disposition of all resolutions considered by the Council and reporting requirements for all resolutions adopted and referred by the Council.

An executive summary of all resolutions considered by the Council and a summary of all resolutions adopted by the Council that require Board action, including the final text of each resolution, is currently provided to the Council within 30 days of the Council meeting. Last year, the report was provided to the Council the same day that the resolutions were acted on by the Board of Directors. This report could easily be updated to include the final language of all adopted Council Standing Rules resolutions and all referred resolutions.

Implementation of most resolutions is completed within the first year of adoption. Some resolutions may require two years for implementation. For example, a resolution may require funding that is not available in the current fiscal year budget when the resolution is adopted, and a budget modification is not feasible. Additional work on the resolution may be accomplished in the third year since adoption while other resolutions, such as federal and state advocacy resolutions, may require even longer to achieve implementation.

Each year the Council Steering Committee reviews the implementation actions on resolutions during their January meeting to ensure that the will of the Council is followed in implementing the resolutions. Their review includes actions on resolutions from the most recent Council meeting and the two years prior resolutions. This requirement is codified in the Council Standing Rules, "Policy Review" section, as directed by Substitute Resolution 30(90) Resolution 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."

Beginning in 1992, a report on implementation of resolutions from the two years prior was provided to the Council. In 2003, the Steering Committee directed that the reports include implementation actions on a three-year rolling basis. For example, the actions on 2002, 2001, and 2000 were reviewed by the Steering Committee and written reports were provided to the Council. The reports included the Council Standing Rules resolutions and the referred resolutions. The reports were also available in the Council area of the ACEP website.

The actions on resolutions reports are updated again prior to the Council meeting to include any additional action that may have occurred since the reports were developed in January. The written reports of actions on resolutions for the three years prior are then provided to the Council and include the most up to date information regarding implementation of the resolutions.

The Council and the Board of Directors adopted Amended Resolution 12(15) Searchable Council Resolution Database, which directed ACEP to create a web-based searchable database for Council resolutions. ACEP's internal database of all resolutions since 1972 was used to develop the framework for this new database for access by all members in the Council area of the ACEP website. The Actions on Council Resolutions includes the original resolution, background information, Council action, testimony in the Reference Committee, Board action, and implementation action for each resolution. The search function includes a global search across all resolutions and a

search capability in a particular year. All resolutions since 1994 are now available and the implementation action for all resolutions since 2013 has been added. Development of this resource is very time consuming and staff will continue to work on it until all resolutions since 1972 have been added.

As mentioned previously, staff update actions on resolutions on a three-year rolling basis in January and again prior to the Council meeting each year. This resolution requests that "a summary of the Board of Directors' intent, discussion, and decision for each referred resolution shall be included." The "intent and "discussion" by the Board is not available since only the decision about the resolution is recorded in the minutes. Minutes of Board meetings are not transcripts and only include the topic and the actions of the Board.

Additionally, the resolution requests that "These communications shall be provided at 30 calendar day intervals until these communications demonstrate that no further Board action is required according to the Bylaws listed previously in this section." Implementation of a resolution can take many months and sometimes multiple years to complete depending on the action required. Compliance with the requirement to report on all outstanding resolutions every 30 days, versus when key milestones are reached, would require reallocation of staff resources from other projects.

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Member Engagement

Fiscal Impact

Budgeted staff resources.

Prior Council Action

Amended Resolution 12(15) Searchable Council Resolution Database adopted. Directed ACEP to create a web-based searchable database for Council resolutions.

Substitute Resolution 30(90) Resolution Review adopted. Revised the Council Standing Rules to include a periodic review of previous resolutions adopted by the Council and the Board of Directors and provide an annual report to the Council.

Prior Board Action

Amended Resolution 12(15) Searchable Council Resolution Database adopted.
Substitute Resolution 30(90) Resolution Review adopted.

Background Information Prepared by: Sonja Montgomery, CAE
Governance Operations Director

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 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: 11(21)

SUBMITTED BY: Membership Committee
Board of Directors

SUBJECT: Eligibility for Retired Membership

PURPOSE: Bylaws amendment to establish a maximum of 280 working hours annually for eligibility for retired status.

FISCAL IMPACT: Reduced dues revenue from retired dues vs. regular member dues.

WHEREAS, The number of emergency physicians nearing retirement has increased significantly since the founding of the College; and

WHEREAS, Most retired emergency physicians do not work clinically at all, some still work an occasional shift, or volunteer doing medical work; and

WHEREAS, It is in the interests of the College to maintain these physicians as members with their many years of dedication to the College and rich experience in emergency medicine; therefore be it

RESOLVED, That the ACEP Bylaws, Article IV – Membership, Section 2.1 Regular Members, paragraph 4, be amended to read:

"Regular members who have retired from medical practice for any reason**, or those working less than 280 hours annually,** shall be assigned to retired status."

Background

This Bylaws amendment would allow members who work less than 280 hours annually to qualify for retired status and pay retired dues.

The Membership Committee conducted a comprehensive review of the various classes of membership this past year and eligibility for retired status was of specific interest. The number of retired members continues to rise and we need to ensure ACEP's policies and procedures reflect the needs of the membership now and in the future.

The dues rate for retired members is set at 1/3 of the regular member dues rate. Many chapters have matched the dues discount for retired members for membership retention, but some have not. These veteran members have significant experience and much to offer the College from continued membership; however, they are often constrained by the cost of continuing membership in ACEP and their constituent state chapters.

The committee discussed the current prohibition of any working hours to be eligible for the retired dues rate as well as the potential to develop a semi-retired category to offer a pathway from full time practice to retirement. After several lengthy discussions, the committee determined that adding an additional category of semi-retired is an unnecessary step. There was consensus that the retired definition should be expanded to include a small number of working hours. This will allow our most senior members to continue to participate in limited ways to support the specialty while receiving the dues discount that may be necessary to maintain membership on a more limited income.

While there is the potential for some fiscal impact if members move from the regular member dues rate to retired dues rate, there is a stronger belief that these individuals will remain involved members longer if they are able to continue to work limited hours and receive a dues discount that concedes their changing financial situation without a full-time salary.

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Member Engagement

- Increase total membership and retain graduating residents.

Fiscal Impact

Reduced dues revenue when members move from the regular member dues rate to retired dues rate.

Prior Council Action

Resolution 9(10) Life, Disabled, and Retired Members – Bylaws Amendment referred to the Board of Directors.

Resolution 18(08) Retaining Retired and Disabled Members adopted. Directed ACEP to study the feasibility of a no cost retired membership category or reducing the cost of life membership as a means of retaining retired members.

Amended Resolution 25(05) Combining Life and Retired Membership Categories adopted. Combined the life and retired membership categories.

Amended Resolution 3(02) Chapter Membership for Retired Members adopted. Allowed retired members who move to another state after retirement to continue their chapter affiliation in the chapter of prior professional practice/residence.

Amended Substitute Resolution 5(00) Retired Membership adopted. Called for the creation of a new category of membership for retired members.

Resolution 9(98) Life Membership not adopted. Called for the redefinition of Life Member to include physicians who are retired from practice.

Prior Board Action

June 2021, approved the recommendation from the Membership Committee to submit a Bylaws resolution to the 2021 Council to establish a maximum number of 280 working hours annually for eligibility for the retired dues rate.

June 2011, approved taking no further action on Referred Resolution 9(10) Life, Disabled, and Retired Members and assigned an objective to the Membership Committee to revise the classes of membership.

June 2011, determined to not submit a resolution to the 2011 Council regarding

June 2010, approved the definition of "retired from active medical practice" as "one no longer engaged in the practice of clinical emergency medicine as evidenced by non-renewal of their medical license or less than 1/3 of their income comes from activities associated with being employed as a physician." Also approved an updated policy and benefits for retired members.

June 2009, approved changing the dues structure for future Life members to eliminate the discount for dues and receive a 15% discount for *Scientific Assembly* registration fees effective July 1, 2009.

Resolution 18(08) Retaining Retired and Disabled Members adopted.

Amended Resolution 25(05) Combining Life and Retired Membership Categories adopted.

Amended Resolution 3(02) Chapter Membership for Retired Members adopted.

Amended Substitute Resolution 5(00) Retired Membership adopted.

September 2000, established dues for the proposed retired category of membership at 33.33% of active dues.

June 2000, approved the Membership Committee's recommendation for a retired category of membership and to submit a resolution to the 2000 Council. Also directed the committee to propose reduced dues rate for the Board to consider in anticipation that the Council would adopt the resolution.

October 1998, assigned an objective to the Membership Committee regarding retired membership that included directives to recommend a new status or revisions to a current status and to recommend a dues rate and options for retired member.

Background Information Prepared by: Sonja Montgomery, CAE
Governance Operations Director

Jana Nelson
Senior Vice President, Communications

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 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: 12(21)

SUBMITTED BY: Sara Chakel, MD, FACEP; Michael McCrea, MD, FACEP; Scott Pasichow, MD, MPH; Paul Pomeroy, MD, FACEP; Todd Slesinger, MD, FACEP, FCCM, FCCP; James Thompson, MD, FACEP; Larisa Traill, MD, FACEP; Nicole Veitinger, DO, FACEP

SUBJECT: Permitting Bylaws Amendments on the Unanimous Consent Agenda

PURPOSE: Amends the Council Standing Rules to allow Bylaws amendments to be included on the Unanimous Consent Agenda with the proviso that the change will become effective after the 2021 Council meeting.

FISCAL IMPACT: Budgeted staff resources to update the Council Standing Rules.

WHEREAS, The ACEP Council Standing Rules (CSR) provide for the use of the "Unanimous Consent Agenda" (UCA) to facilitate the efficiency of the Council; and

WHEREAS, A UCA is for "matters that are routine or expected to be noncontroversial and on which there are likely to be no questions or discussion.[1]"; and

WHEREAS, The CSR prohibit any College Bylaws amendment resolution to be included on the unanimous consent agenda[2]; and

WHEREAS, Any resolution may be extracted from the unanimous consent agenda by a single councillor; and

WHEREAS, Any Bylaws amendment extracted from the unanimous consent agenda will still require a two-thirds vote of credentialled councillors for adoption; and

WHEREAS, Resolutions that amend the CSR do not require Board of Director ratification and become effective immediately; therefore be it

RESOLVED, That the ACEP Council Standing Rules "Unanimous Consent Agenda" section, paragraph two, be amended to read as follows with the proviso that the change will become effective after the 2021 Council meeting:

"All resolutions assigned to a Reference Committee~~, except for Bylaws resolutions,~~ shall be placed on a Unanimous Consent Agenda."

Background

The resolution amends the Council Standing Rules to allow Bylaws resolutions to be included on the Unanimous Consent Agenda for disposition by the Council with the proviso that the change will become effective after the 2021 Council meeting.

[1] Sturgis, Alice. The Standard Code of Parliamentary Procedure, 4th Edition (p. 116). 2001.
[2] "All resolutions assigned to a Reference Committee, except for Bylaws resolutions, shall be placed on a Unanimous Consent Agenda." ACEP Council Standing Rules, Oct 2020.

Last year, the Council adopted a Council Standing Rules amendment to allow all resolutions except Bylaws resolutions to be included on the Unanimous Consent Agenda for disposition by the Council, with the proviso that the changes become effective after the 2020 Council meeting. The resolution further codified that recommendations for amendment or substitution of the resolution will also be included on the Unanimous Consent Agenda.

Bylaws resolutions have previously not been included on the Unanimous Consent Agenda since such amendments require a 2/3 vote for adoption. However, the threshold for adoption, whether a majority vote or a 2/3 vote, is irrelevant since it is the Unanimous Consent Agenda and a request for extraction of any resolution is allowed by any credentialed councillor at the beginning of the Reference Committee report. If a Bylaws amendment is removed from the Unanimous Consent Agenda, the 2/3 vote for adoption would still apply.

ACEP Strategic Plan Reference

None

Fiscal Impact

Budgeted staff resources to update the Council Standing Rules.

Prior Council Action

Resolution 17(20) Unanimous Consent Agenda adopted. Amended the Council Standing Rules to include all resolutions, except Bylaws resolutions, on a Unanimous Consent Agenda for disposition by the Council, with the proviso that the changes become effective after the 2020 Council meeting. The resolution further codified that recommendations for amendment or substitution of the resolution will also be included on the Unanimous Consent Agenda.

Resolution 14(17) Unanimous Consent not adopted. This resolution intended to amend the Council Standing Rules by placing all resolutions, except Bylaws amendments, on the Unanimous Consent Agenda with the Reference Committee's recommendation for adoption, not adoption, or referral for each resolution and requiring a second for extraction.

Resolution 3(16) Unanimous Consent not adopted. The resolution intended to amend the Council Standing Rules to require the requestor for extraction to provide up to a one-minute summary of the reason for extraction and, after reading the summary of the testimony from the Reference Committee report, a one-third affirmative vote of the councillors present and voting would be required to remove the item from consent.

Amended Resolution 30(05) Standing Rules Housekeeping Changes adopted. Revised several sections of the Standing Rules, including Unanimous Consent. The changes to this section were primarily editorial to provide clarity and also revised the section title from "Consent Calendar" to "Unanimous Consent Agenda."

Resolution 19(02) Consent Calendar adopted. The resolution removed the statement "At the speaker's discretion, without objection, such an item is extracted from the consent calendar." If any credentialed councillor can request an item to be removed from consent, it is not at the speaker's discretion.

Prior Board Action

Not applicable – the Board does not take action on Council Standing Rules resolutions.

Background Information Prepared by: Sonja Montgomery, CAE
Governance Operations Director

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 13(21)

SUBMITTED BY: Louisiana Chapter

SUBJECT: ACEP President-Elect Selected Directly by Members

PURPOSE: Change the process for election of the president-elect by allowing any member of the College to seek election for president-elect, that the election be determined by a majority vote of the physician members of the College, and that if a majority vote is not achieved that a runoff of the top two candidates from the initial election would be held within 24 hours to 7 days of the initial vote to determine the president-elect.

FISCAL IMPACT: Unbudgeted costs to obtain and program voting software or for ACEP to develop its own proprietary voting system.

WHEREAS, It is important to have the membership of the American College of Emergency Physicians, engaged in emergency medicine and have significant influence over the direction of the College; and

WHEREAS, It serves the College well to have its membership engaged and have the perception that ACEP serves its membership and the members are ultimately who control the College; and

WHEREAS, The current arrangement of ACEP is such that members do not vote directly for candidates for the Board of Directors or the President of ACEP; and

WHEREAS, The president serves for only one year, has oversight by the Board of Directors to prevent potentially harmful actions to the College or its members should it were a concern; and

WHEREAS, Some perceive a closed system for leadership in the College i.e., the president-elect being elected by the Council as opposed to the membership; and

WHEREAS, While it is possible for someone to be nominated for president-elect from the floor and not the typical existing Board member; and

WHEREAS, The annual election of the figurehead and single individual identifiable by the public to represent the individual emergency physician, it seems most logical for the individual emergency physician members of the College to directly vote for and elect the president-elect; and

WHEREAS, The president-elect candidates rarely if ever, speak directly to the membership to inform them of what his/her intention and goals are if elected president-elect ("campaign"), but instead campaign to the councillors; and

WHEREAS, The Election process of the ACEP president-elect has not always been in its current form; and

WHEREAS, Given technology and the ability to have remote electronic voting, it is much easier now to allow members to vote and tabulate their vote prior to the Council meeting; therefore be it

RESOLVED, That any member of the College in good standing is eligible to seek election for president-elect of the College; and be it further

RESOLVED, That the ACEP president-elect be determined by a vote directly by the individual emergency

physician members of the College with the majority winner becoming the president-elect; and be it further

RESOLVED, Should a non-majority vote for the president-elect by the membership not be achieved in the initial election, a runoff of the top two candidates from the initial election would be held within 24 hours to 7 days of the initial vote to determine the ultimate winner.

Background

This resolution seeks to change the way the president-elect of the College is elected by allowing any member of the College to be eligible to seek election for president-elect, that the election be determined by a majority vote of the physician members of the College, and that if a majority vote is not achieved that a runoff of the top two candidates from the initial election would be held within 24 hours to 7 days of the initial vote to determine the president-elect.

Election of the president-elect of the College is stipulated in the ACEP Bylaws:

- Article VIII – Council, Section 2 – Powers of the Council, paragraph one, second sentence: "…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." Paragraph 2: "…voting rights…are vested exclusively in members currently serving as councillors and are specifically denied to all other members."
- Article VIII – Council, Section 7 – Nominating Committee: "A Nominating Committee for positions elected by the Council shall be appointed annually and chaired by the speaker."
- Article X – Officers/Executive Director, Section 2 – Election of Officers, second sentence: "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."
- Article X – Officers/Executive Director, 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." Fourth sentence: "The president-elect shall be elected by a majority vote of the councillors present and voting at the annual meeting of the Council."

The Council Standing Rules address campaign rules and election procedures. The "Election Procedures" section states: "Elections of the president-elect, Board of Directors, and Council officers shall be by a majority vote of councillors voting. Voting shall be by written or electronic ballot. There shall be no write-in voting." The "Election Procedures" section further delineates how the elections will be conducted and the process for subsequent votes when a majority vote is not achieved.

Additionally, the Council Standing Rules, "Nominating Committee" section, states:

> "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"

Since this resolution would allow for any member of the College in good standing to be eligible to seek election as the president-elect, the role of the Nominating Committee is eliminated regarding candidates for president-elect.

The Council began electing the president-elect in 2005. Prior to 2005, the president-elect was elected by the Board of Directors from among members of the Board of Directors. The Bylaws language governing the election of officers of the Board of Directors, including the president-elect, had been in place since the 1972 revision of the Constitution and Bylaws. In 1990, a proxy vote of the membership was held to codify the existing governance structure and operation establishing councillors with exclusive voting rights to both amend the Bylaws and elect the Board of Directors. This

vote effectively delegated the individual voting rights of members to councillors for those specific purposes.

In 1995, the Council considered a resolution for the Bylaws Committee to develop the necessary Bylaws amendments for election of the president-elect, vice president, and secretary-treasurer by the membership and that the Bylaws amendments be submitted to the 1996 Council. The resolution was not adopted.

As proposed, this resolution would allow any member of the College in good standing to seek election for president-elect. However, the ACEP Bylaws also delineate the eligibility of certain members to hold office:

- Article IV – Membership, Section 2.1 – Regular Members, paragraph 6: "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."
- Article IV – Membership, Section 2.3 – Candidate Members, paragraph 2 (second sentence):"At the national level, candidate members shall not be entitled to hold office, but physician members may serve on the Council." The last sentence of paragraph 3: "Candidate members in inactive status shall not be eligible to hold office, serve on the Council, or serve on committees."
- Article IV – Membership, Section 2.4 – International Members, paragraph 4 (first sentence): "International members may not hold office and may not serve on the Council."

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Member Engagement

Fiscal Impact

Unbudgeted costs to obtain and program voting software or for ACEP to develop its own proprietary voting system.

Prior Council Action

Amended Resolution 12(04) Election of President-Elect by the Council – Council Standing Rules Amendment adopted. Amended sections of the Council Standing Rules to allow for election of the president-elect by the Council.

Amended Resolution 11(04) Election of the President-Elect by the Council – Bylaws Amendment adopted. Proposed changes to the Bylaws to allow for election of the president-elect by the Council.

Resolution 3(03) Election of President-Elect by the Council not adopted. The resolution proposed to amend the Bylaws and Council Standing Rules to allow for direct election of the president-elect by the Council.

Substitute Resolution 6(02) Election of President-Elect by the Council referred to the Steering Committee. The Steering Committee prepared a resolution for submission to the 2003 Council.

Resolution 34(95) Officer Elections not adopted. The resolution directed the Bylaws Committee to develop Bylaws amendments for direct elections by the membership for the positions of president-elect, vice president, and secretary-treasurer for discussion at the 1996 Council meeting.

Resolution 17(95) Election of the President-Elect not adopted. The resolution proposed to transfer the power to directly elect the president-elect from the Board of Directors to the Council.

Amended Resolution 30(94) Officer Elections adopted. It directed the Bylaws Committee to develop the necessary additions and deletions to the Bylaws to directly elect the president-elect by the membership and that the resultant Bylaws amendment be discussed at the 1995 Council meeting.

Amended Resolution 16(94) Board Eligibility for Officer Positions – President-Elect Option A adopted. The resolution defined that a director is eligible for election to the position of president-elect if he or she has at least one year remaining on the Board as an elected director. Resolutions were also adopted at the 1994 Council meeting requiring that the vice president and secretary treasurer also have at least one year remaining on the Board as an elected director.

1972 revision of the Bylaws approved.

Prior Board Action

Amended Resolution 11(04) Election of the President-Elect by the Council – Bylaws Amendment adopted. Proposed changes to the Bylaws to allow for direct election of the president-elect by the Council.

Amended Resolution 30(94) Officer Elections adopted.

Amended Resolution 16(94) Board Eligibility for Officer Positions – President-Elect Option A adopted.

1990 action following proxy vote to amend the Bylaws establishing councillors with exclusive voting rights to both amend the Bylaws and elect the Board of Directors.

Background Information Prepared by: Sonja Montgomery, CAE
Governance Operations Director

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 14(21)

SUBMITTED BY: Young Physicians Section

SUBJECT: Establishing a Young Physician Position on the ACEP Nominating Committee

PURPOSE: Directs the Steering Committee to submit a Bylaws amendment to the Council in 2022 to create a young physician position on the Nominating Committee.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Young physician leaders in ACEP have expressed interest in increased opportunities for leadership and professional development within the College; and

WHEREAS, Participation as a member of the ACEP Nominating Committee provides valuable mentoring and leadership opportunities not gained through other College activities; and

WHEREAS, Several young physician members of ACEP have significant experience in the College including participation on committees, sections, and the Council; and

WHEREAS, Young physician participation in the Nominating Committee ensures representation of our College's largest membership demographic and section[1]; and

WHEREAS, The greatest attrition of ACEP membership has been in those under 40 years of age, during the early years of practice when clinical and financial obligations can overwhelm the call to leadership in organized medicine; and

WHEREAS, The fiscal impact of adding a young physician member to the Nominating Committee is negligible and would be far outweighed by potential retention of young physician members of ACEP; therefore be it

RESOLVED, That the Council Steering Committee submit a Bylaws amendment to the Council in 2022 to support the establishment of a young physician position on the Nominating Committee.

Reference

1. ACEP Annual Report, 2018

Background

This resolution directs the Steering Committee to submit a Bylaws amendment to the Council in 2022 to create a young physician position on the Nominating Committee.

The ACEP Bylaws Article VIII – Council, Section 7 – Nominating Committee, defines the composition of the Nominating Committee:

> "A Nominating Committee for positions elected by the Council shall be appointed annually and chaired by the speaker. The speaker shall appoint five members and the president shall appoint the president-elect plus

> two additional Board members. A member of the College cannot concurrently accept nomination to the Board of Directors and Council Office. Nominations will also be accepted from the floor."

The Council Standing Rules, "Nominating Committee" section, provides additional guidance about the role of the 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."

The definition of a young physician within ACEP is typically someone less than 40 years of age or in the first 10 years of regular ACEP membership, although membership in ACEP's Young Physicians Section is not restricted to any specific time frame or in any respect to age. The current Bylaws language allow for a young physician to be appointed by the Council speaker to serve on the Nominating Committee and young physician members have served on the committee in the past.

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Member Engagement

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

None

Prior Board Action

None

Background Information Prepared by: Sonja Montgomery, CAE
Governance Operations Director

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 15(21)

SUBMITTED BY: Louisiana Chapter
Emergency Telehealth Section

SUBJECT: Member Determined Council Representation

PURPOSE: Assign a task force or a committee to consider an alternative method of determining councillor allocation (with specific considerations) and that a report be provided to the Board no later than June 2, 2022 (at least one month before the resolution submission deadline for the 2022 Council meeting).

FISCAL IMPACT: Budgeted committee/task force and staff resources. Unbudgeted resources of $20,000-$30,000 if an in-person committee/task force meeting is held.

WHEREAS, The current system of representation is determined by the location of the member i.e., state in which they are registered; and

WHEREAS, Many within the College have various interests that may be more important to them than to others; and

WHEREAS, The College (ACEP) wants to best represent what the membership wants the College to represent; and

WHEREAS, Each member essentially gets "one vote" that is counted towards the state that the member is from, without any consideration of other interests that may be more important to the individual member; and

WHEREAS, There are common sense ways to better represent the will of the membership; therefore be it

RESOLVED, That a task force or committee be appointed to consider an alternative method of determining representation of the membership with specific consideration given to addressing the following:

1. Council composition to be determined by the allocation of credits or points that each individual emergency physician members in good standing of the College will be allotted equally.
2. Each and every full member in good standing who pays full membership dues will be assigned five (5) points or credits that the individual emergency physician is free to assign in whatever breakdown the member wishes towards his/her state chapter, another state chapter, a particular section, or any combination the member wishes to assign the points/credits.
3. Council representation will be determined by the total number of votes/points that were assigned by all paying emergency physician members, i.e., total number of Council positions available (councillors) will be divided into the total number of points to determine how many available councillors will be assigned to each specific chapter, section, etc.
4. Consider maintaining a minimum number of councillor positions i.e., one (1) could be assigned to each state and each section with a minimum of 100 paying members, with the remaining councillor positions assigned according to the pro-rated number of credits/points that the individual emergency physicians assigned.
5. Consider a hybrid that gives preference as seen fit; and be it further

RESOLVED, That a task force or committee assigned to review alternative methods of determining representation of the members in the Council conclude its investigation, research, and suggestions and report back to

the Board with sufficient time for the Board to report the information to the Council at least one month before the resolution submission deadline for the 2022 Council meeting.

Background

This resolution requests that a committee or task force be assigned to consider an alternative method of determining councillor allocation by: 1) allocation of credits or points that each member will be allotted; 2) each member in good standing that pays full membership dues will be given five points or credits that each member can assign to their home chapter, another chapter, a section, or any combination the member desires to assign the points/credits; 3) Council representation will be determined by the total number of votes/points that were assigned by all paying emergency physician members, i.e., total number of Council positions available (councillors) will be divided into the total number of points to determine how many available councillors will be assigned to each specific chapter, section, etc.; 4) consider maintaining a minimum number of councillor positions i.e., one could be assigned to each state and each section with a minimum of 100 paying members, with the remaining councillor positions assigned according to the pro-rated number of credits/points that the individual emergency physicians assigned; and 5) consider a hybrid that gives preference as seen fit. The resolution further requests that a report be provided to the Board no later than June 2, 2022 (at least one month before the resolution submission deadline for the 2022 Council meeting).

The ACEP Bylaws, Article VIII – Council, Section 1 – Composition of the Council, states:

> "Each chartered chapter shall have a minimum of one councillor as representative of all of the members of such chartered chapter. There shall be allowed one additional councillor for each 100 members of the College in that chapter as shown by the membership rolls of the College on December 31 of the preceding year."

That section of the Bylaws also specifies that EMRA is entitled to 8 councillors; ACOEP, AACEM, CORD, SAEM, and sections of membership are entitled to one councillor each.

The Council and the Board of Directors adopted Amended Resolution 13(18) Growth of the ACEP Council. The resolution directed the Council officers to appoint a task force of councillors to study the growth of the Council and determine whether to submit a Bylaws amendment to the 2019 Council addressing the size of the Council and the relative allocation of councillors. The task force provided their report to the Council Steering Committee in May 2019. The Steering Committee recommended that the report and the options developed by the task serve as the topic of the Town Hall Meeting during the 2019 Council meeting. The Town Hall meeting focused on the Growth of the Council and five scenarios were presented for consideration by the Council:

1. no changes to the current councillor allocation method as delineated in the Bylaws;
2. capping the maximum number of councillors at 35;
3. two councillors per chapter and additional councillors for each 200 members
4. one councillor per chapter with one additional councillor for each 200 members; and
5. each chapter allocated two councillors and additional councillors based on their percentage of total ACEP members and removing section councillors.

The majority response from the Council was to take no action to change the current councillor allocation method as delineated in the Bylaws.

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Member Engagement

Fiscal Impact

Budgeted committee/task force and staff resources. Unbudgeted resources of $20,000-$30,000 if an in-person

committee/task force meeting is held.

Prior Council Action

Amended Resolution 13(18) Growth of the ACEP Council adopted. Directed the Council officers to appoint a task force of councillors to study the growth of the Council and determine whether to submit a Bylaws amendment to the 2019 Council addressing the size of the Council and the relative allocation of councillors.

Prior Board Action

Amended Resolution 13(18) Growth of the ACEP Council adopted.

Background Information Prepared by: Sonja Montgomery, CAE
Governance Operations Director

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 16(21)

SUBMITTED BY: John C. Moorhead, MD, FACEP
Christopher Strear, MD, FACEP

SUBJECT: ACEP Group Membership

PURPOSE: Provide individual members a 20% discount each year their group maintains 100% membership and that chapters be encouraged to match this discount on chapter dues.

FISCAL IMPACT: Unknown at this time.

WHEREAS, ACEP Group membership is recognized as '100 per cent club' if all group members are ACEP members; and

WHEREAS, "100 % Club" groups are recognized at ACEP meetings and in publications; and

WHEREAS, Benefits to groups who meet criteria for "100 % Club" include 25% discount for membership dues for new members and $25 'ACEP bucks' that can be used for ACEP educational products for existing members; and

WHEREAS, All emergency physicians receive benefits from ACEP advocacy efforts; and

WHEREAS, ACEP's goals should include 100% membership for all emergency physicians; therefore be it

RESOLVED, That ACEP group membership policy be revised to provide individual members a 20% discount on annual ACEP membership dues for every year that the group maintains 100% membership in ACEP beginning in 2022; and be it further

RESOLVED, That ACEP state chapters be encouraged to provide annual state chapter individual dues discount for members of groups who maintain 100% ACEP membership.

Background

This resolution asks ACEP to revise the group membership policy to provide individual members a 20% discount on annual dues every year that the group maintains 100% membership and that chapters be encouraged to provide chapter dues discounts for members of groups that maintain 100% membership.

Promotion of group master billings and ACEP's group recognition program began in 2006. In addition to the efficiency of group billing, which reduced administrative costs to groups, involvement in the 100% Club also included recognition in ACEP publications and online as well as a plaque acknowledging this distinction. Additionally, the application fee of $30 was waived for each new member added to the 100% Club. A $250 rebate was given for groups with 5 or more physicians registered to attend the same ACEP educational meeting.

In 2007, the Membership Committee suggested a discount program for all groups. Because the data regarding group employees was incomplete at that time, a fiscal analysis could not be completed. As an alternative, a 10% discount for new members was suggested by the Membership Committee and considered by the Finance Committee. It was agreed

that using only new members would have a positive fiscal impact. The recommended discount program was considered but ultimately not adopted because ACEP lacked the software needed to efficiently implement the discounts. At the time, the billing process and procedures would have required significant revision and required significant investment to implement. Using a variable discount added to the complexity of combined billing of both national and chapter dues making it a daunting task.

The Council and the Board of Directors adopted Resolution 16(08) Dues Discount for Groups Participating in the "100% Club." The Board approved the group membership benefit program in April 2009 and implementation began in July 2009. The current group discount program includes:

- $25 coupon for each of individual physician to use on any ACEP meeting or product.
- 15% discount with 15 or more physicians registered to attend the annual conference.
- 15% discount on all job postings and ad products on EM Career Central (ACEP and EMRA's online job board).
- Waiver of the $30 ACEP application fee for each ACEP member that is added to the physician employment group.

As of 2020, ACEP launched a group billing portal that has streamlined the group billing process. This portal has increased efficiency in group billing significantly and it allows bi-directional communication between ACEP and groups as well as simplified payment processing. Currently, there are:

TOTAL # OF ACEP GROUPS	1,897
# GROUPS 100% Club	137
# GROUP BILLING	144
# INDIVIDUAL MEMBERS	4,754

While national ACEP can encourage chapters to provide individual dues discount for members of groups who maintain 100% ACEP membership, the decision is ultimately determined by each chapter. There would need to be consistency applied across all chapters to launch this type of discounted rates in an effective manner. Variable discount rates selected by various chapters can create implementation problems.

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Member Engagement

- Objective B – Increase total membership and retain graduating residents.
  - Tactic 1 – Grow total ACEP membership by expanding on the following membership categories:
    A. Recruitment and retention of Regular Members
       i. Increase retention of graduating members
       ii. Increase retention of early career physicians at 2nd, 3rd, and 4th year post residency
       iii. Increase business development strategies to increase group membership participation
    B. Test multiple membership models to determine potential path for ACEP's future structure.

Fiscal Impact

The actual fiscal impact cannot be calculated as groups move in and out of group billing and participation in the 100% Club.

Prior Council Action

Resolution 16(08) Dues Discount for Groups Participating in the "100% Club" adopted. The resolution directed ACEP to provide a dues discount for members of the 100% Club.

Amended Substitute Resolution 55(05) Recognition of Group Participation in ACEP adopted. The resolution directed that a recognition program be developed for groups with 100% participation of eligible members.

Prior Board Action

April 2009, approved the group membership benefit program. Implementation began in July 2009.

Resolution 16(08) Dues Discount for Groups Participating in the "100% Club" adopted.

April 2007, supported the Membership Committee's member recruitment recommendations that included a continued promotional plan with an ultimate goal of 50% participation by groups.

January 2006, approved the Membership Committee recommendation to implement and promote a comprehensive master billing and recognition program to emergency physician groups.

Amended Substitute Resolution 55(05) Recognition of Group Participation in ACEP adopted.

Background Information Prepared by: Jana Nelson
Senior Vice President, Communications

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 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(21)

SUBMITTED BY: Louisiana Chapter

SUBJECT: Fair Emergency Physician Employment Contract Template

PURPOSE: Develop sample contracts for employees and independent contractors to ensure members are effective and educated self-advocates when considering potential employment opportunities.

FISCAL IMPACT: Budgeted committee or task force and staff resources. Additional unbudgeted resources to implement the resolution as written, which could likely include the need to add a part-time legal department staff member to work with members and outside counsel to revise, review, and develop the contract templates and manage the creation of a database. Potential cost is a minimum of $25,000.

WHEREAS, All, or almost every emergency physician must contract with an employer, contract management group, hospital or other entity for employment; and

WHEREAS, Many emergency physicians, particularly residents who are still in their training have little legal or contractual training or experience relative to the entity they will be contracting with; and

WHEREAS, Emergency physicians do not fully understand or have vast experience with contract negotiations to understand the many factors and variables that are associated with a contract; and

WHEREAS, Many emergency physicians often make an error or assume that a contract is not negotiable; and

WHEREAS, Many emergency physicians are told that the contract that they are presented with is a “standard contract” and make the mistake or assume that the contract must be fair if others agree to it; and

WHEREAS, The party that represents the entity that the emergency physician is to contract with does not often clearly explain the many points that are negotiable; and

WHEREAS, The reality is that most every contract is negotiable; and

WHEREAS, The emergency physician often does not fully understand market forces and often undervalues the market value of his or her services; and

WHEREAS, It would behoove ACEP to provide a service or a template of a “favorable” contract for an emergency physician that could be of significant value to its members and serve as a template or guidance to the emergency physician to better understand the many factors involved in a negotiation that have value and not to simply allow a contract management group, hospital or other employer to take advantage of the emergency physician; and

WHEREAS, Many emergency physicians may view such a template as a very valuable service and alone could help the emergency physician avoid agreeing to a contract that they will regret and may save or make the emergency physicians enough money to pay for ACEP membership many times over; and

WHEREAS, Even if the emergency physician did not get each of the items, the emergency physician would at least be aware of the variables and likely could negotiate the variables to achieve other items of value that the emergency physician might not have otherwise gotten; and

WHEREAS, Even if the emergency physician chooses to sign the "standard contract" that the contract management group, physician group or hospital offers, the emergency physician would at least be aware of the items that could be negotiated and would not be worse off by having the knowledge and the choice to accept them, negotiate for more, or walk away; and

WHEREAS, Other professional organizations have "standard contracts" available for their members and the public to use in a contract negotiation; and

WHEREAS, Many of these templates are available at no cost online; and

WHEREAS, It is understood that ACEP would provide this sample favorable emergency physician template only for informational purposes at no charge to its members, would not be giving legal advice, not offering to represent the emergency physician in contractual negotiations, or having any sort of contractual or other relationship because of producing such a template; therefore be it

RESOLVED, ACEP develop a sample employment and independent contract template specific that is fair to emergency physicians and specifically points out numerous items that can and should be part of the negotiation, understanding that when an emergency physician is asked to give up a right or agree to something that favors the employer, it is reasonable to expect or negotiate something favorable to the emergency physician in return, including but not limited to the following items:

1. Compensation and how it is determined with base or minimum amount
2. Other compensation that the employer may generate directly or indirectly as a result of emergency physician services and how much of that the emergency physician is entitled to
3. Incentives, what ones, how they are determined, who determines them, by what measure/metrics, is the data available to both parties to review, etc.
4. Percentage of gross billing or collection, how is it determined, who collects data, how accessible is this data by the emergency physician, etc.
5. Deductions that are often taken from income and how much may be reasonable i.e. medical malpractice, scheduling, etc.
6. Equitable scheduling of shifts and a reasonable differential pay or incentives for accepting less favorable shift distribution
7. Equal treatment as all members of the medical staff at the facility the emergency physician will work i.e. employer will not agree that emergency physicians have less rights than other members of the same medical staff, etc.
8. Emergency physician's right and final say to determine whether or not to settle a claim without trial
9. Specific language as to the transparency of the operations of the group/company that the emergency physician will be joining/working with/for and what power i.e. vote percentage the emergency physician will have and when
10. Severance pay to the emergency physician should the employer contract to hire and then withdraw the contract; terminate the physician; or there is separation of the parties (emergency physician and the group)
11. Non-compete clauses or specific language that there are no non-compete clauses (NCC). If there is a non-compete clause, is it only to prevent taking over a staffing contract? What is the duration of the NCC? Is the NCC only at the same facility, same town or city? What is the geographic distance of the NCC? Is there a buy out of the NCC? How much does the employer compensate the emergency physician to agree to a non-compete clause?
12. Whether the emergency physician is required to supervise, oversee, or collaborate with non-physicians and what control the emergency physician has to select who they work with, what control they have over quality measures, assurance, and enforcement including termination of the non-physician? How much additional compensation does the emergency physician receive for this service of oversight? How is it calculated? Who measures it? How accessible is the data?
13. The emergency physician should be aware of and should consider negotiating/demanding in their particular circumstances
14. Clear language requiring the employer to provide billing information that is complete, clear and transparent to

the emergency physician regarding that emergency physician's billing on a regular i.e. monthly, quarterly, semi-annual basis, without the emergency physician having to request it and not allowing the employer to require the emergency physician to have to ask for the information

15. Other topics and points that are deemed appropriate; and be it further

RESOLVED, That the ACEP Board of Directors expeditiously appoint a task force or committee to identify many factors to include in a sample employment document that is fair to emergency physicians that identifies as many items that can be separately negotiated, and provide favorable and unfavorable examples of each negotiating item, and to have such task force or committee submit their final recommendations to the Board within six (6) months and for ACEP to have a final document produced and out for viewing by the membership as soon as possible but no later than before the 2022 Council meeting begins.

Background

This resolution asks the College to appoint a task force to create template employment and independent contractor agreements that would include, at a minimum, sample provisions addressing fifteen potential employment and compensation concerns.

In 1994, the Board approved a resolution calling for the College to provide members with practical and comprehensive resources to assist them in negotiating contracts that meet their needs. Since that time, ACEP has created and updated several resources seeking to accomplish this goal, with additional educational materials being planned in 2021-22. Based on contract guidelines developed by the Medical-Legal Committee for EMRA, ACEP recently created a contract checklist for members to utilize when reviewing an employment contract.

Staff is currently working with member volunteers to update many of the contract resources found on our website such as policy statements, model contracts, and articles on fairness and due process considerations.

In March 2021, a promotional campaign was launched reminding ACEP members of resources available through Mines & Associates, a vendor that provides members financial and legal support. For $15 annually, ACEP members can schedule an unlimited number of 30-minute in-person consultations for each individual legal matter. Members can also take advantage of a 25% discount on select legal services within the Mines & Associates legal network if additional support is required.

On May 6, 2021, the Young Physicians Section hosted a webinar, "Standard Contract Precautions," that was promoted in advance and now resides on ACEP's Career Resources page and is referenced in career-related communications.

Staff is reviewing and updating existing resources (Indemnification Clauses, Fairness and Due Process, and more) found at acep.org/contracts. We are currently working to curate external resources and create new resources to expand member's understanding of contract nuances.

Because contract needs are individualized, plans are underway for a contract clause library based on many of the recommended subjects in this resolution. This online library will be categorized by topic and will provide favorable clauses for consideration.

There are also plans underway to recruit member volunteers to participate in a peer-to-peer mentoring program addressing common issues that arise in contract negotiations. We will host several virtual training opportunities with experts in employment law as well as organize webinars with veteran emergency physicians who will answer member questions and discuss real life examples, both successes and pitfalls, of their own contract negotiation wins and losses.

ACEP Strategic Plan Reference
Goal 2 – Enhance Membership Value and Member Engagement

- Objective A – Improve the practice environment and member well-being.

- Tactic 1 – Enhance and promote availability of a clearinghouse of materials, resources, and courses on professional liability and litigation stress.

Fiscal Impact

Budgeted committee or task force and staff resources. Additional unbudgeted resources to implement the resolution as written, which could likely include the need to add a part-time legal department staff member to work with members and outside counsel to revise, review, and develop the contract templates and manage the creation of a database. Potential cost is a minimum of $25,000.

Prior Council Action

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 17(19) Pay Transparency adopted. Directed ACEP to develop a policy statement in favor of physician salary and benefit package equity and transparency.

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 29(11) Due Process for Emergency Physicians adopted. Directed ACEP to review and update the policy statement "Emergency Physician Contractual Relationships" regarding due process and distribute the updated policy to other organizations and request that it be distributed to their membership and to other entities deemed appropriate by the Board of Directors.

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.

Resolution 59(95) Due Process for Emergency Physicians referred to the Board of Directors. The resolution called for the College to support, and incorporate into educational and advocacy efforts, promotion of the concepts of due process in all employment arrangements for emergency physicians, that any emergency physician being terminated has the right to receive the reasons for such termination and to formally respond to those reasons prior to the effective date of the termination.

Amended Resolution 54(94) Due Process adopted in lieu of resolutions 52(94) Due Process Exclusion Clauses and 54(94) Due Process. The amended resolution directed the College to study the issue of peer review and due process exclusion clauses in emergency physician contracts.

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.

Prior Board Action

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.

October 2020, approved the policy statement "Emergency Physician Compensation Transparency."

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.

Amended Resolution 17(19) Pay Transparency 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."

April 2016 approved the revised policy statement "Fair Payment for Emergency Department Services;" originally approved April 2009.

April 2016, reviewed the information paper "Indemnification Clauses in Emergency Medicine Contracts."

Amended Resolution 30(11) Emergency Physician Contracts and Medical Staff Activities/Membership adopted.

Resolution 29(11) Due Process for Emergency Physicians 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.

Amended Resolution 54(94) Due Process adopted in lieu of resolutions 52(94) Due Process Exclusion Clauses and 54(94) Due Process.

Amended Resolution 49(94) Information on Contract Issues adopted.

Background Information Prepared by: Jana Nelson
Senior Vice President, Communications

Leslie Moore, JD
Senior Vice President, General Counsel

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 18(21)

SUBMITTED BY: Howard K. Mell, MD, MPH, FACEP
Phillip Luke LeBas, MD, FACEP

SUBJECT: Change to ACEP Conflict of Interest Statement

PURPOSE: 1) Revise ACEP's Conflict of Interest (COI) disclosure form to include all immediate family members, intimate partners, and non-adopted children of a current spouse; 2) provide the COI forms to all members and staff working on the project, committee, or task force and be included in the materials for that project, committee, or task force; 3) revise the COI disclosure form to include a question to indicate whether the person completing the form is related to a non-physician provider (e.g., nurse practitioner or physician assistant) and if that person formerly or currently works in an ED or urgent care facility; and 4) all candidates for election by the Council, including anyone running from the floor, complete the COI form and copies of the forms be included in the election materials and available to all councillors

FISCAL IMPACT: Budgeted staff resources.

WHEREAS, ACEP policy requires "key leaders" of the College and staff of the College to complete a Conflict of Interest (COI) form; and

WHEREAS, Current ACEP policy calls for:

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

a. Positions of leadership in other organizations, chapters, commissions, groups, coalitions, agencies, and entities – e.g., board of directors, committees, spokesperson role. Include a brief description of the nature and purposes of the organization or entity.
b. Positions of employment, including the nature of the business of the employer, the position held, and a description of the daily responsibilities of the employment.
c. Direct financial interest (other than a less than 1% interest in a publicly traded company) or positions of responsibility in any entity:
    i. From which ACEP obtains substantial amounts of goods or services;
    ii. That provides services that substantially compete with ACEP; and
    iii. That provides goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company).
d. Industry-sponsored research support within the preceding twenty-four (24) months.
e. Speaking fees from non-academic entities during the preceding twenty-four (24) months.
f. The receipt of any unusual gifts or favors from an outside entity or person, or the expectation that a future gift or favor will be received in return for a specific action, position, or viewpoint taken in regard to ACEP or its products.
g. Any other interest the Key Leader believes may create a conflict with the fiduciary duty to ACEP or that may create the appearance of a conflict of interest.; and

WHEREAS, The current ACEP policy states:

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

a. The individual;

b. A member of that individual's immediate family; or
c. Any party, group, or organization to which the individual has allegiance that can cause ACEP to be legally or otherwise vulnerable to criticism, embarrassment or litigation."; and

WHEREAS, The role and use of non-physician providers (e.g., nurse practitioners or physician assistants – term used as it remains the legal term in most states) in the emergency department is a subject of frequent debate and the questions of their role permeates many projects within the College; and

WHEREAS, Some individuals may be blinded to their own biases, especially when it comes to the influence exerted by immediate family members or intimate partners; therefore be it

RESOLVED, That the ACEP Conflict of Interest form include all immediate family members or intimate partners in situations of same sex couples not recognized by local law as well as non-adopted children of a current spouse; and be it further

RESOLVED, That the ACEP Conflict of Interest forms be provided to all members and relevant staff and be included in the introductory materials for the project, committee, or task force; and be it further

RESOLVED, That a question be added to the College's Conflict of Interest form to indicate if the person completing the form is related to a non-physician provider and if that non-physician provider formerly or currently works in an emergency department or urgent care; and be it further

RESOLVED, That every candidate for the College President, Board of Directors, or Council Officer positions, including those running from the floor, complete the ACEP Conflict of Interest (COI) form and copies of those COI statements be included in election materials and available to all councillors.

Background

This resolution seeks to revise ACEP's Conflict of Interest (COI) disclosure form to include all immediate family members, intimate partners, and non-adopted children of a current spouse; provide the COI forms to all members and staff working on the project, committee, or task force and be included in the materials for the project, committee, or task force; revise the COI disclosure form to include a question to indicate whether the person completing the form is related to a non-physician provider (e.g., nurse practitioner or physician assistant) and if that person formerly or currently works in an ED or urgent care facility; and that all candidates for election by the Council, including anyone running from the floor, complete the COI form and copies of the forms be included in the election materials and available to all councillors.

ACEP's "Conflict of Interest" policy statement was first adopted in 1996 and it has undergone multiple revisions since that time. The policy statement is also informed by external standards such as the Council of Medical Specialty Societies' (CMSS) "Code for Interactions with Companies" and the Accreditation Council for Continuing Medical Education's (ACCME) "Standards for Integrity and Independence in Accredited Continuing Education."

ACEP adopted the CMSS "Code for Interactions with Companies" in 2010. The purpose of the Code is to guide Medical Specialty Societies in the development of policies and procedures that safeguard the independence of their programs, policies, and advocacy positions. Because Societies can vary in their activities and corporate structures, each Society that chooses to sign on to the Code is encouraged to adopt policies and procedures that are tailored to meet its individual organizational needs. Collectively, adopting this Code helps to ensure that a Society's interactions with Companies will be for the benefit of patients and members and for the improvement of care in their respective specialty fields.

ACEP must adhere to the ACCME "Standards for Integrity and Independence in Accredited Continuing Education" as an accredited provider of continuing medical education (CME). The Standards cover a variety of issues, including preventing commercial bias and marketing in accredited CME and identifying, mitigating, and disclosing relevant financial relationships.

"Key leaders," as defined in the "Conflict of Interest" policy statement, are "Officers, Directors, Committee Chairs and Members, Section Chairs, Task Force Chairs, *Annals* Editor, and the Executive Director." The policy requires key leaders to sign an annual conflict of interest disclosure form. ACEP also requires all task force members to complete the disclosure form. The disclosure form is the same for all key leaders, except that the heading on the form is updated for each type of key leader (e.g., Board members, committee chairs, etc.). The COI forms are maintained in each key leader's membership record and they are required to submit updated disclosure forms any time throughout the year as necessary to continuously keep the information current. The questions on the disclosure form can be modified at any time to include additional questions that may be needed at any time such as those requested in this resolution.

The COI disclosure forms are available to any committee or task force member and staff. The forms can be provided to all committee and task force members with any materials distributed for that project, committee, or task force.

All candidates seeking election as president-elect, Board member, or Council officer, including those running from the floor, must complete a Candidate Data Sheet and a Candidate Disclosure Form.

The Candidate Data Sheet requests candidates to provide the following information:

- current and past professional position(s)
- education (including internships and residency information), medical degree, and year received
- specialty certifications and dates certified and recertified
- membership in professional societies
- national ACEP and chapter activities
- practice profile
- description of current emergency medicine practice (e.g., type of employment, type of facility, single or multi-hospital group, etc.) including title and position
- expert witness experience.

The Candidate Disclosure Form requests candidates to provide the following information:

- employer, position held, type of organization
- Board of Directors positions held (current and past) including the name of the organization, address, type of organization, and duration on the Board

The Candidate Disclosure Form also requests the following information:

- I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination. (answer none or if yes describe)
- Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.
- Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.
- 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.
- 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?

The information requested on the Candidate Disclosure Form is essentially the same as what is requested on the COI disclosure form. Additionally, the CVs of all candidates are provided to the Council. Upon election, all new Board members and Council officers are required to submit the COI form.

Information on each of this year's candidates is provided in the PDF compendium of Council meeting materials and

will also be emailed separately to the Council.

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Member Engagement

Fiscal Impact

Budgeted staff resources.

Prior Council Action

Amended Resolution 8(12) Conflict of Interest Disclosure. Added a new section to the Council Standing Rules on conflict of interest disclosure.

Resolution 23(03) Conflict of Interest for ACEP Leaders not adopted. The resolution sought to have all members serving on committees, in the Council, and Board members disclose any leadership positions with potential conflict by written notification to the Council speaker and Board president.

Substitute Resolution 23(97) Conflict of Interest adopted. The resolution directed that the Council support the Conflict of Interest policy as approved by the ACEP Board of Directors and that the Council commend the Board of Directors for its rapid and decisive action in establishing this policy.

Resolution 42(95) Executive Officer Business Interests referred to the Board of Directors. Called for ACEP's top ten executives to not have any financial arrangement and/or direct affiliation with any corporate or private organization that profits financially from the field of emergency medicine.

Resolution 40(95) NEMPAC Officer Business Interests not adopted. Called for NEMPAC officers members to report and publish annually in *ACEP News* any personal business investments in emergency medicine related companies. Substitute Resolution 37(95) was adopted in lieu of this resolution.

Resolution 39(95) Board Member Business Interests not adopted. Called for ACEP Board members to disclose and publish annually in *ACEP News* any personal business investments in emergency medicine related companies. Substitute Resolution 37(95) was adopted in lieu of this resolution.

Resolution 38(95) Conflict of Interest Disclosure Statement not adopted. Called for ACEP to add a fourth category to the Conflict of Interest disclosure form regarding personal or family material interest in any outside concern that profits financially from the clinical practice of emergency medicine. Substitute Resolution 37(95) was adopted in lieu of this resolution.

Substitute Resolution 37(95) Disclosure Prior to Board Elections adopted in lieu of resolutions 37, 38, 39, and 40. The substitute resolution directed ACEP to amend the Conflict of Interest form by adding specific language about known financial interest in any business or organization that profits financially from the practice of emergency medicine.

Substitute Resolution 59(94) adopted. Board officer candidates to disclose financial interests prior to election.

Substitute Resolution 31(90) Elected Officer Activities adopted. Directed the Board to examine the current endorsement and conflict of interest policies to assure they adequately address potential conflicts and review recommended revisions with the Council Steering Committee.

Prior Board Action

April 2010, adopted the Council of Medical Specialty Societies' "Code for Interactions with Companies."

January 2017, approved the revised policy statement "Conflict of Interest;" revised and approved June 2011, June

2008; reaffirmed October 2001; revised and approved September 1997; originally approved January 1996.

Substitute Resolution 23(97) Conflict of Interest adopted.

Substitute Resolution 37(95) Disclosure Prior to Board Elections adopted.

Substitute Resolution 31(90) Elected Officer Activities adopted.

Background Information Prepared by: Sonja Montgomery, CAE
Governance Operations Director

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 19(21)

SUBMITTED BY: Louisiana Chapter

SUBJECT: Clear and Complete Conflict of Interest Disclosure at the Council Meeting

PURPOSE: 1) Requests a requirement that all councillors, alternate councillors, and anyone else with speaking rights on the Council floor or otherwise complete a conflict of interest disclosure form; 2) implement a system, i.e., electronic wristband, that can be scanned and will display pertinent elements of the conflict of interest disclosure form.

FISCAL IMPACT: Budgeted staff resources to collect conflict of interest forms. Unbudgeted and unknown costs to obtain a system to scan wristbands or other devices, program the system, and upload data. Additional unknown costs to employ the technology in the Council meeting and Reference Committee hearing rooms.

WHEREAS, It is important to have constructive discussions at the Council meeting; and

WHEREAS, It is important to disclose conflict of interests before speaking so it is clear and apparent to others if they perceive the speaker to have a conflict of interest or bias on the subject matter being discussed; and

WHEREAS, The conflict of interests are based on the "honor system' for the speaker to determine if a conflict exists or not and to disclose it to the Council before stating the speaker's opinion on the topic being discussed or debated; and

WHEREAS, Many in the College have biases and conflicts that they themselves may not fully appreciate that others may find important to be aware of; and

WHEREAS, Many in the College and Council may be significantly influenced by, or have a financial incentive to argue i.e. they are employed by or hold a compensated leadership position, and may have a personal or financial incentive to make a particular argument; and

WHEREAS, Many who may have a conflict of interest, or a perceived conflict of interest may not even realize it themselves; and

WHEREAS, An officer of a contract management group has spoken on the Council floor during a discussion of private equity involvement without disclosing that speaker's leadership position with a contract management group owned by private equity; and

WHEREAS, Candidates for office within ACEP have run for office and help leadership positions without clearly communicating and all Councilor and ACEP members being made aware of the potential influence or perceived conflict of interest that might exist; and

WHEREAS, ACEP has been viewed in the past as being too influenced by contract management groups or private equity, and

WHEREAS, It is important for the integrity of the Council and ACEP, and the debate being made to have clear and full disclosures to allow for the entire Council to reasonably determine for themselves if the speaker has a bias or conflict regarding the topic being discussed or debated; and

WHEREAS, The advancements of technology has allowed us to do things today that were impossible or much more difficult or expensive to do before; therefore be it

RESOLVED, That all councillors, alternate councillors, and anyone else who may speak during Council on the Council floor or otherwise complete a disclosure form prior to the Council meeting with specific questions regarding potential conflicts that may be of importance to the Council at large to be aware; and be it further

RESOLVED, That the College implement a system i.e., electronic wristband that can be scanned when person approaches any microphone, that will display on the large screens in the room where Council is taking place that will reveal pertinent elements of the disclosure form that the speaker completed prior to Council i.e., employer, position with employer, percentage of clinical time vs. non-clinical time, other sources of revenue, etc., without disclosing specific amounts or data that the Council would find too invasive.

Background

This resolution requests that all councillors, alternate councillors, and anyone else with speaking rights on the Council floor or otherwise complete a conflict of interest disclosure form prior to the Council meeting and that ACEP implement a system, i.e., electronic wristband, that can be scanned and will display pertinent elements of the conflict of interest disclosure form regarding employer, position with employer, percentage of clinical time vs. non-clinical time, other sources of revenue, etc.

ACEP's "Conflict of Interest" policy statement was first adopted in 1996 and it has undergone multiple revisions since that time. The policy statement is also informed by external standards such as the Council of Medical Specialty Societies' (CMSS) "Code for Interactions with Companies" and the Accreditation Council for Continuing Medical Education's (ACCME) "Standards for Integrity and Independence in Accredited Continuing Education."

ACEP adopted the CMSS "Code for Interactions with Companies" in 2010. The purpose of the Code is to guide Medical Specialty Societies in the development of policies and procedures that safeguard the independence of their programs, policies, and advocacy positions. Because Societies can vary in their activities and corporate structures, each Society that chooses to sign on to the Code is encouraged to adopt policies and procedures that are tailored to meet its individual organizational needs. Collectively, adopting this Code helps to ensure that a Society's interactions with Companies will be for the benefit of patients and members and for the improvement of care in their respective specialty fields.

ACEP must adhere to the ACCME "Standards for Integrity and Independence in Accredited Continuing Education" as an accredited provider of continuing medical education (CME). The Standards cover a variety of issues, including preventing commercial bias and marketing in accredited CME and identifying, mitigating, and disclosing relevant financial relationships.

ACEP's current Conflict of Interest" policy statement requires "Key Leaders" to complete Conflict of Interest (COI) disclosure forms. "Key leaders" are defined as "Officers, Directors, Committee Chairs and Members, Section Chairs, Task Force Chairs, *Annals* Editor, and the Executive Director."

Councillors, alternate councillors, and others that have speaking rights as defined in the Council Standing Rules do not complete COI disclosure forms unless they meet the definition of a Key Leader. Per the Council Standing Rules, those with speaking rights include councillors, members of the Board of Directors, past presidents, past speakers, and past chairs of the Board as well as alternate councillors not currently seated and other individuals authorized by the presiding officer to speak at a designated time. Reference Committee meetings are open to all members of the College, its committees, and invited guests (which may include non-members, such as representatives from other organizations) and anyone may speak on any resolution under consideration upon recognition by the Reference Committee chair.

The Council Standing Rules, "Conflict of Interest Disclosure" section states:

> "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."

Guidelines and compliance procedures would need to be developed to implement a system as described in the resolution.

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Member Engagement

Fiscal Impact

Budgeted staff resources to collect conflict of interest forms. Unbudgeted and unknown costs to obtain a system to scan wristbands or other devices, program the system, and upload data. Additional unknown costs to employ the technology in the Council meeting and Reference Committee hearing rooms.

Prior Council Action

Amended Resolution 8(12) Conflict of Interest Disclosure. Added a new section to the Council Standing Rules on conflict of interest disclosure.

Resolution 23(03) Conflict of Interest for ACEP Leaders not adopted. The resolution sought to have all members serving on committees, in the Council, and Board members disclose any leadership positions with potential conflict by written notification to the Council speaker and Board president.

Substitute Resolution 23(97) Conflict of Interest adopted. The resolution directed that the Council support the Conflict of Interest policy as approved by the ACEP Board of Directors and that the Council commend the Board of Directors for its rapid and decisive action in establishing this policy.

Resolution 42(95) Executive Officer Business Interests referred to the Board of Directors. Called for ACEP's top ten executives to not have any financial arrangement and/or direct affiliation with any corporate or private organization that profits financially from the field of emergency medicine.

Resolution 40(95) NEMPAC Officer Business Interests not adopted. Called for NEMPAC officers members to report and publish annually in *ACEP News* any personal business investments in emergency medicine related companies. Substitute Resolution 37(95) was adopted in lieu of this resolution.

Resolution 39(95) Board Member Business Interests not adopted. Called for ACEP Board members to disclose and publish annually in *ACEP News* any personal business investments in emergency medicine related companies. Substitute Resolution 37(95) was adopted in lieu of this resolution.

Resolution 38(95) Conflict of Interest Disclosure Statement not adopted. Called for ACEP to add a fourth category to the Conflict of Interest disclosure form regarding personal or family material interest in any outside concern that profits financially from the clinical practice of emergency medicine. Substitute Resolution 37(95) was adopted in lieu of this resolution.

Substitute Resolution 37(95) Disclosure Prior to Board Elections adopted in lieu of resolutions 37, 38, 39, and 40. The substitute resolution directed ACEP to amend the Conflict of Interest form by adding specific language about known financial interest in any business or organization that profits financially from the practice of emergency medicine.

Substitute Resolution 59(94) adopted. Board officer candidates to disclose financial interests prior to election.

Substitute Resolution 31(90) Elected Officer Activities adopted. Directed the Board to examine the current endorsement and conflict of interest policies to assure they adequately address potential conflicts and review recommended revisions with the Council Steering Committee.

Prior Board Action

April 2010, adopted the Council of Medical Specialty Societies' "Code for Interactions with Companies."

January 2017, approved the revised policy statement "Conflict of Interest;" revised and approved June 2011, June 2008; reaffirmed October 2001; revised and approved September 1997; originally approved January 1996.

Substitute Resolution 23(97) Conflict of Interest adopted.

Substitute Resolution 37(95) Disclosure Prior to Board Elections adopted.

Substitute Resolution 31(90) Elected Officer Activities adopted.

Background Information Prepared by: Sonja Montgomery, CAE
Governance Operations Director

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 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(21)

SUBMITTED BY: Howard Mell, MD, MPH, FACEP
Taylor Nichols, MD

SUBJECT: Creation of the Social Emergency Medicine Association

PURPOSE: Create a new 501c(3) non-profit organization called the "Social Emergency Medicine Association" under the umbrella of ACEP and develop the governing documents by the Council meeting in 2022.

FISCAL IMPACT: Establishing the entity costs – $7,000 – $13,500; one-time start-up costs – $22,000; ongoing annual costs $152,000; annual audit and tax services – $10,000. Additional undetermined direct and indirect costs.

WHEREAS, There are a number of issues of a nature commonly referred to as "social emergency medicine" issues that directly affect the daily practice of all emergency physicians; and

WHEREAS, The Andrew Levitt Center for Social Emergency Medicine describes the field as "Today's emergency departments can be viewed as the crucibles of social experimentation. As we modify American social structure, providing or withdrawing this or that benefit or element of the social safety net, the results are manifest in the emergency department. Most obviously, the decline of private health insurance has led to increased use of the ED as a provider of primary care. But in so many ways, perhaps more so than any other discipline in medicine, emergency medicine is enmeshed in the mores and practices of its immediate community, as well as the larger social and regulatory milieu."; and

WHEREAS, Each year any number of increasingly complex and nuanced issues in social emergency medicine (e.g., the presence of law enforcement body worn cameras in the emergency department or the effect of race on pain control in the ED) have been brought before the Council for action; and

WHEREAS, The Council has limited time to educate themselves on and debate these complex issues resulting in difficulties prioritizing the expenditure of increasingly very limited resources on such issues; and

WHEREAS, The creation of the Emergency Medicine Foundation (EMF) has allowed for the Council to no longer be the focal point of debate about funding emergency medicine research or prioritizing specific research objectives; and

WHEREAS, The creation of the National Emergency Medicine Political Action Committee (NEMPAC) has largely kept questions of direct political action for or against specific candidates off the Council floor; therefore be it

RESOLVED, That ACEP create a 501c(3) non-profit fund to be called the "Social Emergency Medicine Association" (SEMA) as a daughter organization in the same fashion as the Emergency Medicine Foundation and the National Emergency Medicine Political Action Committee for the purpose of funding, prioritizing, and administering efforts in social emergency medicine; and be it further

RESOLVED, That the ACEP Board of Directors and staff create the Social Emergency Medicine Association, including its rules and bylaws, by the Council meeting in 2022.

Background

This resolution calls for the establishment of a separate tax-exempt entity that could raise money through member donations and corporate and foundation support to fund work on unique social emergency medicine issues. ACEP works with two entities with close affiliation to help the College carry out related work: the Emergency Medicine Foundation (EMF) and the National Emergency Medicine Political Action Committee (NEMPAC).

The Social Emergency Medicine section was established in 2017 with a vision to incorporate social context into the structure and practice of emergency care. The section has 329 active member and is focused on:

- promoting the incorporation of patients' social context into routine emergency care.
- serving as a central organizing point for emergency providers interested in the interplay of the emergency care system and social forces affecting both patients and communities.
- fostering high-quality research and translate this research into best practices for the application of social determinants of health at the bedside and beyond.
- disseminating emergency department (ED) interventions that improve population health through emergency care informed by community needs, with a focus on EDs that see underserved patients.
- proposing, evaluating, and critiquing health policies that affect the social determinants of health of our communities, especially as they pertain to marginalized and vulnerable populations that frequently present to EDs for their care.

NEMPAC was established more than 40 years ago. It started with a small group of ACEP advocates who raised $10,000 (each one contributed $1,000) and has grown to $1 million + per year. NEMPAC is not a separately incorporated entity; rather it is a separate segregated fund, connected with and dependent on administrative funding from ACEP and operates with Articles of Association approved both by ACEP Board of Directors and the NEMPAC Board of Trustees. The purpose of NEMPAC is to provide the opportunity for individuals interested in the future of emergency medicine to contribute to the support of worthy candidates for federal offices who believe, and have demonstrated their beliefs, in the principles to which emergency medicine is dedicated. To further these purposes, NEMPAC is empowered to solicit, directly or indirectly, and accept voluntary personal contributions, and to make expenditures in connection with the attempt to influence the selection, nomination, or election of any individual to any elective federal office. Under Federal election law governed by the Federal Election Commission, NEMPAC may only solicit active ACEP members and cannot go outside of the membership for support. NEMPAC is the fourth largest physician specialty PAC and for the past several years has outraised and outspent the AMA. More information about NEMPAC can be found here.

The Emergency Medicine Foundation (EMF) was founded in 1972 by leaders of the American College of Emergency Physicians (ACEP) and is a 501(c)3 tax exempt nonprofit organization. EMF's mission is to develop career emergency medicine researchers, improve patient care, and provide the basis for effective health policy. To date, EMF has awarded more than $17 million in research grants to advance emergency medicine science and health policy. Donations are received primarily from ACEP members who are solicited annually through the ACEP dues statement. ACEP and EMF, while separate organizations, have common goals and interest in furthering and promoting emergency medicine education and research. The parties operate under a shared services agreement in which ACEP provides EMF certain resources, including an annual $200,000 donation, in kind personnel, office space, and equipment. EMF commitment's to ACEP is to work within the agreement and continue to advance the mission of emergency medicine research. EMF has awarded a $50,000 COVID-19 research grant "Social Determinants of Health and COVID-19 Infection in North Carolina: A Geospatial and Qualitative Analysis." Additionally, EMF has approved funding of $50,000 each for two health disparities grants during the FY 21-22 grant cycle: EMF Health Disparities Grant and the EMF/ENAF Health Disparities Grant.

Establishing a separate legally incorporated entity would require legal and financial resources. In addition, staff support would need to be established to support the fundraising work and any grant making work. Consideration would need to be given to the Board composition up for this new entity as well as the criteria and process to be used for awarding funding to support social emergency medicine issues. Fundraising and communication coordination

would be needed between this new entity, EMF, and NEMPAC to avoid confusing or diverting donors from ACEP's already existing allied entities as well as ongoing financial support for ACEP.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care.

- Objective C – Promote the value of emergency medicine and emergency physicians as essential components of the health care system.
- Objective I – Play a defining role in addressing health care equity in emergency medicine.

Fiscal Impact

Establishing the Entity Costs – $7,000 – $13,500

- Drafting articles of incorporation, bylaws, organizational minutes, and state filing fees = $3,000 – $5,000
- Filing 1023 application with the IRS = $2,500 – $5,000
- Logo/name registration with the USPTO = $1,500 – 3,500

One Time Start Up Costs – $22,000

- Set up Great Plains financial database – $3,000
- Donor database annual fee – $4,500
- Finance Department (staff labor and benefits expense) = $6,500 = 80 hours of work
  - establish bank account
  - establish merchant account (credit card payments)
  - assist IT with Great Plains database set up – GL account set up, AP check printing, AR module, etc.
- Technology Services – $7,000 – $8,000 = 80 hours of work
  - create website
  - create online donation interface with new merchant account and donor database

Ongoing Annual Costs – $152,000

- $37,000 (salary and benefits) for executive director role – 20% of existing staff person's time to manage the governance/Board meetings, set strategy, etc.
- $4,000 – Technology Services staff (salary and benefits) 160 hours per year to update the website, etc.
- $50,000 – 25% of grants manager salary and benefits to write grants/fundraise, etc.
- $35,000 – A combination of 35% of staff time from Member Care and Marketing to answer questions about donations, etc. and to create marketing emails, etc.
- $26,000 – Staff labor and benefit expense for 30% of Finance FTE to prepare monthly financials, reconcile the bank accounts, assist with budget preparation, IRS 1099 annual filings, AP payment processing, deposit checks, etc.

**as support and programs grow annual operating cost would increase as staff time needed to support the work would increase.*

Annual Audit and Tax Services – $10,000

- Annual Financial Audit – $7,000
- IRS 990 Preparation Assistance and Filing – $3,000

Undetermined Direct and Indirect Cost Considerations:

- Annual costs do not include additional personnel required to undertake funded programs and/or ongoing activities, including donor relations.
- No projections can be made at this time about the feasibility or sustainability of individual donations or organizational grants, nor about the extent to which these would simply redirect funds currently received by ACEP, NEMPAC, or EMF.

Prior Council Action

None

Prior Board Action

None

Background Information Prepared by: Bobby Heard, MBA, CAE
Chief Operating Officer

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 21(21)

SUBMITTED BY: Ramon W. Johnson, MD, FACEP
Nicholas Jouriles, MD, FACEP
Marcus Wooten, MD
Yvette Calderon, MD, FACEP
Diversity, Inclusion, & Health Equity Section

SUBJECT: Diversity, Equity, and Inclusion

PURPOSE: 1) 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: 2) embed diversity, equity, and inclusion into the strategic plan as well as the internal and external work of ACEP; and 3) provide a report to the 2022 Council regarding the outcome of the summit.

FISCAL IMPACT: Budgeted task force and staff resources if a meeting is held virtually. Unbudgeted expenses of $20,000 – $30,000 for an in- person meeting depending on the size of the group.

WHEREAS, ACEP members serve a diversified public; and

WHEREAS, ACEP champions and promotes health equity and racial justice to reduce health disparities and build structural competency within emergency medicine; and

WHEREAS, ACEP hopes to contribute to a diverse emergency medicine workforce; and

WHEREAS, The AMA has a center for health equity and which has created a strategic plan to address health equity; and

WHEREAS, Achieving optimally equitable solutions requires disruption and dismantling of existing norms, collective advocacy, and action across multiple sectors and disciplines; therefore be it

RESOLVED, That ACEP convene a summit meeting inviting the societies of emergency medicine to align efforts to address diversity, equity, and inclusion within the next year; and be it further

RESOLVED, That ACEP embed diversity, equity, and inclusion into its strategic plan and the internal and external work of ACEP; and be it further

RESOLVED, That ACEP report back to the 2022 Council meeting the outcome of the summit and have a road map created to promote diversity, equity, and inclusion in the specialty of emergency medicine.

Background

This resolution asks ACEP 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: 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.

The ACEP Board of Directors have embarked on an extensive strategic planning process to help guide the future

direction of the College. During this process ACEP has been working to create a roadmap for developing a new strategic plan for the College and is engaging key stakeholders throughout this process. Ensuring diversity, inclusion and equity is part of that process has been very deliberate. Representatives from the Diversity, Inclusion & Health Equity (DIHE) Section participated with the Board for the first strategic planning retreat meeting held in July in Washington DC and will also be part of the second retreat meeting scheduled for September. The DIHE Section has also been invited to provide representatives to participate on some of the eight strategic issues action teams. As the process moves forward, diversity, inclusion and equity will be an important consideration in all aspects of the new strategic plan.

ACEP's policy statement "Workforce Diversity in Health Care Settings Policy Statement" supports ACEP's priority that hospitals and emergency physicians should staff emergency departments with a diverse workforce. ACEP's goal is to attain a diverse, well-qualified physician workforce that truly reflects our multicultural society. Implicit bias serves as an influencer of management and medical staff and is a hindrance of the career advancement of physicians based on characteristics, such as gender, race, age, sexual orientation, or religious preference.

ACEP's policy statement "Cultural Awareness and Emergency Care Policy Statement" supports that "cultural awareness is essential to the training of healthcare professionals in providing quality patient care. It also confirms ACEP's position that resources should be made available to emergency departments and emergency physicians to assure they properly respond to the needs of all patients regardless of background. This is important to the subject of implicit bias, as cultural awareness helps combat negative assumptions and associations.

ACEP hosted a Diversity Summit on Thursday, April 14, 2016, at the ACEP Headquarters. The summit was highlighted in an ACEP Now article in June 2016. There were two visions for ACEP: establishing emergency medicine as the nucleus of a new acute care continuum and fostering generational, racial, and gender diversity within the specialty. ACEP utilized the services of a diversity consultant to help facilitate this summit.

The primary objectives for this summit were:

- Provide environmental data important to the specialty of emergency medicine.
- Create a safe space to share stories, create dialogue, new ideas, and awareness.
- Capture results and identify areas of focus that will influence diversity and inclusion for ACEP.

In June 2016, a Diversity & Inclusion Task Force was created. The primary objectives of the task force were:

1. To engage the specialty of emergency medicine on diversity and inclusion.
2. To identify obstacles to advancement within the profession of emergency medicine related to diversity and inclusion, and ways to overcome these obstacles.
3. To highlight the effects of diversity and inclusion on patient outcomes and to identify ways to improve these outcomes and to identify ways to improve these outcomes.

Following on the work of the task force, ACEP's Diversity, Inclusion, & Health Equity Section was formed.

ACEP is supporting the Society for Academic Emergency Medicine's SAEM22 Consensus Conference on "Diversity, Equity and Inclusion. The conference, as described by SAEM: "The overarching goal of this Consensus Conference is to stimulate researchers and educators in our specialty to generate a research agenda around the role of racism in modern healthcare and medical education that results in disparate outcomes for our patients. The themes of the conference have been informed by national experts both within and outside our specialty and include: Education and Training; Leadership; Research, and Social Determinants of Health. The specific objectives are to: 1) Identify best practices, clarify knowledge gaps and prioritize research questions; 2) Bring together key stakeholders with varied backgrounds to develop collaborative research networks; and 3) Disseminate findings of the consensus conference through peer-reviewed publications, national meetings, policy briefs, and other venues."

ACEP and the Council of Residency Directors in Emergency Medicine (CORD) are participating in a collaboration between the Accreditation Council for Graduate Medical Education (ACGME) and the Council of Medical Specialty

Societies (CMSS) called "Equity Matters." The program, as described by CMSS: "Equity Matters is an Accreditation ACGME initiative that supplies a framework for continuous learning and process improvement in the areas of diversity, equity, and inclusion (DEI) and anti-racism practices. The purpose of this initiative is to achieve health equity through increasing physician workforce diversity, and by creating clinical learning environments that are safe, inclusive, and equitable." ACEP's participation in the program will run through December 2022 and will culminate in capstone project.

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Member Engagement

- Objective G – Promote/facilitate diversity and inclusion and cultural sensitivity within emergency medicine.
  - Tactic 3 – Work with organizations such as SAEM's Academy for Diversity and Inclusion in Emergency Medicine to advance diversity in emergency medicine.

Fiscal Impact

Budgeted task force and staff resources if a meeting is held virtually. Unbudgeted expenses of $20,000 – $30,000 for an in- person meeting depending on the size of the group.

Prior Council Action

None

Prior Board Action

The Board of Directors approves the Strategic Plan annually.

April 2021, approved the revised policy statement "Cultural Awareness and Emergency Care;" revised and approved April 2020; reaffirmed April 2014; originally approved April 2008 with the current title replacing "Cultural Competence and Emergency Care" approved October 2001.

November 2017, approved the revised policy statement "Workforce Diversity in Health Care Settings Policy Statement;" reaffirmed June 2013 and October 2007; originally approved October 2001.

April 2017, approved the revised Strategic Plan objective "Promote/facilitate diversity and inclusion and cultural sensitivity within emergency medicine."

April 2016, approved adding the objective "Promote and facilitate diversity and cultural sensitivity with ACEP" to ACEP's Strategic Plan.

Background Information Prepared by: Riane Gay, MPA, CAE
Director, Corporate Development

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 22(21)

SUBMITTED BY: New York Chapter

SUBJECT: Expanding Diversity and Inclusion in Educational Programs

PURPOSE: Survey ACEP 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.

FISCAL IMPACT: Budgeted staff resources for development and analysis of survey and results, data entry into CRM for data collected. Potential unbudgeted costs for temporary staff assistance.

WHEREAS, ACEP is committed to increasing diversity and inclusion in its membership; and

WHEREAS, There is benefit in understanding the collective perspectives and diverse set of experiences to adequately address disparities in healthcare and healthcare outcomes; and

WHEREAS, ACEP educational programs are a significant source of training and continuing education for the Emergency Medicine community; and

WHEREAS, Differences in care and diagnosis related to age, gender, identity, race, culture, sexual orientation, physical disability/limitation, ethnicity and social status are classically understudied and taught; and

WHEREAS, The ACEP Leadership Diversity Task Force has already been assigned to look at the nominating processes and pipeline programs within the Council component bodies; therefore be it

RESOLVED, That ACEP survey its speakers and educational presenters and report on speaker/educator demographics; and be it further

RESOLVED, That ACEP set guidelines for including material pertaining to diversity, inclusion, and/or healthcare disparities related to educational content being presented.

Background

This resolution requests 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.

The Education Committee has an ongoing objective to increase diversity in the faculty for ACEP educational meetings and programs and ensure educational products include diversity and inclusion throughout offerings and include topics such as implicit bias or microaggressions in clinical care and practice management.

The Educational Meetings Subcommittee that plans the annual *Sceintific Assembly* meeting has an ongoing strategy to increase diversity among speakers at ACEP meetings as one of many factors considered when selecting speakers. They subcommittee also continues to identify content that specifically addresses diversity, equity, and inclusion (DEI) within its objectives and strives to include at least five courses on the topic. The committee continues to foster DEI through the composition of the committee and its leadership and through the engagement of a diverse set of faculty

with strong representation from racial and ethnic populations that are underrepresented in the medical profession.

Staff encounters challenges in gathering this information about faculty since our membership data does not include ethnicity. A decision was made to identify a minimum number of required fields to complete an online form to ensure a streamlined experience for member registration and renewals. While this has improved the user experience, it has created a void in the critical demographic information that ACEP needs. Attempts have been made for members to update their records with minimal results. Therefore, staff must use manual processes to identify speaker/educator ethnicity for the purposes of gauging diversity in our educational programs and seeking new content experts that are underrepresented.

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Member Engagement

- Objective G – Promote/facilitate diversity and inclusion and cultural sensitivity within emergency medicine.

Fiscal Impact

Budgeted staff resources for development and analysis of survey and results, data entry into CRM for data collected. Potential unbudgeted costs for temporary staff assistance.

Prior Council Action

None

Prior Board Action

None

Background Information Prepared by: Debbie Smithey, CMP, CAE
Educational Meetings Director

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 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: 23(21)

SUBMITTED BY: Louisiana Chapter

SUBJECT: Media Marketing of Value of Emergency Medicine Board Certification

PURPOSE: Create a public awareness campaign to highlight the unique skill set, knowledge base, and value of residency trained and board-certified emergency medicine physicians.

FISCAL IMPACT: Budgeted resources. A public awareness campaign is currently in progress.

WHEREAS, There has been significant threats to the practice of emergency medicine and the safety of emergency physicians and patients, including balanced billing, creep of practice by non-physicians, lack of equal rights of emergency physicians as compared to others on medical staffs; and

WHEREAS, Many in the public do not understand or appreciate the difference between an emergency physician and a doctor in the emergency room, or a nurse practitioner, physician assistant or a physician associate;

WHEREAS, Insurers are continually trying to lessen reimbursement or substitute lesser trained or qualified persons, deny payment for emergency services and act in ways that threaten the safety and security of patients and the public safety net; and

WHEREAS, Contract management groups regularly hire non-emergency physicians instead of emergency physicians because of lower costs, or pay non-emergency physicians the same as emergency physicians in spite of less training and lack of residency training or board certification in emergency medicine; and

WHEREAS, Hospitals do not require or exert significant pressure on contract groups to hire emergency physicians, choosing lower costs, or higher profits, over better emergency training or better patient care; and

WHEREAS, If the public was aware of the difference in training, knowledge and ability of emergency physicians as compared to non-board certified physicians and non-physicians, they may be outraged or demand emergency physicians to staff emergency departments; and

WHEREAS, With more education of the public, the public will appreciate the difference in education and training, and appreciate the value of having emergency physicians provide emergency care to them; and

WHEREAS, Many of the issues facing emergency medicine and the patients we serve would likely be better served by having public support of emergency physicians and facilities requiring emergency physicians be used; therefore be it

RESOLVED, That ACEP focus more on marketing to and educating the public on the value of emergency physicians focusing on the differences in education and training that emergency physicians go through compared to non-emergency physicians; and be it further

RESOLVED, That ACEP focus more resources on a local, state, and national level campaign of marketing to the public through TV, radio, newspaper, social media, and public service announcements.

Background

This resolution calls for the College to create a public awareness campaign to highlight the unique skill set, knowledge base, and value of residency trained and board-certified emergency medicine physicians.

This resolution is similar to Amended Resolution 18(19) Promoting Emergency Medicine Physicians and builds on ACEP's "Value of Emergency Medicine" campaign that is currently underway. ACEP is refining the campaign to specifically address the difference in training, knowledge, and ability of emergency physicians as compared to non-board-certified physicians and non-physicians. In August 2021, ACEP launched the findings of a public opinion poll that was conducted with Morning Consult. The results demonstrate that emergency physicians are extremely valued by their communities, but many people have difficulty identifying who leads their care while they are in the emergency department. In addition to a proactive earned media push, ACEP will be infusing this data into our campaign messaging and materials. As part of the campaign, ACEP is currently working with a professional agency to develop engaging digital collateral (e.g., videos, animated gifs, social cards, infographics). ACEP is also in the process of hiring an external public relations firm to help execute and amplify the campaign.

ACEP has a repository of public relations materials on the ACEP website that demonstrates the value of emergency medicine.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective C – Promote the value of emergency medicine and emergency physicians as essential components of the health care system.
- Objective H – Position ACEP as a leader in emergency preparedness and response.

Goal 2 – Enhance Membership Value and Member Engagement

- Objective C – Provide robust communications and educational offerings via the website and novel delivery methods.
- Objective D – Increase ACEP brand awareness, growth, and impact internationally in a cost-effective manner.

Fiscal Impact

Budgeted resources.

Prior Council Action

Amended Resolution 18(19) Promoting Emergency Medicine Physicians adopted. Directed ACEP to create a public awareness campaign to highlight the unique skill set, knowledge base, and value of those that meet the ACEP definition of an emergency physician and partner with the American Medical Association and 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.

Amended Resolution 18(19) Promoting Emergency Medicine Physicians adopted.

October 2017, approved funding of up to $100,000 to fund a study on the value and cost effectiveness of emergency care.

Amended Resolution 30(17) Demonstrating the Value of Emergency Medicine to Policy Makers and the Public adopted.

Amended Resolution 24(13) Promulgation of Emergency Medicine adopted.

Background Information Prepared by: Maggie McGillick
Public Relations Director

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 24(21)

SUBMITTED BY: Louisiana Chapter

SUBJECT: More Focused College

PURPOSE: 1) Coordinate with, work with, or allow other groups or entities that hold common values and interests, to advocate for some issues important to members of the College to conserve resources to use for higher priority issues; 2) lessen the number of initiatives ACEP chooses to promote or pursue as a means of focusing on fewer initiatives it can do very well; and 3) choose initiatives that affect the highest percentage of ACEP members, are the greatest threat to emergency medicine profession, ACEP members and patients, and are the least divisive to ACEP members.

FISCAL IMPACT: Budgeted Board, committee, and staff resources.

WHEREAS, There are over 30,000 members of our College from all states, with many very diverse interests, but all, or the majority of all, having some common interests; and

WHEREAS, The College has tried to address more and more of the interests of its members, even those that may not be held by a supermajority of its members; and

WHEREAS, When one tries to do too many things with limited resources, often the effectiveness is diminished and many of the issues pursued are not done well; and

WHEREAS, There are other organizations and entities that may have similar interests and goals as our College and it may be worthwhile to always consider working or coordinating with them in order to achieve common goals and do so using fewer resources; and

WHEREAS, The College has pursued some topics that are strongly supported by some of its members, but strongly opposed to by other members of the College, creating a divisiveness amongst its members; and

WHEREAS, Too much divisiveness amongst members of the College is detrimental to the College and its members; and

WHEREAS, The topics that divide us do not have to be pursued by the College and can be pursued in other organizations or groups; and

WHEREAS, The College and its members must be especially united due to the increased threat to our profession, our specialty and the health and safety of the public and our patients; therefore be it

RESOLVED, That the College give consideration to coordinating or working with, or allowing other groups or entities that hold common values and interests to advocate for some issues important to members of the College, to conserve resources to use for higher priority issues facing the membership and the College; and be it further

RESOLVED, That the College lessen the number of initiatives it chooses to promote or pursue, but instead focus on fewer initiates and do them very well; and be it further

RESOLVED, That the College choose the few initiatives that affect the highest percentage of its membership, is the greatest threat to our profession, our members, and patients, and is of the least divisiveness to our members.

Background

This resolution calls for the College to consider coordinating with, working with, or allowing other groups or entities that hold common values and interests to advocate for some issues important to members of the College, in order to conserve resources to use for higher priority issues. Further, it asks the College to lessen the number of initiatives it chooses to promote or pursue, as a means of focusing on fewer initiatives it can do very well. Finally, it asks the College choose initiatives that affect the highest percentage of its membership, are the greatest threat to the emergency medicine profession, ACEP members and patients, and are the least divisive to ACEP members.

ACEP often collaborates with other groups or entities in advocating for issues important to the College and its members. In some cases, the decision to collaborate conserves staff and direct resources; at other times, collaboration can serve to strengthen ACEP's voice. Maintaining such relationships with those who hold common values and interests is an active part of the work of ACEP staff and leadership. When opportunities for collaboration are either brought to ACEP or are identified by ACEP, staff and leadership assess not only the merits of the opportunity from the lens of value to the membership and the organization, but also the extent to which ACEP and the potential partners has the needed expertise and resources to be successful. The current process is conducted in a manner consistent with this resolution.

The work of balancing the quality and quantity of initiatives undertaken by ACEP is similarly the focus of ACEP staff, the Board, and other volunteers. The vetting of each year's budget proposal by the Finance Committee and the Board works as an important checks and balance to ensure initiatives are meeting their intended goals with the appropriate use of limited resources. Finding the way to lessen the number of initiatives it chooses to pursue is a common challenge for non-profit professional organizations, and the reason why many non-profits are rethinking how they do business and compete. Over the past year, and under the direction of the Executive Director, ACEP has begun using a tool called the MacMillan Matrix to conduct an assessment of programs. This competitive assessment tool, developed by Ian MacMillan of the Wharton School of Business, is designed specifically to help non-profits assess how well their programs "fit" and are a good strategic investment for their organization.

The operating assumptions are:

- There are more opportunities to respond to member/customer needs, wants, and expectations than there are resources to meet those expectations.
- In light of limited resources, the organization generally should not directly duplicate the services of other organizations.
- Focus is important. Providing mediocre or low-quality programs in many areas is inferior to delivering higher quality programs in a more focused (limited) way.

The assessment is conducted by rating programs, products, and initiatives on:

- Overall fit within the organization's mission.
- High or low appeal to members, customers, partners, or volunteers.
- Strong or weak operational capacity (money, expertise, track record).
- Low or high alternative coverage by others who deliver a similar program to similar constituents.

Program scores are placed into a matrix that guides what changes in direction are needed. Currently, staff have conducted two rounds of reviews (50% of programs), with the goal of completing the remaining 50% by the end of the calendar year. The results will be shared with the Board, Finance Committee, and key stakeholders and used to reframe ACEP's operating and strategic plan for the coming years.

These program assessment scores will be informed by the recently completed ACEP 2021 Needs Assessment Survey. A survey of this kind is fielded to members and non-members every few years and is designed to help ACEP assess the needs of emergency physicians, obtain needed feedback to improve the programs, services, and materials we offer, and to learn about the workforce landscape and job satisfaction.

Further, the ACEP Board and staff have begun a formal process of building a new strategic plan to guide the next three to five years. The six-month process is being guided by Daniel Stone, a highly experienced facilitator of strategic planning, and involves ACEP leaders, members, and staff to ensure the final product both sets a big and bold vision and will also ensure the College focuses on what it can do best and what is needed by individual emergency physicians now and in the future. A draft of a new strategic plan will be shared with members, chapters, and councillors during ACEP21. Stakeholder feedback will be incorporated into the final action plan that will launch in 2022.

ACEP Strategic Plan Reference

Broadly, this work is integral with all aspects of ACEP's strategic plan

Fiscal Impact

Budgeted staff resources.

Prior Council Action

None

Prior Board Action

June 2021, approved funds in the FY 2021-22 budget to revise the strategic plan.

The Board approves the Strategic Plan each year.

Background Information Prepared by: Susan Sedory, MA, CAE
Executive Director

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2021 Council Meeting
Reference Committee Members

Reference Committee B – Advocacy & Public Policy
Resolutions 25-41

Ashley Booth-Norse, MD, FACEP (FL), Chair
Erik Blutinger, MD, MSc, (NY)
Paul Kozak, MD, FACEP (AZ)
Catherine Marco, MD, FACEP (OH)
Howard K. Mell, MD, CPE, FACEP (IL)
Thomas J. Sugarman, MD, FACEP (CA)

Jeff Davis
Ryan McBride, MPP

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 25(21)

SUBMITTED BY: John Moorhead, MD, FACEP
Christopher Strear, MD, FACEP

SUBJECT: ACEP Report Card

PURPOSE: Undertake a new state chapter survey with questions similar to previous Report Card studies, publish distribute the results of the survey in a National Report Card 2022, and provide assistance and resources for chapter activities to improve access and quality of emergency care in their state.

FISCAL IMPACT: Unbudgeted national and chapter staff resources to develop the survey, collect and analyze data, develop and employ grading methodology, and publicize results at the national and state level. Costs for using an outside contractor(s) to perform many of the tasks, without conducting the additional primary and secondary research performed in the first three Report Cards, could exceed $150,000.

WHEREAS, ACEP National Report Cards published in 2010 and again in 2014 provided a comparison (including national ranking) among states in areas of emergency care including Public Health/Injury Prevention, Access to Emergency Care, Quality of Emergency Care, Medical Liability Environment, and Disaster Preparedness. These data provided assistance to many state chapters' advocacy efforts; and

WHEREAS, State chapters were able to leverage these reports and media attention to focus on areas of reform, including the establishment of state task forces and recommendations for policy changes; therefore be it

RESOLVED, That ACEP undertake a new state chapter survey with questions similar to previous Report Card studies but edited to reflect current emergency medicine practice issues in 2021; and be it further

RESOLVED, That ACEP publish and widely distribute the results of a state chapter survey in a National Report Card 2022 and provide assistance and resources for chapter activities to improve access and quality of emergency care in their state.

Background

The resolution calls for ACEP to undertake a new state chapter survey with questions similar to previous Report Card studies but edited to reflect current emergency medicine practice issues in 2021, and to publish and widely distribute the results of the survey in a National Report Card 2022, and provide assistance and resources for chapter activities to improve access and quality of emergency care in their state.

In 2006, ACEP released its first "National Report Card on the State of Emergency Medicine," grading each state on its support for emergency medicine in four categories: 1) Access to Emergency Care; 2) Quality and Patient Safety; 3) Public Health and Injury Prevention; and 4) Medical Liability Environment. The 2009 Report Card expanded on the number of metrics analyzed in each of those four categories and added Disaster Preparedness as a fifth category. It contained 116 overall indicators across the five categories. In 2014, the College released its third Report Card "America's Emergency Care Environment: A State-By-State Report Card", utilizing the same categories as the 2009 version.

The 2014 Report Card included 136 measures across the five categories. As with the previous Report Cards, a research consultant was retained to conduct research to collect, analyze, and compare 50-state data. Data sources

included the Centers for Medicare and Medicaid Services, the Centers for Disease Control and Prevention, the National Highway Traffic Safety Administration, the Department of Health and Human Services, the Department of Labor, the National Practitioner Data Bank, the American Medical Association, the American Hospital Association, the National Conference of State Legislatures, the National Association of Insurance Commissioners and many more. Two surveys were also developed and sent to health officials in each state. More details on the 2014 Report Card can be found at www.emreportcard.org.

The Report Cards, which were heavily supported and promoted by extensive ACEP media relations efforts at the national and state levels, resulted in widespread coverage by major national and local news outlets, with more than 2,000 news stories across the country in 2014. Chapters were engaged in the development of the reports and were equipped and mobilized to utilize Report Card results to bolster their state advocacy efforts on priority issues. Dozens of printed copies of the report were sent to each chapter for distribution to state policymakers. Many chapters utilized the Report Card to engage state leaders in discussions of key state policy deficiencies and some chapters cited the Report Card as being a key contributor to state legislative and other successes in their state, including the passage of liability reform protections for emergency physicians, trauma system funding, and creation of new emergency medicine residency programs.

A survey of chapters taken a few months after the release of the 2014 Report Card showed that 28 chapters reported using the Report Card in a state advocacy effort, while 12 indicated that they had not. When asked how valuable they thought the Report Card was to their chapter, 10 indicated very valuable, 23 answered somewhat valuable, and 7 indicated not valuable.

Development of each Report Card was a two-to-three-year project with total costs of each exceeding $400,000, including the cost of a research consultant, public relations support, printing, travel, and staff labor. Some outside funding was obtained for the 2009 Report Card. The Wellpoint Foundation provided $250,000 and the Robert Wood Johnson Foundation provided $50,000 to support data collection, public relations, and distribution efforts for the Report Card. No outside funds were secured for the 2006 or the 2014 Report Cards.

The resolution calls for a chapter survey with questions similar to previous Report Cards, which would apparently not entail the utilization or expense of an outside consultant to conduct the research, analysis, and state grading that occurred with previous Report Cards. Such an approach may glean useful results but without efforts to conduct additional primary and secondary research, such as what was performed with the first three Report Cards, may pose challenges in obtaining a sufficient range of standardized data in each state from all chapters to make results comparable either to previous Report Cards or to other states. The validity of the data may be questioned if an outside consultant is not used.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective A – Promote/advocate for efficient, sustainable, and fulfilling clinical practice environments.
- Objective C – Promote the value of emergency medicine and emergency physicians as essential components of the health care system
- Objective D – Promote quality and patient safety, including continued development and refinement of quality measures and resources.
- Objective G – Pursue meaningful medical liability reform and other initiatives at the state and federal levels.
- Objective H – Position ACEP as a leader in emergency preparedness and response.

Fiscal Impact

Unbudgeted national and chapter staff resources to develop the survey, collect and analyze data, develop and employ grading methodology, and publicize results at the national and state level. Costs for using an outside contractor(s) to perform many of the tasks, without conducting the additional primary and secondary research performed in the first three Report Cards, could exceed $150,000.

Prior Council Action

Amended Resolution 24(14) Future Funding for ACEP Report Cards on the Emergency Care Environment adopted. Directed the Board of Directors to continue to identify potential private, public, foundational, and other funding sources to support future creation and dissemination of the ACEP National Report Card and that a report of the investigation be provided to the 2015 Council.

Prior Board Action

June 2015, reviewed the report on Amended Resolution 24(14) and approved it for distribution to the 2015 Council.

October 2014, Amended Resolution 24(14) Future Funding for ACEP Report Cards on the Emergency Care Environment adopted.

Approved funding in the annual budget for the 2006, 2009, and 2014 Report Cards.

Background Information Prepared by: Craig Price, CAE
Senior Director, Practice Affairs

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 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(21)

SUBMITTED BY: Ohio Chapter ACEP
Pennsylvania College of Emergency Physicians

SUBJECT: Advocacy for Syringe Services Programs and Fentanyl Test Strips

PURPOSE: 1) Support federal funding of syringe services programs (SSPs); 2) develop advocacy materials to assist and encourage chapters to advocate for local/state laws permitting SSPs to reduce risks associated with injection drug use in addition to naloxone and educational material; and 3) update harm reduction materials for members regarding risks of fentanyl analogues and use and limitations of fentanyl test strips.

FISCAL IMPACT: Budgeted committee and staff resources. Additional financial impact depends on the extent of associated costs of developing and updating materials and making resources available to members and chapters.

WHEREAS, Overdose deaths continue to surge in the United States with recent data published by the Centers for Disease Control and Prevention (CDC) showing a 30% increase from October 2019 to October 2021; and

WHEREAS, Injection drug use represents a significant proportion of overdose deaths and morbidity associated with substance use; and

WHEREAS, Illicit, non-pharmaceutical synthetic opioids including fentanyl and its analogues account for the largest proportion of overdose deaths; and

WHEREAS, Illicit fentanyl has been increasingly identified in pill form pressed to resemble prescription opioids or benzodiazepines; and

WHEREAS, Illicit fentanyl and its analogues have been found to either adulterate or be mistaken for other substances such as cocaine; and

WHEREAS, Infectious complications of injection drug use such as HIV, Hepatitis C, and severe bacterial infections are a significant source of morbidity, mortality, as well as healthcare utilization and cost; and

WHEREAS, People who inject drugs represent 7% of new HIV cases in the U.S.[2]; and

WHEREAS, Newly reported cases of hepatitis C rose 133% from 2012 to 2019 with injection drug use identified as the most common contributing risk factor[3]; and

WHEREAS, The ACEP Council has previously passed a resolution to endorse and support syringe services programs as well as investing in educating its members on harm reduction techniques and the importance of emergency departments (EDs) to partner with local Syringe Services Programs (SSPs) to advance the care of people who inject drugs[4]; and

WHEREAS, The ACEP Council has previously passed a resolution calling for the development of guidelines for harm reduction strategies with health providers, local officials, and insurers for safely transitioning patients with substance use disorders to sustainable long-term treatment programs from the ED while providing educational resources to ED providers for improving direct referral of patients with substance use disorder (SUD) to treatment[5]; and

WHEREAS, Members of the ACEP Public Health and Injury Prevention Committee developed a report which was reviewed by the ACEP Board of Directors in June, 2019, entitled "After the Emergency Department Visit: The Role of Harm Reduction Programs in Mitigating the Harms Associated with Injection Drug Use, An Information Paper" concluding that "Emergency Physicians can help lead and effect change by providing testimony about the human suffering, economic burden, and the demand placed on the healthcare system by IDU; and

WHEREAS, Emergency physicians who have studied or witnessed the positive effects of these interventions in the communities they serve can provide supportive arguments for expansion of harm reduction; and

WHEREAS, Unfortunately, policy papers and research studies have not been enough to facilitate SSP and SIF implementation; and

WHEREAS, It is therefore incumbent on clinicians, particularly emergency physicians who treat the complications of IDU daily, to advance public health advocacy efforts on behalf of harm reduction for PWID and the communities supporting them[6]; and

WHEREAS, ACEP has developed a smart phrase to promote the utilization of harm reduction services including SSPs but not fentanyl test strips[7]; and

WHEREAS, AMA supports community implementation of syringe services programs, encouraging state medical organizations to advocate for expanded availability of syringe services programs, and advocating for local, state, and federal legislation to ensure accessibility[8]; and

WHEREAS, Fentanyl test strips have been shown to alter behaviors leading to less risky drug use[9]; and

WHEREAS, SSPs are associated with a 50% decline in HIV and Hepatitis C transmission among injection drug users[10]; and

WHEREAS, SSPs were associated with more than $240 million in health care savings in one city (Philadelphia, PA) over a 10 year time period[11]; and

WHEREAS, While the federal government will provide funding for SSPs, multiple barriers exist to accessing that funding and those funds are not permitted to be used for purchasing syringes or needles[12]; and

WHEREAS, The CDC and the Substance Abuse and Mental Health Services Administration (SAMHSA) announced on April 7, 2021, that federal funding could be used to purchase fentanyl test strips[13]; and

WHEREAS, SSPs and fentanyl test strips remain illegal under many local and state drug paraphernalia laws throughout much of the United States; and

WHEREAS, ACEP and its members should continue to employ all available means to engage and refer patients with substance use disorders to evidence-based treatment programs, but also recognize that not all patients with substance use disorders and risky drug use will be ready to enter treatment so should be educated on strategies to minimize injury and death associated with ongoing drug use; and

WHEREAS, Emergency physicians have an obligation to advocate for evidence-based interventions that will benefit the health of our patients; therefore be it

RESOLVED, That ACEP support federal funding of syringe services programs; and be it further

RESOLVED, That ACEP develop advocacy materials to assist and encourage chapters to advocate for state and local laws permitting syringe services programs intended to reduce the risk of harm associated with injection drug use in addition to naloxone and educational material; and be it further

RESOLVED, That ACEP update harm reduction materials and resources available to its members to include informing patients of the risks of fentanyl analogues and other potentially harmful admixtures and the utilization and limitations of fentanyl test strips to better inform decision-making when using drugs.

References

1. Products - Vital Statistics Rapid Release - Provisional Drug Overdose Data (cdc.gov). Accessed 6/10/2021
2. U.S. Statistics | HIV.gov. Accessed 6/10/2021
3. Figure 3.1 of 2019 Viral Hepatitis Surveillance report | CDC. Accessed 6/10/2021
4. Resolution 52(17): Support for Harm Reduction and Syringe Services Programs
5. Resolution 21(16): Best Practices for Harm Reduction Strategies
6. after-the-ed-visit---the-role-of-harm-reduc-progs-in-mitigating-the-harms-assoc-with-inj-drug-use.pdf (acep.org) Accessed 6/10/2021
7. Injection Drug Use Smart Phrase. ACEP // Injection Drug Use Accessed 6/11/2021
8. H-95.958 Syringe and Needle Exchange Programs | AMA (ama-assn.org) Accessed 6/10/2021
9. Peiper NC, Clarke SD, Vincent LB, Ciccarone D, Kral AH, Zibbell JE. Fentanyl test strips as an opioid overdose prevention strategy: Findings from a syringe services program in the Southeastern United States. Int J Drug Policy. 2019 Jan;63:122-128. doi: 10.1016/j.drugpo.2018.08.007. Epub 2018 Oct 3. PMID: 30292493.
10. Platt L, Minozzi S, Reed J, Vickerman P, Hagan H, French C, Jordan A, Degenhardt L, Hope V, Hutchinson S, Maher L, Palmateer N, Taylor A, Bruneau J, Hickman M. Needle syringe programmes and opioid substitution therapy for preventing hepatitis C transmission in people who inject drugs. Cochrane Database Syst Rev. 2017 Sep 18;9(9):CD012021. doi: 10.1002/14651858.CD012021.pub2. PMID: 28922449; PMCID: PMC5621373.
11. Ruiz MS, O'Rourke A, Allen ST, Holtgrave DR, Metzger D, Benitez J, Brady KA, Chaulk CP, Wen LS. Using Interrupted Time Series Analysis to Measure the Impact of Legalized Syringe Exchange on HIV Diagnoses in Baltimore and Philadelphia. J Acquir Immune Defic Syndr. 2019 Dec 1;82 Suppl 2(2):S148-S154. doi: 10.1097/QAI.0000000000002176. Erratum in: J Acquir Immune Defic Syndr. 2020 Feb 1;83(2):e12. PMID: 31658203; PMCID: PMC6820712.
12. Determination of Need for Syringe Services Programs | CDC Accessed 6/11/2021
13. Federal Grantees May Now Use Funds to Purchase Fentanyl Test Strips | CDC Online Newsroom | CDC Accessed 6/10/2021

Background

The resolution calls for ACEP to support federal funding for syringe services programs and to develop advocacy materials to assist and encourage chapters to advocate for state and local laws permitting syringe services programs intended to reduce the risk of harm associated with injection drug use. It also calls for the College to update harm reduction materials and resources available to its members to include informing patients of the risks of fentanyl analogues and other potentially harmful admixtures and the utilization and limitations of fentanyl test strips to better inform decision-making when using drugs.

The use of, and addiction to, various opioids, both prescription medication and illegal substances, has become a serious global health problem. It is estimated that more than two million people in the United States suffer from a substance abuse disorder related to prescription opioids and another 500,000 are addicted to heroin. In 2020, the Centers for Disease Control and Prevention (CDC) reported more than 93,000 opioid deaths, the highest number on record and a nearly 30 percent increase from 2019. This increase was driven primarily by illicitly manufactured fentanyl and synthetic opioids, and also thought to be exacerbated by the COVID-19 pandemic. An additional effect of the opioid crisis is a significant increase in the infectious diseases often associated with injection drug use, including acute hepatitis C virus (HCV), HIV, and other bloodborne infections. The CDC noted that over from 2010-2016, HCV cases more than tripled.

According to the CDC, syringe services programs (SSP) are community-based programs that provide comprehensive harm-reduction services which can include sterile needles, syringes, and other injection equipment; safe disposal containers for needles and syringes; HIV testing and linkage to treatment; education about overdose prevention and safer injection practices; referral for substance use disorder treatment; referral to medical, mental health and social services and tools to prevent HIV, STDs and viral hepatitis. The CDC website noted that persons who inject drugs can access sterile needles and syringes through SSPs and through pharmacies without a prescription. Laws vary by state concerning over-the-counter sales of syringes but barriers exist even in states where such sales are legal. A study published in the Journal of the American Pharmacist Association in January 2015 found that only 21% of 248 attempts to purchase syringes at community pharmacies in two California counties were successful, despite the fact that the law allows anyone 18 years or older to purchase syringes from a community pharmacy without a prescription.

One of the study authors noted that there appeared to be "a widely held belief among pharmacists and staff that selling syringes to people who inject drugs promotes drug use."

In February 2011, the Health and Human Services Department determined that there is scientific evidence supporting the important public health benefits of SSPs, and that a demonstration needles exchange program would be effective in reducing drug abuse and the risk of HIV infection among injection drug users. The CDC Fact Sheet on SSPs states that these programs are an effective public health intervention, associated with a 50% decrease in HIV and HCV incidence. They also help serve to connect individuals to other health services, such as HCV or HIV testing and treatment as well as medication-assisted treatment (MAT) for opioid use disorder. Some SSPs also educate people who inject drugs with education and training on how to recognize, respond to, and reverse a drug overdose through the use of naloxone, with some SSPs even providing kits containing naloxone to help prevent overdose deaths. Federal funding for states and local communities is available under limited circumstances to support certain components of SSPs.

With regard to fentanyl test strips, these strips are used to identify the presence of fentanyl and many known fentanyl analogues in a sample of an illicit drug, whether injectable drugs, powders, or pills. The test strips typically take only one or two minutes to determine if a drug has been mixed or cut with fentanyl or an analogue. As the resolution notes, fentanyl test strips do have limitations and may not be able to detect certain fentanyl-like substances such as carfentanil, sufentanil, alfentanil, benzylfentanyl, benzoylfentanyl, U47700, U49900, or other substances the test strips are not able to find. Federal, state, and local governmental entities and other organizations are also adopting and promoting the use of fentanyl test strips as part of overdose prevention efforts. As of April 7, 2021, the CDC and the Substance Abuse and Mental Health Services Administration (SAMHSA) announced federal grants for the purchase of fentanyl test strips. Other examples include local governments like Arlington County, VA recently adding fentanyl test strips to emergency release kits (which include treatment resources, toiletries, a public transportation card, and NARCAN nasal spray) provided to individuals being released from incarceration.

The Council and the Board adopted Resolution 21(16) Best Practices for Harm Reduction Strategies, which directed ACEP to develop guidelines for harm reduction strategies with health providers, local officials, and insurers for safely transitioning substance use disorder patients to sustainable long-term treatment programs from the ED, and to provide educational resources to ED providers for improving direct referral of substance use disorder patients to treatment. The Emergency Medicine Practice and the Public Health & Injury Prevention Committee developed alcohol screening and brief intervention in the ED resources and opioid resources. The Pain Management & Addiction Medicine Section continues to develop resources on pain management and addiction medicine. ACEP has developed the E-QUAL Network Opioid Initiative, which includes toolkits, webinar series, podcasts, and other resources.

A year later, the Council and the Board adopted Resolution 52(17) Support for Harm Reduction and Syringe Services Programs. The resolution directed the College to endorse SSPs for those who inject drugs, promote the access of SSPs to people who inject drugs, and to invest in educating members on harm reduction techniques and the importance of Emergency Departments to partner with local SSPs to advance the care of people who inject drugs. The Public Health & Injury Prevention Committee developed the information paper "After the Emergency Department Visit: The Role of Harm Reduction Programs in Mitigating the Harms Associated with Injection Drug Use."

ACEP supports other related harm reduction strategies related to IV drug use as well. In 2017, the Council and the Board adopted Amended Resolution 31(17) Development and Study of Supervised Injection Facilities that directed the College support the development of pilot facilities where people who use intravenous drugs can inject self-provided drugs under medical supervision and endorse Supervised Injection Facilities (SIFs) as an effective public health intervention in areas and communities heavily impacted by IV drug use. SIFs include an additional layer of services beyond those provided by SSPs, providing people who inject drugs to do so in a safe environment under direct supervision of a medical professional. In communities that have established SIFs, these facilities have also shown promising results in reducing drug overdoses, deaths, and preventable illnesses like HIV, Hepatitis C, and soft tissue infections.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum, including rural areas.

Fiscal Impact

Budgeted committee and staff resources. Additional financial impact depends on the extent of associated costs of developing and updating materials and making resources available to members and chapters.

Prior Council Action

Resolution 52(17) Support for Harm Reduction and Syringe Services Programs adopted. Directed the College to endorse syringe services programs, promote access to these programs for people who inject drugs, educate members on harm reduction techniques and the importance of EDs partnering with local syringe services programs for patients who inject drugs.

Amended Resolution 31(17) Development and Study of Supervised Injection Facilities adopted. Directed the College to work with the AMA in supporting the development of pilot facilities where people who use intravenous drugs can inject self-provided drugs under medical supervision and endorse Supervised Injection Facilities as an effective public health intervention in areas and communities heavily impacted by IV drug use.

Resolution 21(16) Best Practices for Harm Reduction Strategies adopted. Directed ACEP to set a standard for linking patients with a Substance Use Disorder to appropriate potential treatment resources after receiving medical care from the ED.

Prior Board Action

June 2019, reviewed the information paper "After the Emergency Department Visit: The Role of Harm Reduction Programs in Mitigating the Harms Associated with Injection Drug Use."

Resolution 52(17) Support for Harm Reduction and Syringe Services Programs adopted.

Amended Resolution 31(17) Development and Study of Supervised Injection Facilities adopted.

June 2017, approved the revised policy statement "Bloodborne Pathogens in Emergency Medicine;" previously titled "Bloodborne Infections in Emergency Medicine" approved April 2011, April 2004, and October 2000; originally approved September 1996 with the title "HIV and Bloodborne Infections in Emergency Medicine."

Resolution 21(16) Best Practices for Harm Reduction Strategies, Including Warm Handoffs in the ED adopted.

Background Information Prepared by: Ryan McBride, MPP
Senior Congressional Lobbyist

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 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(21)

SUBMITTED BY:
Kathleen Cowling, DO, MS, MBA, FACEP
Larry Bedard, MD, FACEP
Gregory Gafni-Pappas, DO, FACEP
Cai Glushak, MD, FACEP
Michael Gratson, MD, MHSA, FACEP
James Maloy, MD
Jacob Manteuffel, MD, FACEP
James Mitchiner, MD, MPH, FACEP
Charles Pattavina, MD, FACEP
Megan Ranney, MD, MPH, FACEP
Rachel Solnick, MD, MSc
Robert Solomon, MD, FACEP
Peter Viccellio, MD, FACEP
Bradford Walters, MD, FACEP

SUBJECT: Conditional Support for Medicare-for-All

PURPOSE: 1) Provide conditional support for Medicare-for-All, conditioned on the ability of such a program to provide universal access, foster competition, preserve patient choice, promote physician autonomy, and recognize the essential value of emergency medicine; and 2) explore opportunities to partner with other like-minded organizations that favor the Medicare-for-All approach.

FISCAL IMPACT: Budgeted committee and staff resources. Potential additional unbudgeted costs associated with working with like-minded partners or coalitions depending on the scope.

WHEREAS, The primary business objective of a for-profit health insurer is to make a profit, which directly leads to decreased or denied reimbursement for legitimate emergency care; and

WHEREAS, The 2010 Affordable Care Act (ACA) created a complex and inefficient bureaucracy that works through private insurers with high administrative overhead, and even prior to COVID-19 left 28 million Americans uninsured and another 44 million underinsured, causing them to receive care at an advanced stage of disease or to forego care altogether[1]; and

WHEREAS, Tying insurance to employment creates an undue burden on both employees and businesses alike; and

WHEREAS, Medicare-for-All is based on *expanding* and *improving* the current non-profit Medicare program, in a way that would both provide more services and cover more Americans; and

WHEREAS, There is no truth to the belief that Medicare-for-All implies physician reimbursement at current Medicare fee-for-service rates[2]; and

WHEREAS, There is no truth to the memes that Medicare-for-All is "socialized medicine"; that it is "government-controlled health care"; or that it will block health care competition, diminish quality, forestall medical innovation, or inhibit patient choice of provider; and

WHEREAS, Polls have consistently demonstrated majority support for Medicare-for-All or single-payer insurance by the general public[3,4,5,6] and among clinicians[7]; and

WHEREAS, The ACEP Council adopted Resolution 15 in 1999, stipulating that ACEP "develop a strategic plan to promote expansion of health insurance coverage for the uninsured and underinsured," a stipulation that has yet to be consummated; and

WHEREAS, ACEP's Health Care Financing Task Force, created in 2017 to study alternative financing

models that foster competition and preserve patient choice, did not provide any actionable conclusions; therefore, be it

RESOLVED, That ACEP provide conditional support for Medicare-for-All, conditioned on the ability of such a program to provide universal access, foster competition, preserve patient choice, promote physician autonomy, and recognize the essential value of emergency medicine; and be it further

RESOLVED, That ACEP explore opportunities to partner with other like-minded organizations that favor the Medicare-for-All approach to providing universal health care to all Americans.

References

[1]Collins SR, Bhupal HK, Doty MM. Health insurance coverage eight years after the ACA: fewer uninsured Americans and shorter coverage gaps, but more underinsured (Commonwealth Fund, February 2019), at: https://www.commonwealthfund.org/publications/issue-briefs/2019/feb/health-insurance-coverage-eight-years-after-aca.
[2]117th Congress (2021-2022), U.S. House of Representatives, H.R. 1976 ("Medicare for All Act of 2021"), introduced March 17, 2021, Sec. 612(b)(1), p. 74 of 131, at: BILLS-117hr1976ih.pdf (congress.gov)
[3]KFF Health Tracking Poll. Public opinion on single-payer, national health plans, and expanding access to Medicare coverage (slide file; published May 27, 2020), at: http://files.kff.org/attachment/SP_5.21.20
[4]Poll: 69 percent of voters support Medicare for All. *The Hill.* Published April 24, 2020, at: https://thehill.com/hilltv/what-americas-thinking/494602-poll-69-percent-of-voters-support-medicare-for-all
[5]Murad Y. As coronavirus surges, 'Medicare for All' support hits 9-month high. *Morning Consult/Politico* poll (February 21-23, 2020 and March 27-29, 2020; published April 1, 2020), at: https://morningconsult.com/2020/04/01/medicare-for-all-coronavirus-pandemic/
[6]Galvin G. About 7 in 10 voters favor a public health insurance option. Medicare for All remains polarizing. *Morning Consult*/*Politico* poll (March 19-22, 2021; published March 24, 2021), at: https://morningconsult.com/2021/03/24/medicare-for-all-public-option-polling/
[7]Serafini M. Why clinicians support single-payer – and who will win and lose. *NEJM Catalyst*. Published on January 17, 2018, at: https://catalyst.nejm.org/doi/full/10.1056/CAT.18.0278

Background

The resolution asks ACEP to provide conditional support for Medicare-for-All, conditioned on the ability of such a program to provide universal access, foster competition, preserve patient choice, promote physician autonomy, and recognize the essential value of emergency medicine. The resolution also asks ACEP to explore opportunities to partner with other like-minded organizations that favor a Medicare-for-All approach to providing universal health care to all Americans.

Public support for Medicare-for-All often varies depending on the details provided in polling questions and surveys. A 2016 poll conducted by Kaiser Family Foundation (KFF) found significant variation in support among Democratic voters for various proposals, including Medicare-for-All (53% very positive), guaranteed universal health coverage (44% very positive), single-payer health insurance (21% very positive), and socialized medicine (22% very positive). However, those variations appear to have diminished within the past few years – according to a 2019 Morning Consult poll, a majority of voters support either Medicare-for-all (53%) or single-payer (51%). Regardless, as the Morning Consult notes, while the terms are often used interchangeably, "there are differences between the two: Single-payer is a sweeping term for a system in which the costs of essential care for all residents are covered by one public system, while a "Medicare for all" program could be single-payer but does not necessarily have to be." Most recently, a 2021 Morning Consult Poll of registered voters found that 55% of voters support Medicare-for-All (unchanged from previous results in March 2020). However, Medicare-for-All is significantly more politically polarizing, with 62% of Republican voters outright opposing the proposal. The same poll also found that support for a public option had increased from 63% to 68%, a steady upward trend over the past several years from both Republican and Democrat voters.

The resolution references the Health Care Financing Task Force (HCFTF) established by Amended Resolution 19(16) to study alternative health care financing models delivered its report in Fall 2018. The report notes:

> Although the HCFTF cannot recommend a financing system at this time, a majority of the HCFTF agree that there are elements of [single payer] systems that strongly adhere to the '9 Principles' outlined. Therefore, if ACEP were to advocate for significant health care financing reform in the future, HCFTF members would want some elements of varied SP models to be considered and included in an ACEP-endorsed model.

The task force determined that ACEP should continue to advocate for and propose meaningful ideas for health care financing reform, but at the current time, no one system – single payer, two-tier, or the current health care system – could be espoused over another. The HCFTF concluded "ACEP shall focus on securing access to coverage for our patients and their families for, acute unscheduled care services in any health care financing model, including single payer."

The United States currently operates under a multi-payer system. Individuals and businesses pay taxes to the government, in the form of payroll taxes and income taxes, as well as paying premiums to private insurers. The government then reimburses health care providers who deliver care through one of the public programs, such as Medicare, Medicaid, CHIP, or military health care (TRICARE or VA/CHAMPVA). For those who are privately insured, health care providers seek reimbursement from the respective insurance company. Presently, there are dozens of private health insurance companies and thousands of private health insurance plans offered through state and federal insurance exchanges, public programs, and in the private marketplace. According to the CDC's National Health Interview Survey Early Release Program for January-June 2020, among adults 18-64 years of age who had health insurance in 2020, 67.9% were covered by private insurance, 20.8% were covered by public insurance, and 13.4% of adults 18-64 were uninsured (about 30 million Americans). Some observers have also noted that these figures may not reflect the potential impact of COVID-19 with respect to individuals losing their jobs and their employer-sponsored insurance coverage, so these numbers could shift as new data become available.

Among the more prominent Medicare-for-All legislative proposals put forward in Congress, a bill (S. 1129) introduced by Senator Bernie Sanders (D-VT) in the 116th Congress would establish a single-payer national health insurance program through a phased-in process, essentially replacing all private coverage (with narrow exceptions), including employer-sponsored coverage, state insurance exchanges, as well as Medicaid. To briefly summarize an expansive bill: Medicare would be expanded to provide comprehensive coverage, including dental, vision, hearing, and all prescription drug benefits, as well as home- and community-based long-term care services, mental health and substance use disorder treatment, and reproductive and maternity care. Beneficiaries would be subject to no cost sharing requirements (deductibles, copays, coinsurance, etc.) except for some prescription drugs and biologics (but with a $200 annual cap on out of pocket expenses per individual, adjusted for inflation) as well as some long-term care services.

In the case of single-payer financing, individuals and businesses would pay taxes to the government. The government would then reimburse health service providers directly for care delivered through a national health insurance program. Although the collection of funds and the process of reimbursement are conducted by one entity, the delivery of care would be through both public and private sources.

In another example, under the terms of the single-payer system proposed by Physicians for a National Health Program (published in the Journal of the American Medical Association in 2003), all residents of the U.S. would be enrolled and all medically necessary care would be covered. Obviously, the question of what is considered medically necessary could be contentious, especially given the recent developments in the State of Washington.

Financing the proposal would be achieved using existing sources of government funding (for public programs) and supplemented with new taxes. According to PNHP, businesses and individuals would pay more taxes, but those taxes would be offset because there would no longer be health insurance premiums.

Hospitals would receive a global budget for operating expenses every month. Medications and supplies would be purchased by the federal government according to a national formulary and using its bulk purchasing power to negotiate the lowest prices for medications and supplies. Physicians would have three reimbursement options: (1) fee-for-service (with a simplified, binding fee schedule); (2) salaried positions in facilities that receive global budget payments (i.e. hospitals); or (3) salaried positions within group practices or HMOs receiving capitation payments.

Two of the more common economic arguments in favor of single-payer are administrative simplification and the ability to control costs. According to a 2003 New England Journal of Medicine study, the U.S. spends more than $294 billion annually on administrative costs, which represents 31% of health expenditures in this country.

However, not all administrative costs are harmful or inappropriate, thus diminishing the amount of savings generated by administrative simplification. Furthermore, these savings would only be generated one time.

With regard to cost control, the U.S. has a fragmented, non-centrally coordinated system where different payers operate by different rules. Some argue that these variances have curtailed efforts to implement effective, systemic cost control measures, such as global budgeting (lump-sum monthly payments for all care provided); price controls; supply controls; reimbursement caps; and overall expenditure targets. Centrally administered plans, such as single-payer, provide policy makers who wish to institute cost controls with a substantial tool for obtaining that objective. Although, implementing that option would be largely dependent on public opinion. Additionally, if cost containment measures are too aggressive, it can lead to an underfunded system with significant wait times for elective procedures, insufficient resources, and diminished research and development.

Some argue that the biggest disadvantage to a single-payer system is the threat of underfunding by the government (due to fiscal or policy determinations). A single-payer system is particularly reliant upon a government that is committed to high funding levels to ensure quality of care is not diminished. As the Medicare and Medicaid Trust Funds rapidly approach projected insolvency, questions arise about the federal government's ability to sufficiently provide benefits even under our current system. Another acknowledged disadvantage is that the transition from the current U.S. system to single-payer would be very difficult and disruptive. The ACEP HCFTF also notes several potential tradeoffs with regard to implementing a single-payer system. These include: "restricted availability and lengthy wait times for certain elective procedures, as well as the potential for capitation that could limit reimbursement for providers." Finally, it has been suggested that Americans would have to be willing to accept other certain sacrifices under a single-payer system, such as accepting less choice in their coverage options and a willingness to accept more government control, oversight, and regulations through a single-payer system.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum, including rural areas.
- Objective E – Pursue strategies for fair payment and practice sustainability to ensure patient access to care.

Fiscal Impact

Budgeted staff time and resources. Potential additional costs associated with working with like-minded partners or coalitions.

Prior Council Action

Resolution 32(20) Loss of Health Insurance Due to COVID-19 not adopted. The resolution requested ACEP to support adoption of Medicare-for-All as an alternative to employment-based insurance (with conditions) and explore opportunities to partner with other like-minded organizations favoring a Medicare-for-All approach

Resolution 37(19) Single-Payer Health Insurance not adopted. The resolution asked for ACEP to support the adoption of a single-payer health insurance program and explore opportunities to partner with other organizations that favor the single-payer approach to providing universal health care to all Americans.

October 2018, the Health Care Financing Task Force report served as the foundation for the 2018 Council Town Hall Meeting.

Amended Resolution 19(16) Health Care Financing Task Force adopted. Directed ACEP to establish a Health Care Financing Task Force to study alternative health care financing models, including single-payer, and provide a report to the 2017 Council.

Substitute Resolution 31(14) Financing Health Insurance adopted. Directed ACEP to create a Health Care Financing Task Force to study alternative financing models that foster competition and preserve choice for patients and that the task force report to the 2015 ACEP Council regarding its investigation.

Resolution 20(12) Single Payer Universal Health Insurance not adopted. The resolution supported the adoption of single payer health insurance and explore opportunities to partner with other organizations that favor the single payer approach.

Resolution 26(11) Single-Payer Universal Health Insurance not adopted. The resolution supported the adoption of single-payer health insurance and explore opportunities to partner with other organizations that favor the single payer approach.

Substitute Resolution 21(10) Medicare-for-All Health Insurance referred to the Board. The original resolution Supported the adoption of Medicare for everyone and work with organizations that favor this approach to providing health insurance for all Americans. The substitute resolution directed the Board to appoint a task force to investigate alternative models of healthcare financing.

Resolution 18(09) Single-Payer Health Insurance not adopted. Directed ACEP to support the adoption of single payer health insurance and work with organizations that favor the single-payer approach.

Substitute Resolution 24(08) Single-Payer Health Insurance adopted. Directed ACEP to support the adoption of single-payer health insurance and work with organizations that favor the single-payer approach. A substitute resolution was adopted, although the title of the resolution was not changed. The substitute resolution directed the Board of Directors to derive a list of essential components to be included in any new healthcare system and create a white paper.

Resolution 21(07) Single-Payer Health insurance referred to the Board of Directors. The resolution asked the College to support the adoption of single-payer health insurance and to work with organizations that favor the single-payer approach.

Resolution 34(05) Single-Payer Health Insurance referred to the Board of Directors. The resolution called for ACEP to explore opportunities toward a single-payer approach for health insurance.

Resolution 11(00) Funding the Mandate referred to the Board. The resolution called for the College to work with chapters to obtain funding for uncompensated services provided by emergency physicians and to assist chapters to sponsor legislation to provide funding, as well as use funds such as tobacco settlement monies and tax subsidies. Further, the College should work with HCFA to encourage health plans contracted with Medicare and Medicaid to reimburse EMTALA mandated care and create a task force to explore alternative funding sources including establishing regional case rates and a public utility model.

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.

Substitute Resolution 17(98) Responsibilities of On-call Physicians adopted. It called for a study on the ramifications of on-call physicians and EMTALA including reimbursement issues.

Resolution 46(96) Medicaid and the Welfare Reform Act of 1996 adopted. The resolution asked for swift action to identify any adverse effects on public health, safety, and access to emergency services resulting from the Act that could result in making many persons covered by Medicaid ineligible, thus increasing the number of uninsured, and to seek immediate government action if any of these are jeopardized.

Amended Resolution 48(94) Increased Taxes on Handguns and Ammunition adopted. The resolution called for the increase of federal taxes on handguns and ammunition to support increased coverage for the uninsured.

Amended Resolution 38(94) Single-Payer System adopted. The resolution asked the Board to facilitate debate and discussion within ACEP about the merits to emergency physicians and patients regarding a single-payer system, all payer system, and other reform options and report back to the Steering Committee.

Substitute Resolution 44(92) Universal Access to Health Insurance adopted. The resolution directed ACEP to develop a policy statement outlining a national health care reform plan that addressed access to care for all, cost containment mechanisms, basic benefits package, health care insurance for all, freedom of choice by consumers, patient responsibility, quality improvement and ethical standards, education and research, and malpractice reform.

Prior Board Action

September 2018, accepted the final report from the Health Care Financing Task Force. The report was distributed to the Council.

Amended Resolution 19(16) Health Care Financing Task Force adopted.

June 2015, reaffirmed the policy statement, "Universal Health Care Coverage;" reaffirmed August 2009; originally approved December 1999.

Substitute Resolution 31(14) Single Payer Health Insurance adopted.

April 2014, approved the revised policy statement "Health Care Cost Assignments by Taxes," replacing the policy statement "Health Promotion Revenues ("Sin Taxes"); reaffirmed October 2006; revised and approved July 2000; originally approved in 1993.

April 2012, the Board reviewed a report regarding policies and regulations that were in process since enactment of the Affordable Care Act. ACEP submitted comment letters on a wide range of issues and held multiple meetings with department and agency officials over various provisions of the Act (accountable care organizations, the Physicians Quality Reporting System, information technology, workforce challenges etc.). The Board determined that no further action was needed on the resolution.

Substitute Resolution 24(08) Single-Payer Health Insurance adopted.

January 2008, discussed whether ACEP should have a more defined position on health care reform, including universal health care coverage. There was consensus that system reform and health care coverage were ACEP's primary goals in the health care debate.

August 2007, agreed with the assessment of the Federal Government Affairs Committee that support of reform principles and involvement in discussions regarding health care reform constitute sound approach to health care reform and thus took no action on Resolution 34(05).

January 2006, endorsed the "Principles of Reform of the U.S. Health Care System" developed by eleven physicians' organizations, including ACEP.

June 2005 discussed whether ACEP should take the lead in advocating for fundamental changes in public financing of health care to provide universal coverage of basic benefits.

Resolution 11(00) Funding the Mandate was assigned to the EMS Committee, Reimbursement Committee, Federal Government Affairs Committee, and the State Legislative/Regulatory Committee. ACEP addressed the resolution through ongoing legislative and regulatory activities, both nationally and at the state level.

Amended Resolution 15(99) Promotion of Health Care Insurance adopted.

Substitute Resolution 12(99) Education Program Addressing Underinsured and Uninsured adopted.

Substitute Resolution 17(98) Responsibilities of On Call Physicians adopted.

Resolution 46(96) Medicaid and the Welfare Reform Act of 1996 adopted.

Amended Resolution 48(94) Increased Taxes on Handguns and Ammunition adopted.

Amended Resolution 38(94) Single-Payer System adopted.

Substitute Resolution 44(92) Universal Access to Health Insurance adopted.

Background Information Prepared by: Ryan McBride, MPP

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 28(21)

SUBMITTED BY: Paul Kivela, MD, FACEP
California Chapter
Delaware Chapter
Florida College of Emergency Physicians
Maryland Chapter

SUBJECT: Consumer Awareness Through Classification of Emergency Departments

PURPOSE: 1) Create a system to classify EDs by 5 types; 2) work with a variety of groups to promote this classification and the criteria so it is widely known and understood by the public and the media; 3) promote any and all EDs that meet the standard at no or minimal charge and assist all members to document these standards; 4) work with a wide range of organizations to create an enforcement agency to ensure such classifications are accurate and up-to-date; 5) report on this process on an annual basis to the Council and ACEP membership.

FISCAL IMPACT: Unbudgeted expenses of $20,000 – $30,000 for in-person stakeholder meeting/task force depending on the size of the group. A public media campaign could cost $100,000. Potential loss of income from ACEP's ED Accreditation program (non-dues revenue) $500,000 + per year.

WHEREAS, Patients cannot decide and often do not know who will provide them care in the emergency department and patients seeking emergency care should ideally be entitled to physician-delivered or physician-led medical care, and ideally a specially-trained emergency physician; and

WHEREAS, There are varying standards as to whom provides care in emergency departments and patients are often not aware of the varying degrees of training and experience among physicians and non-physician providers; and

WHEREAS, Patients and communities deserve to have transparent information on the credentials of the professionals providing them care in an emergency department and clear knowledge if they are going to be cared by an emergency physician, other physician, or non-physician; and

WHEREAS, ABMS has determined that specific standards should be in place for each specialty and determined in emergency medicine specialty that should be defined by ABEM and AOBEM; and

WHEREAS, ABEM and AOBEM standards are such that EM physicians require both graduation from an undergraduate and approved medical school usually consisting of 3-4 years of additional emergency medicine specialty specific training;-and

WHEREAS, Medical schools require nearly 10,000 hours of generalized training and EM residency requires an additional nearly 10,000 hours of emergency medicine specialty specific training; and

WHEREAS, Supplemental non-physician training programs such as "bootcamp" programs or post-graduate "residency" programs may provide valuable education and training, they are not commensurate with the standards required by ABEM/AOBEM for the practice of Emergency Medicine;

WHEREAS, One of the fundamental issues core to physician specialization is that training matters;

WHEREAS, ACEP is studying creating its own accreditation of emergency departments, this proposed

resolution may stand alone and also serve to direct the College; therefore be it

RESOLVED, That:

1. ACEP advocate with professional, consumer, other health organizations and all other interested parties to classify emergency departments as follows

   Type A: All patients will be seen and evaluated exclusively by either:
   a. an ABEM or AOBEM certified emergency physician; or
   b. a physician recently graduated from a Residency Review Committee approved emergency medicine residency; or
   c. an emergency medicine resident in a Residency Review Committee approved emergency medicine residency under the onsite supervision of an ABEM or AOBEM certified emergency physician faculty member; or
   d. an emergency physician (who has been practicing emergency medicine greater than 20 years and has greater than 20,000 hours of emergency medicine experience) who is a member in good standing with an emergency medicine professional organization that has a method to enforce ethical behavior of its members including documentation of meeting these practice standards.

   Type B: All patients will have their care provided by the same criteria as Type A or by a physician assistant (PA) or nurse practitioner (NP) overseen by a ABEM or AOBEM certified or emergency medicine residency trained and/or can request and be seen by an emergency medicine residency trained or emergency physician (who has been practicing greater than 20 years and has greater than 20,000 hours of experience.)

   Type C: Patients may be seen by a PA or NP with supervision (either onsite or by telemedicine) by an ABEM or AOBEM certified, or by an emergency physician (who has been practicing greater than 20 years and has greater than 20,000 hours of emergency medicine experience) or patients may be seen by a MD or DO that does not meet the above criteria.

   Type D: Patients may be seen by a PA or NP (with 10,000 hours of emergency medicine experience) and without any direct or indirect supervision by an ABEM or AOBEM certified, approved emergency medicine residency trained, or emergency physician (who has been practicing greater than 20 years and has greater than 20,000 hours of emergency medicine experience).

   Type E: None of above criteria have been met.

2. ACEP will work with other likeminded medical professional, hospital organizations, and consumer groups to make available the classification and criteria so that it is widely known to the public and media.
3. ACEP will work to promote at no or minimal charge any and all emergency departments that meet the standards and assist all members to document these standards.
4. ACEP will work with other likeminded medical professional, hospital organizations, consumer groups, and governmental organizations to create an enforcement agency to ensure classifications are accurate and up to date.
5. ACEP will provide a report on this process and developments to the Council and ACEP membership on an annual basis.

Background

This resolution calls for ACEP to create a system by which hospital emergency departments (EDs) are classified by the criteria stated in the resolution. It calls for ACEP to advocate with a very wide variety of groups to create such a classification including professional organizations, consumer groups, and other health organizations; work with these groups to promote this classification and the criteria that define that so that it is widely known and understood by the public and the media; promote any and all EDs that meet the standard at no or minimal charge and assist all members in documenting these standards; work with a wide range of organizations to create an enforcement agency that would

ensure that such classifications are accurate and up-to-date; and report on this process and developments annually to the Council and the membership..

Accreditation of hospitals is limited to four organizations, The Joint Commission (TJC), Healthcare Facilities Accreditation Program, DNV GL Healthcare, and the Center for Improvement in Healthcare Quality.[1] Accreditation is required for participation in CMS and MC/MA reimbursement. TJC, the largest accreditation group, created a classification of EDs in the early 1970s but abandoned them in the early 1980s because they were poorly understood by the public. It was also difficult to enforce, "irrelevant," and they believed it was too complicated and blunted investment in increasing resources for emergency departments. TJC has no interest in reopening such a classification system. (Personal communication with TJC staff).

The Australasian College of Emergency Medicine proposed a similar system for Australia in 1997.[2] After 10 years of advocacy work, a new commission was established in 2017 to investigate the feasibility of such a system and to begin to classify possible criteria of inclusion.[3,4] It now appears to have been repurposed to create a reimbursement system rather than a classification of ED capabilities.

In June, 2021 ACEP President Mark Rosenberg, DO, FACEP, created the ED Accreditation Task Force to establish the feasibility of an accreditation program and create criteria for such a program. The task force is chaired by Adrian Tyndall, MD, FACEP, currently Dean at Morehouse School of Medicine, and the Board Liaison is Arvind Venkat, MD, FACEP. The task force is composed of emergency physicians from across the U.S., several of them in administrative jobs, including a CEO, and with expertise in reimbursement. The task force is charged with creating a system that will ensure that "a patient's zip code does not dictate the emergency care they receive." The task force is also charged with providing a final report, with recommended criteria and a business plan, to the Board by June 2022. If approved by the Board, ACEP is committed to have the accreditation program established, marketed, and enrolling EDs no later than by the end of 2022.

The task force has already discussed using accreditation to promote the policies of the College including the emergency physician as the leader of every emergency care team. ACEP's policies do not support the independent practice of NPs and PAs and this would be incorporated into the criteria for accreditation.

The task force will provide a written update to the Board of Directors and the Council Officers at each Board meeting during its deliberation. ACEP has had great success with its hospital-based geriatric ED accreditation program (GEDA) and, despite the pandemic, is seeing growing interest in the hospital-based program for pain and addiction accreditation (PACED). There are many anecdotal examples of facilities that make significant changes to meet the criteria for accreditation. More importantly, accreditation standards can be changed over time, and, as every teaching hospital knows, losing accreditation or even receiving a citation is taken very seriously. Accreditation is important to the C-Suite, which is why there are such representatives on the task force. Ideally, accreditation would be tied to payment/reimbursement. Most importantly, we have seen accreditation to be important for market share (larger hospitals and systems), and for small hospitals who wish to attract/retain patients from the community. It also provides a non-dues revenue source for the College.

This resolution calls for a proscribed classification system, which would remove the need for the task force and remove accreditation as an option. The resolution also calls on ACEP to establish a way to classify all 5,000 EDs in the U.S., an enforcement system that would likely require on-site investigation, and then a public campaign to inform the public of the multiple types of EDs. Even after the current EDs are classified, it would still be difficult to ensure public understanding what level of care they require for a given incident. There are a myriad of public websites and insurance campaigns that attempt to educate the public on identifying an emergency.

More importantly, this resolution calls for ACEP to help the public differentiate between departments staffed by emergency physicians and those staff by NPs/PAs. The literature suggests that the general public does not understand the difference between NPs/PAs and physicians, and at least in primary care, some prefer to see an NP/PA over a physician.[5] Despite the existence of trauma centers for several decades, the literature suggests that the public lacks awareness of the system, other than that they exist.[6]

Finally, using the classifications proposed in the resolution, it can be anticipated that the Type C, D, E facilities will be largely in rural America. About 30% of EDs have an annual volume of less than 10,000 visits or about 25 visits per day.[7] Patients who live in rural areas do not have a choice in emergency care as the next nearest facility may be many miles away.[8] In one national study 19% of Americans live more than 10 miles from their nearest hospital, while 24% live between 5 and 10 miles.[9] Using any classification of a stroke center as a surrogate for Type A, B facilities, 33% of the population live > 60 minutes from the nearest facility.[10]

Background References

[1]Healthcare Facilities Accreditation Program, DNV GL Healthcare and the Center for Improvement in Healthcare Quality.
[2]Australasian College for Emergency Medicine. Statement on the Delineation of Emergency Departments. November 2012.
[3]Health Policy Analysis 2014, Investigative review of classification systems for emergency care – Final report, Independent Hospital Pricing Authority, Sydney.
[4]Australasian College for Emergency Medicine. Australasian Emergency Care Classification. 2016.
[5]Leach B, Gradison M, Morgan P, et al. Patient preference in primary care provider type. *Healthc (Amst)*. 2018;6(1):13-6.
[6]Champion HR, Mabee MS, Meredith JW. The state of US trauma systems: public perceptions versus reality--implications for US response to terrorism and mass casualty events. *J Am Coll Surg*. 2006;203(6):951-61.
[7]Camargo C, Freess D, Marco CA, et al. Future of Emergency Medicine – People. 2020.
[8]Pew Research Center. How far Americans live from the closest hospital differs by community type. December 2018.
[9]Mullen MT, Wiebe DJ, Bowman A, et al. Disparities in accessibility of certified primary stroke centers. *Stroke*. 2014;45(11):3381-8.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum, including rural areas.
  - Tactic 1 – Advocate for ACEP's principles for healthcare reform in current and future legislation that supports the practice of emergency physicians
- Objective C – Promote the value of emergency medicine and emergency physicians as essential components of the health care system.
  - Tactic 3 – Promote emergency medicine to the general public using communication tools such as health and safety press releases, social media, ACEP's consumer website EmergencyPhysicians.org, or other marketing campaigns.

Goal 2 – Enhance Membership Value and Member Engagement

- Objective D – Increase ACEP brand awareness, growth, and impact internationally in a cost-effective manner.
  - Tactic 9 – Explore expansion of ACEP accreditation programs.

Fiscal Impact

Unbudgeted expenses of $20,000 - $30,000 for in-person stakeholder meeting/task force depending on the size of the group. A public media campaign could cost $100,000. Potential loss of income from ACEP's ED Accreditation program (non-dues revenue) $500,000 + per year.

Prior Council Action

Amended Resolution 20(08) Emergency Department Categorization Task Force adopted. Directed ACEP to convene a task force to explore the feasibility of sponsoring a national emergency center categorization program.

Resolution 15(98) Certifying Emergency Departments adopted. Directed the Board to appoint a task force to study the advisability of regionalization of care, developing a strategy to consolidate certifying agencies, and consider development of an ACEP certifying agency to replace as many other certifying agencies as possible.

Substitute Resolution 24(87) Levels of Staffing for Hospital Emergency Departments adopted. Directed ACEP to develop criteria within the next year to categorize the emergency services capabilities of healthcare facilities, include the qualification of emergency physicians, and continue to participate with the Joint Commission on Accreditation of

Healthcare Organizations in developing categorization criteria for emergency services accreditation standards.

Prior Board Action

October 2009, accepted for information the ED Categorization Task Force report. The report was distributed to the 2009 Council.

Amended Resolution 20(08) Emergency Department Categorization Task Force adopted.

Resolution 15(98) Certifying Emergency Departments adopted. A task force was appointed to further study the issues and potentially collaborate with SAEM. The task force report was distributed to the 2000 Council.

September 1997, sunsetted the policy statement "Categorization of Emergency Services;" previously reaffirmed June 1992 and originally approved April 1984.

January 1996, elected not to pursue ACEP certification of EDs but to continue to influence JCAHO and NCQA on emergency services certification issues.

April 1994, rescinded the policy statement "Health Care Facility Definitions;" previously approved June 1985.

Substitute Resolution Adopted 24(87) Levels of Staffing for Hospital Emergency Departments adopted.

Background Information Prepared by: Sandy Schneider, MD, FACEP
Senior Vice President, Clinical Affairs

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 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(21)

SUBMITTED BY: Florida College of Emergency Physicians
Illinois College of Emergency Physicians
Minnesota Chapter
Missouri College of Emergency Physicians

SUBJECT: Downcoding

PURPOSE: 1) Develop strategies to assist chapters in identifying if downcoding is occurring in their state; 2) develop model legislative language to include downcoding in existing prudent layperson statutes; 3) work with CMS and private insurers to prevent downcoding practices in Medicaid programs; and 4) work with chapters on model legislative language requiring transparency by insurers making changes to or requiring additional information for a claim.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, The Prudent Layperson Standard guarantees patients the right to receive treatment in the emergency department if they feel they have a medical emergency; and

WHEREAS, Emergency providers have an unfunded mandate to provide a medical screening exam and evaluate for an emergency condition under the Emergency Medical and Labor Act (EMTALA); and

WHEREAS, Determining whether an emergent condition exists and stabilizing it as required by EMTALA requires a thorough evaluation that may include multiple diagnostics and treatment modalities; and

WHEREAS, The presenting, or chief complaint, is inadequate to determine if a patient has a medical emergency and does not consistently correlate with a non-emergent final diagnosis; and

WHEREAS, according to the Federal Register Final Rule, 2016, the final determination of coverage and payment must be made taking into account the presenting symptoms rather than the final diagnosis; and

WHEREAS, The Prudent Layperson Standard requires health insurance companies to cover a patient's emergency department (ED) evaluation based on the patient's symptoms and not their final diagnosis; and

WHEREAS, Insurance companies are arbitrarily downcoding ED charts based on a final diagnosis without reviewing the medical record or presenting symptoms or chief complaint; and

WHEREAS, Insurance companies are using both arbitrary diagnosis lists and tools developed for non-billing and coding purposes to downcode ED charts; therefore be it

RESOLVED, That ACEP develop strategies to assist chapters in identifying if downcoding is occurring in their state; and be it further

RESOLVED, That ACEP develop specific model legislative language to include downcoding in existing prudent layperson statutes; and be it further.

RESOLVED, That ACEP work with the Centers for Medicare & Medicaid Services and private insurers to prevent the practice of downcoding in state Medicaid programs and by private insurers; and be it further

RESOLVED, That ACEP work with chapters to develop specific model legislative language to require transparency when insurance companies make changes to or require additional information for a claim.

Background

The resolution calls upon the College to develop model legislative language to include downcoding restrictions in existing prudent layperson statutes, work with CMS and private insurers to prevent downcoding practices, and work with chapters on model legislative language requiring transparency by insurers making changes to or requiring additional information for a claim.

The State of Maryland enacted the first prudent layperson law in 1993, and the federal government followed suit for Medicaid Managed Care and Medicaid recipients in the Balanced Budget Act of 1997. The scope of the laws applying the standard has expanded with its inclusion in the laws of 48 states, the District of Colombia, and the 2010 federal ACA Bill of Rights. However, both commercial insurers and government programs have persisted in efforts to reduce payments for emergency care that they deem non-emergent based on diagnosis.

ACEP has repeatedly reached out to Centers for Medicare & Medicaid Services (CMS) on the issue of downcoding, attempting to point out that downcoding is a violation of the prudent layperson standard (PLP). Most recently, ACEP has talked to CMS staff implementing the *No Surprises Act*. After an initial conversation, on June 14, 2021, ACEP and Emergency Department Practice Management Association (EDPMA) wrote a letter to CMS staff detailing this issue. The letter conveyed that both the Obama and Trump Administrations clearly stated that the PLP standard prevents plans from modifying payment (downcoding) of emergency claims based on diagnosis. The letter further explains that there are clear documentation standards and guidelines that dictate what level of service should be included on the claim. The letter also included a list of private payor and Medicaid policies that violate the PLP. This information will be reiterated in the key points of a letter in official response to the Interim Final Rules implementing the *No Surprises Act*.

ACEP developed a toolkit in 2018 for third-party stakeholders to begin an ACEP-led outreach to all impacted groups to ensure a coordinated approach and encourage information sharing and a unified message. Congressional and state legislative activity has focused on identifying legislative champions to lead various efforts, such as Congressional pressure on the third-party payers that violate PLP in their state, Congressional pressure on the insurance commissioner within their state to limit enforcement, Congressional outreach to HHS or CCIIO to encourage their action, and a Hill briefing (featuring a panel of emergency physician(s), a consumer representative, and an impacted patient). The toolkit and Congressional pressure in 2018 led to the publication by Senator McCaskill (D-MO) of the report, “Coverage Denied: Anthem BCBS’ Emergency Room Initiative,” which included data ACEP had compiled and shared with the Senator’s office.

ACEP provided data on specific retroactive denials collected from various emergency physician groups to several federal agencies to supplement any investigative work on PLP denials they might have had underway. ACEP continues to advocate for PLP strengthening in federal law as part of our surprise billing advocacy. Finally, ACEP has written letters to CMS and had calls with and sent letters to several states to address various issues with state Medicaid agencies and/or managed care plans’ downcoding or retroactively denying claims.

ACEP is working with chapters to identify champions in the state legislatures and/or governors’ offices who might have influence with insurance commissioners, develop op-eds in key markets to influence state lawmakers, and encourage impacted constituents to write to their legislators. Favorable legislation passed in Missouri in 2019 and in Maine in 2020. Model legislation drafted by EDPMA/ACEP to prevent down coding was recently introduced in the California Assembly.

ACEP will continue to explore legal options to prevent third-party payers from enforcing policies that violate PLP, including possible injunctions. ACEP filed suit against Anthem Blue Cross Blue Shield of Georgia in July 2018. On October 22, 2020, the 11th Circuit Court ruled in favor of the appeal filed by ACEP and the Medical Association of Georgia. The case was remanded back to the Northern District Court in Georgia. The wording of the opinion is strongly supportive of ACEP’s position.

In June 2021, the Board of Directors approved an RFP to commission an independent study on the financial influence of health insurers on emergency physicians, with a focus on Emergency Medical Treatment and Labor Act (EMTALA)-related mandates and associated reimbursement issues affecting emergency physicians.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective E – Pursue strategies for fair payment and practice sustainability to ensure patient access to care.

Fiscal Impact

Budgeted committee and staff resources.

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 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 state that have the definition in law.

Prior Board Action

June 2021, approved and RFP to commission an independent study on the financial influence of health insurers on emergency physicians, with a focus on Emergency Medical Treatment and Labor Act (EMTALA)-related mandates and associated reimbursement issues affecting emergency physicians.

Resolution 25(20) Adverse Impact of Healthcare Insurers on Emergency Medicine Reimbursement and Optimal Coverage adopted.

October 2020, approved the revised policy statement "Third-Party Payers and Emergency Medical Care;" revised and approved April 2014, June 2007, July 2000, and January 1999; approved March 1993 with title "Managed Health Care Plans and Emergency Care;" originally approved September 1987.

February 2020, approved prudent layperson model state legislation stipulating that "the health plan shall, in accordance with payment timeliness regulations, reimburse any undisputed amount while review of disputed portions of the claim is underway."

Amended Resolution 35(19) Prudent Layperson Visit Downcoding adopted.

February 2018, reaffirmed the policy statement "Assignment of Benefits;" reaffirmed April 2012; originally approved April 2006.

July 2018, ACEP and the Medical Association of Georgia filed suit against Anthem's Blue Cross Blue Shield of Georgia in federal court to compel the insurance giant to rescind its controversial and dangerous emergency care policy that retroactively denies coverage for emergency patients.

January 2018, ACEP and 11 other medical societies, sent a letter to Anthem stating concerns with several of their reimbursement policies (outpatient radiology, emergency denials, modifier-25).

Amended Resolution 40(17) Reimbursement for Emergency Services adopted.

April 2017, approved the revised policy statement "Fair Coverage When Services Are Mandated;" reaffirmed April 2011 and September 2005 with the title "Compensation When Services are Mandated;" originally approved September 1992.

April 2017, approved the revised policy statement "Prior Authorization;" revised and approved October 1998; originally approved November 1987.

April 2016, approved the revised policy statement "Fair Payment for Emergency Department Services;" originally approved April 2009.

Resolution 43(97) Prudent Layperson Legislation adopted.

Background Information Prepared by: Harry J. Monroe, Jr.
State Legislation Director

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 30(21)

SUBMITTED BY: Douglas P Brosnan, MD, JD, FACEP
Bing S Pao, MD, FACEP
Thomas J. Sugarman, MD, FACEP
California Chapter
Michigan College of Emergency Physicians
Missouri Chapter

SUBJECT: Unfair Health Plan Payment Policies

PURPOSE: 1) Develop model legislation and advocate for enactment at both the state and federal levels, prohibiting health plans from implementing new payment policies during the term of a provider's contracts unless the new policy is required by new laws or regulations; 2) advocate at the American Medical Association to pass legislation prohibiting health plan contracts from requiring adherence to new health plan payment policies unless the new policy is required by new laws or regulations.

FISCAL IMPACT: Budgeted staff resources.

WHEREAS, Health plans have been increasingly introducing new payment policies to reduce or deny emergency provider payments; and

WHEREAS, These payment policies include downcoding, bundling charges, unreasonable timely filing requirements, payment reductions for physician extenders and ancillary care services, and non-emergent denials; and

WHEREAS, In-network providers are required to follow the policies during the term of the contract in order to stay in-network; and

WHEREAS, Emergency physicians are compelled to agree to the policies unless the provider terminates the contract with the health plan; and

WHEREAS, Health plans will often unilaterally implement the payment policies even if the provider is out-of-network; therefore be it

RESOLVED, That ACEP develop model legislation and advocate for enactment at both the state and federal levels, prohibiting health plans from implementing new payment policies during the term of a provider's contracts unless the new policy is required by new laws or regulations; or the provider consents in writing to the specific policy change prior to its being implemented; and be it further

RESOLVED, That ACEP advocate at the American Medical Association to promote legislation prohibiting health plan contracts from requiring adherence to new health plan payment policies unless the new policy is required by new laws or regulations.

Background

This resolution calls for the College to develop model legislation and advocate for enactment at both the state and federal levels, prohibiting health plans from implementing new payment policies during the term of a provider's contracts, unless the new policy is required by new laws or regulations, as well as to advocate at the American

Medical Association to pass legislation prohibiting health plan contracts from requiring adherence to new health plan payment policies unless the new policy is required by new laws or regulations.

ACEP has increasingly seen insurers change the payment terms of a contract during the agreed upon term of the existing contract. While most contracts contain provisions to modify or terminate a contract within certain parameters and length of notice, changes that enact unfavorable payment policies leave the emergency physician with the unfortunate option of either terminating the contract and being out of network or accepting less favorable payment policy. Health plans have been known to use this tactic to force groups to either be out-of-network to take advantage of balance billing prohibitions or other state language, which create administrative hassles, delay in obtaining payment, and sometimes unfavorable publicity in the community and with lawmakers.

Health plans have been increasingly introducing new payment policies to unfairly deny or unreasonably reduce payment to emergency physicians. These payment policies include, but are not limited to, downcoding, bundling, unreasonable timely filing requirements, payment reductions or denials for separate billable procedures, unconventional payment reductions for ancillary care clinicians, non-emergent denials, and unreasonable usual and customary payments. In most cases, in-network emergency physicians are required to abide by the health plan policies, but insurers often unilaterally apply the same policies to out-of-network emergency physicians. Emergency physicians are often compelled to agree to new policies during the term of a contract to stay in-network.

ACEP advocacy has produced some tangible results in response to unfair health plan payment policies. Forming coalitions with state ACEP chapters and medical societies has been a key ingredient for success. Involving government regulators has caused payers to respond to complaints and at least delay implementation. Some advocacy successes against unfair health plan payment policies include:

1. delayed implementation of United Health Care's evaluation and management coding policy;
2. reversing Medicaid downcoding policies in Kansas and Illinois;
3. improvements to Anthem's problematic policy denying coverage for what it deemed nonemergent in several States; and
4. suspension of Centene's (Managed Health Services [MHS], Indiana) downcoding policy and reduced payment policy for claims billed with a modifier-25. A Centene subsidiary (HealthNet) suspended a similar modifier-25 policy in California.

Legislation has been an effective tool to curb unfair health plan payment practices. Most states have statutes that waive authorization requirements and provide prudent layperson protection for coverage of emergency services. States often require timely payments for emergency clinician claims and an appeal process for denied claims. Some states mandate assignment of benefits for emergency services. Many of these laws have successfully achieved the intended purpose. It is not clear if legislation that was designed to reduce non-emergent denials or downcoding has been effective. Maine passed legislation that would require utilization review by a board-certified emergency physician to prevent non-emergent denials and downcoding. There are reports that downcoding continues to occur in Maine, but it is unknown if the frequency decreased following passage of the bill. Missouri requires a review of the medical records by a board-certified physician before denying payment based on the absence of an emergency medical condition. However, an analysis by one emergency physician group in Missouri found the frequency of downcoding did not decrease after passage of the bill. Model legislation drafted by EDPMA/ACEP to prevent downcoding was recently introduced in the California Assembly. A separate bill that was introduced in the California Senate would shift the responsibility of collecting the patient cost share to the health plans. Oklahoma recently introduced a bill that would require the policyholder to agree to any changes to a policy benefit, including removal of a patient's physician from his or her network contract, at any time the policy is in force. The impact of some of these legislative efforts is still unknown. Passing legislation to prevent the implementation of harmful health plan payment policies during the term of a contract could be another effective method to prevent underpayment of claims.

ACEP has lobbied extensively on unfair health plan payment polices for the past few years, but not specifically to midterm changes in existing contracts. ACEP could submit a resolution to the AMA House of Delegates calling for advocacy on this issue.

The AMA does have current policy that calls for a mechanism to address grievances and supports advocacy on behalf of patients, 11.2.3 Contracts to Deliver Health Care Services, which was last modified in 2017:
E-11.2.3 11.2.3 Contracts to Deliver Health Care Services| AMA (ama-assn.org)

A second AMA policy on Physician Negotiations says that physicians should have the right to set the parameters and acceptable terms for their contracts with managed care plans in advance of contract negotiations and that physicians should have the opportunity to request alternative dispute resolution mechanisms to resolve disputes with the hospital concerning managed care contracting, H-383.997 Hospital Based Physician Contacting:
H-383.997 Hospital-Based Physician Contracting | AMA (ama-assn.org)

A third AMA policy urges CMS to ban "no cause" terminations of MA network physicians during the initial term or any subsequent renewal term of a physician's participation contract with a MA plan, H-285.902 Ban on Medicare Advantage "No Cause" Network Terminations:
H-285.902 Ban on Medicare Advantage "No Cause" Network Terminations | AMA (ama-assn.org)

Finally, an AMA policy requiring managed care organizations to provide due process to physicians in all adverse selective contracting decisions, H-285.981 Fair Market Practices:
H-285.981 Fair Market Practices | AMA (ama-assn.org)

ACEP has several policy statements that address this resolution::

1. Compensation Arrangements for Emergency Physicians
2. Fair Payment for Emergency Department Services
3. Emergency Physician Compensation Transparency
4. Emergency Physician Rights and Responsibilities
5. Protecting Emergency Physician Compensation During Contract Transitions

ACEP's Policy Resource and Education Paper (PREP) "Emergency Physician Contractual Relationships" states that "contracting parties should be ethically bound to honor the terms of any contractual agreement to which it's a party and to relate to one another in an ethical manner." The PREP is an adjunct to the ACEP's policy statement "Emergency Physician Contractual Relationships."

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective E – Pursue strategies for fair payment and practice sustainability to ensure patient access to care.
  - Strategy 2 – Collaborate with the AMA, state medical societies, and other medical organizations on payment and practice sustainability issues such as out-of-network reimbursement and balance billing issues, including advocacy with entities such as FAIR Health, NCOIL, NAIC, and PFC, as appropriate.

Fiscal Impact

Budgeted staff resources.

Prior Council Action

Amended Resolution 29(20) Billing and Collections Transparency in Emergency Medicine first two resolveds adopted and last three resolveds referred to the Board of Directors.

Resolution 15(02) Promotion of College Policies on Contracting and Compensation not adopted. Requested the Board of Directors to review the policy statement " Promotion of College Policies on Contracting and Compensation" and

Resolution 14(02) Emergency Physician Rights and Self-Disclosure not adopted. The resolution would have required any exhibitor, advertiser, grant provider, and sponsor who employs emergency physicians as medical care providers to disclose their level of compliance with College policies on compensation and contractual relationships. Amended

Resolution 14(01) Fair and Equitable EM Practice Environments adopted. Directed ACEP to continue to study the issue of contract management groups and determine what steps should be taken by ACEP to more strongly encourage a fair and equitable practice environment and to continue to promote the adoption of the principles outlined in the "Emergency Physician Rights and Responsibilities" policy statement by the various emergency medicine contract management groups, the American Hospital Association, and other pertinent organizations.

Resolution 12(01) Coercive Contracting not adopted. Directed ACEP to discourage any contracting practice that may be illegal, unethical, or any practice that may circumvent fair and equitable negotiations and to explore 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.

Amended Resolution 74(95) Support Part B of the Health Care Quality Improvement Act not adopted. There were concerns about anti-kickback statutes and the need to recognize where it occurs between both hospitals and contracting entities and management companies and physicians.

Substitute Resolution 56(94) Exploitation of Emergency Physicians adopted. Called for ACEP to reaffirm its value statement that "the best interests of the patient are served when emergency physicians practice in a fair, equitable, and supportive environment," and its accompanying objective that "fair and equitable compensation for emergency physicians will be established through fair business practices and be available for all emergency services rendered."

Amended Resolution 49(94) Information on Contract Issues adopted. Directed ACEP to continue efforts to provide members with current and comprehensive information to assist them in negotiating contracts.

Substitute Resolution 9(93) Contractual Relationships adopted. Called for ACEP to support fair and equitable contractual business arrangements and promote these relationships through a public relations campaign and the development of a policy statement on fair and equitable contractual relationships. Substitute Resolution 18(85) Fairness adopted. Directed the development of a position statement on contractual relationships between emergency physicians and contracting/employing entities that addresses emergency physicians' rights to fair and equitable treatment.

Substitute Resolution 18(85) Fairness adopted. Directed the development of a position statement on contractual relationships between emergency physicians and contracting/employing entities that addresses emergency physicians' rights to fair and equitable treatment.

Prior Board Action

June 2021, approved filing the report of the EDPMA/ACEP Unfair Health Plan Payment Policy Task Force and utilizing the recommendations contained in the report as options for future implementation to address unfair health plan payment policies.

April 2021, approved the revised policy statement "Compensation Arrangements for Emergency Physicians;" revised and approved April 2015, April 2002 and June 1997; reaffirmed October 2008 and April 1982; originally approved June 1988.

April 2021, approved the revised policy statement "Emergency Physician Contractual Relationships;" revised and approved June 2018, October 2012, January 2006, March 1999, and August 1993 with the current title; originally approved October 1984 titled "Contractual Relationships between Emergency Physicians and Hospitals."

April 2021, approved the revised policy statement "Emergency Physician Rights and Responsibilities;" revised and approved October 2015, April 2008, July 2001; originally approved September 2000.

Amended Resolution 29(20) Billing and Collections Transparency in Emergency Medicine first two resolveds adopted. Directed ACEP to revise the policy statement "Emergency Physician Rights and Responsibilities" with specific language.

October 2020, approved the policy statement "Emergency Physician Compensation Transparency."

February 2020, approved the policy statement "Protecting Emergency Physician Compensation During Contract Transitions."

July 2018, reviewed the Policy Resource & Education Paper (PREP) " Emergency Physician Contractual Relationships" as an adjunct to the policy statement " Emergency Physician Contractual Relationships."

June 2018, approved the revised policy statement "Emergency Physician Contractual Relationships;" revised and approved Octobe4 2012, January 2006, March 1999, and August 1993 with the current title. Originally approved October 1984 titled "Contractual Relationships between Emergency Physicians and Hospitals."

January 2017, approved the revised policy statement " Code of Ethics for Emergency Physicians;" revised and approved June 2016 and June 2008; reaffirmed October 2001; revised and approved June 1997 with the current title; originally approved January 1991 titled "Ethics Manual."

Amended Resolution 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 Groups adopted. June 1997 reviewed the information paper " Fairness Issues and Due Process Considerations in Various Emergency Physician Relationships."

Substitute Resolution 56(94) Exploitation of Emergency Physicians adopted. Amended Resolution 49(94) Information on Contract Issues adopted.

Amended Resolution 49(94) Information on Contract Issues adopted.

Substitute Resolution 9(93) Contractual Relationships adopted. A Contracts Task Force was appointed as a result of this resolution.

Substitute Resolution 18(85) Fairness adopted.

Background Information Prepared by: David McKenzie, CAE
Reimbursement Director

Harry Monroe
State Legislative & Regulatory Affairs Director

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 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(21)

SUBMITTED BY: Olga Gokova, MD, FACEP
Rebecca Parker, MD, FACEP
Amish Shah, MD, FACEP
Arizona College of Emergency Physicians

SUBJECT: Employment-Retaliation, Whistleblower, Wrongful Termination

PURPOSE: Submit a resolution at the June 2022 AMA House of Delegates Annual Meeting promoting Arizona House Bill 2622 (2021) and promote the legislation to chapters through mechanisms such as the State Legislative/ Regulatory Committee and other membership outreach.

FISCAL IMPACT: Budgeted staff resources.

WHEREAS, "Doctors often hesitate to speak out because of the prospect of losing their jobs. A 2013 study of emergency physicians found that nearly 20% reported a possible or real threat to their employment if they expressed concerns about quality of care."[1]; and

WHEREAS, Emergency physicians have been retaliated against numerous times for raising concerns regarding patient safety, harassment, and/or fraud and these physicians have been affected mentally and financially as results of such retaliation and job loss and many report worsening anxiety, depression, financial hardships, family trouble and need to relocate; and

WHEREAS, The interests of patients are best served when emergency physicians practice in a stable, fair, equitable, and supportive environment and quality patient care is best promoted within a framework of fair and appropriate contractual relationships among various involved parties. [Emergency Physician Contractual Relationships Policy Resource and Education Paper (PREP)][2]; and

WHEREAS, "The COVID-19 pandemic put to the test physicians' ability to speak publicly about troublesome issues and in the first few weeks, healthcare facilities were struggling to obtain personal protective equipment (PPE) and to create policies that would keep patients and caregivers safe."[1,6]; and

WHEREAS, According to AAEM "Both the JCAHO and the Health Care Quality Assurance Act of 1986 require hospitals to give physicians appropriate due process before taking an adverse action on their privileges… There are also a number of state and federal laws which protect employees from discrimination or retribution for "whistle-blowing." These protections may be weakened or inapplicable if the physician is an independent contractor."[3]; and

WHEREAS, ACEP has a policy statement on due process: "Emergency physicians are entitled to due process before any adverse final action with respect to employment or contract status, the effect of which would be the loss or limitation of medical staff privileges or their ability to see patients. Emergency physicians' medical and/or clinical staff privileges should not be reduced, terminated, or otherwise restricted except for grounds related to their competency, health status, limits placed by professional practice boards or state law."[4]; and

WHEREAS, Arizona House Bill 2622 (2021) as signed into law has the following provisions:

1. Prohibits a third-party contractor of a health care institution from taking retaliatory action against a health professional.
2. Makes the period of time before there is a rebuttable presumption six months.

3. Defines third-party contractor as an entity that contracts with a health care institution to provide health care services in the health care institution by contracting or hiring health professionals.
4. Makes technical and conforming changes.[5]; therefore be it

RESOLVED, That ACEP submit a resolution to the June 2022 AMA House of Delegates Annual Meeting promoting Arizona house bill 2622 (2021) as signed into law as model state and national legislation to protect emergency physicians from corporate, workplace, and/or employer retaliation when reporting safety, harassment, or fraud concerns at the places of work (licensed health care institution) or government, which also includes independent and third-party contractors providing patient services at said facilities; and be it further

RESOLVED, That ACEP promote Arizona house bill 2622 (2021) to chapters through mechanisms such as the State Legislative/Regulatory Committee and other membership outreach.

References

1. https://www.medscape.com/viewarticle/950074
2. https://www.acep.org/globalassets/new-pdfs/preps/emergency-physician-contractual-relationships---prep.pdf
3. https://www.aaemrsa.org/get-involved/residents/key-contract-issues
4. https://www.acep.org/patient-care/policy-statements/emergency-physician-rights-and-responsibilities/
5. https://www.azleg.gov/legtext/55leg/1R/bills/HB2622P.pdf
6. https://verdictsearch.com/verdict/hospitals-firing-of-doctor-was-retaliation-plaintiff-alleged/
https://www.reliasmedia.com/articles/146234-enforcement-action-likely-if-hospital-retaliates-against-ed-staff
https://www.npr.org/sections/health-shots/2020/05/29/865042307/an-er-doctor-lost-his-job-after-criticizing-his-hospital-on-covid-19-now-hes-sui

Background

This resolution calls for ACEP to submit a resolution at the June 2022 AMA House of Delegates Annual Meeting promoting Arizona House Bill 2622 (2021) as signed into law as model state and national legislation to protect emergency physicians from corporate, workplace, and/or employer retaliation when reporting safety, harassment, or fraud concerns at the places of work (licensed health care institution) or government, which also includes independent and third-party contractors providing patient services at said facilities. It also directs ACEP to promote the legislation to chapters through mechanisms such as the State Legislative/Regulatory Committee and other membership outreach.

Whistleblower protection laws applying to health care workers vary widely in their degree and scope. At the federal level, the Occupational Safety and Health Administration, "Section 11(c) of the Occupational Safety and Health Act of 1970 (OSH Act) prohibits employers from retaliating against employees for exercising a variety of rights guaranteed under the OSH Act, such as filing a safety or health complaint with OSHA, raising a health and safety concern with their employers, participating in an OSHA inspection, or reporting a work-related injury or illness." In April 2020, OSHA issued a news release reminding employers that they cannot retaliate against employees reporting unsafe conditions during the pandemic, and the agency specifically included an anti-retaliation provision in its COVID-19 Emergency Temporary Standard issued this year.

While many states provide some level of whistleblower protection for healthcare workers, this year Arizona notably expanded its law related to protections for those working in health care institutions through House Bill 2622, to specifically extend requirements to apply to workers of third-party contractors of a health care institution. The previous law just covered the health care institution itself. Under the revised statute, health care institutions and third parties (those that contract to provide health care services to health care institutions by contracting or hiring health professionals) are precluded from taking retaliatory action against health care professionals who report an activity, policy or practice that the health professional reasonably believes violates professional standards of practice or is against the law and poses a substantial risk to the health, safety or welfare of a patient. If the institution or third party fail to address the initial report, the health care professionals are similarly protected from retaliation if they subsequently report the activity to an accrediting body or governmental entity. The bill also extended the length of time for a "rebuttable presumption" that any termination or other adverse action would be considered a retaliatory action from 180 days after the report is made by the health professional to six months.

ACEP policy supports protection of emergency physicians from retaliation for speaking out about conditions that could negatively impact patient care. The policy statement "Emergency Physician Rights and Responsibilities" states in part that "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." The policy statement "Safer Working Conditions for Emergency Department Staff" contains a provision under the section "Leadership promotion of a culture of safety and open reporting of safety concerns" that includes "Protections and support for physicians who raise or report safety concerns." Further, ACEP's policy statement "Supporting Political Advocacy in the Emergency Department" states that "Physicians should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment. Physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests."

During the pandemic, ACEP has expressed strong opposition to retaliation against physicians for speaking out against policies and practices that created unsafe working conditions. On March 30, 2020, ACEP issued a press release entitled "ACEP Strongly Supports Emergency Physicians who Advocate for Safer Working Conditions Amidst Pandemic." In July 2020, then ACEP President William Jaquis, MD, FACEP, and ACEP staff met with officials from the Occupational Safety and Health Administration (OSHA). During the meeting, ACEP shared de-identified stories from emergency physicians who have been penalized by their hospitals for wearing their own PPE or for speaking out publicly about PPE shortages or other issues. The College strongly urged OSHA to revise their standards and guidance to better protect emergency physicians and re-enforce their right to wear PPE that they believe keeps them safe. ACEP also asked OSHA to respond as quickly as possible to formal complaints filed by emergency physicians. ACEP also shared similar information with The Joint Commission and the American Hospital Association.

The AMA has also been vocal about this issue. In April of 2020, the AMA released a statement quoting AMA President Patrice Harris, MD as saying "No employer should restrict physicians' freedom to advocate for the best interest of their patients." The AMA also has several policies addressing the issue of retaliation against whistleblowers, including "Fair Process for Employed Physicians (H-435.942)" which states "Our AMA supports whistleblower protections for health care professionals and parties who raise questions that include, but are not limited to, issues of quality, safety, and efficacy of health care and are adversely treated by any health care organization or entity. Our AMA will advocate for protection in medical staff bylaws to minimize negative repercussions for physicians who report problems within their workplace." The AMA policy "Physician and Medical Staff Member Bill of Rights (H-225.942)" states in part that "Our AMA recognizes that the following fundamental rights apply to individual medical staff members, regardless of employment, contractual, or independent status, and are essential to each member's ability to fulfill the responsibilities owed to his or her patients, the medical staff, and the health care organization:… the right to exercise personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care, medical staff matters, or personal safety, including the right to refuse to work in unsafe situations, without fear of retaliation by the medical staff or the health care organization's administration or governing body, including advocacy both in collaboration with and independent of the organization's advocacy efforts with federal, state, and local government and other regulatory authorities." In a policy entitled "The Physician's Right to Engage in Independent Advocacy on Behalf of Patients, the Profession and the Community (H-285.910)", the AMA endorses specific language of a clause to be included in physician employment contracts and independent contractor agreements for physician services that precludes the employer from retaliating against the physician for exercising his/her right to advocate on behalf of patients' interests or good patient care.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective D – Promote quality and patient safety, including continued development and refinement of quality measures and resources.

Goal 2 – Enhance Membership Value and Member Engagement

- Objective H – Strengthen job security and opportunity for individual members at all stages of their careers.

Fiscal Impact

Budgeted staff resources.

Prior Council Action

Amended Resolution 44(20) Due Process in Emergency Medicine referred to the Board of Directors. The resolution called for the College to 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. The resolution further called for wording changes in the policy statement "Emergency Physician Rights and Responsibilities" and the adoption of 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 41(20) Personal Protection Equipment adopted. The amended resolution directed the College to work with relevant stakeholders to develop establish appropriate minimum standards and regulations for hospitals to maintain accessible storage of appropriate levels of personal protective equipment, to strengthen whistleblower protections for those reporting deficiencies in the quantity or quality of PPE provided to them, and to establish new policy supporting emergency physicians providing their own PPE without penalty if proper PPE is not provided.

Resolution 47(13) Supporting Political Advocacy in the ED adopted. The resolution called for the College to adopt a policy statement incorporating a provision in the AMA's Principles for Physician Employment stating that "employed physicians should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter, regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment. Employed physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests."

Resolution 45(13) Revision of "AMA Principles for Physician Employment" referred to the Board of Directors. The resolution called for ACEP to work to amend the AMA Principles for Physician Employment to state that no physician employment agreement should limit a physician's right to due process as a member of the medical staff if terminated. The AMA Section Council on Emergency Medicine recommended that the AMA Organized Medical Staff Section (OMSS) review the information and potentially submit a resolution to the AMA Interim Meeting in November 2014. However, AMA staff reported that the AMA amended the Principles for Physician Employment in June 2014 to address the issue of automatic termination of staff privileges following termination of an employment agreement (sections 3e and 5f) based on a report from the OMSS Governing Council that outlined the rationale for the amended language.

Amended Resolution 30(11) Emergency Physician Contracts and Medical Staff Activities/Membership adopted. Called for 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 29(11) Due Process for Emergency Physicians adopted. Called for ACEP to review and update the policy statement "Emergency Physician Contractual Relationships" regarding due process and distribute the updated policy to the American Hospital Association, the American College of Health Care Executives and other entities.

Resolution 17(03) Certificate of Compliance referred. 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."

Amended Resolution 14(02) Emergency Physician Rights and Self-Disclosure defeated. The resolution called for ACEP to require exhibitors, advertisers, grant providers and sponsors who employ emergency physicians as medical care providers to disclose to their program audience their level of compliance with ACEP policies addressing due

process and other emergency physician rights outlined in the policy statements "Emergency Physician Rights and Responsibilities," Emergency Physician Contractual Relationships," "Agreements Restricting the Practice of Emergency Medicine," and "Compensation Arrangements for Emergency Physicians." It would require that those claiming to be in substantial compliance with the policies must be able to support the claims by producing documentation for review, and those whose self-disclosure is determined through due process to be false would be prohibited from sponsoring, exhibiting or advertising with ACEP.

Amended Resolution 14(01) Fair and Equitable EM Practice Environments adopted. The resolution called for 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 report back to the Council, 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.

Substitute Resolution 10(01) Commercial Sponsorships adopted. The substitute resolution called for ACEP to continue initiatives to develop and implement policies on self-disclosure by sponsors, grant providers, advertisers, and exhibitors at ACEP meetings regarding their compliance with ACEP physicians' rights policies.

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.

Resolution 59(95) Due Process for Emergency Physicians referred to the Board of Directors. The resolution called for ACEP to support, and incorporate into educational and advocacy efforts, promotion of the concepts of due process in all employment arrangements for emergency physicians, that any emergency physician being terminated has the right to receive the reasons for such termination and to formally respond to those reasons prior to the effective date of the termination.

Amended Resolution 54(94) Due Process adopted in lieu of resolutions 52(94) Due Process Exclusion Clause and 54(94) Due Process. The amended resolution directed the College to study the issue of peer review and due process exclusion clauses in emergency physician contracts.

Resolution 52(94) Due Process Exclusion Clauses not adopted. This resolution called for ACEP to lobby to ban peer review and due process exclusion clauses from emergency physician contracts. Amended Resolution 54(94) was adopted in lieu of 52(94).

Resolution 38(90) Due Process Rights of Hospital Based Physicians not adopted. This resolution called for ACEP to work with The Joint Commission to develop standards to protect due process rights of hospital-based physicians.

Prior Board Action

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 Rights and Responsibilities;" revised and approved October 2015, April 2008, July 2001; originally approved September 2000.

April 2021, approved the revised policy statement "Emergency Physician Contractual Relationships;" revised and approved June 2018, October 2012, January 2006, March 1999, and August 1993 with the current title; originally approved October 1984 titled "Contractual Relationships between Emergency Physicians and Hospitals."

April 2021, approved the policy statement "Safer Working Conditions for Emergency Department Staff."

Amended Resolution 41(20) Personal Protection Equipment adopted.

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.

June 2019, approved the revised policy statement "Supporting Political Advocacy in the Emergency Department;" originally approved October 2013.

September 2018, approved the policy statement "Due Process for Physician Medical Directors of Emergency Medical Services."

July 2018, reviewed the Policy Resource & Education Paper (PREP) " Emergency Physician Contractual Relationships" as an adjunct to the policy statement " Emergency Physician Contractual Relationships."

January 2017, approved the revised policy statement "Code of Ethics for Emergency Physicians;" revised and approved June 2016, June 2008; reaffirmed October 2001; revised and approved June 1997 with the current title; originally approved January 1991 titled "Ethics Manual."

Resolution 47(13) Supporting Political Advocacy in the ED adopted.

Amended Resolution 30(11) Emergency Physician Contracts and Medical Staff Activities/Membership adopted.

Resolution 29(11) Due Process for Emergency Physicians adopted.

September 2004, approved a report to the Council with a letter from the Federal Trade Commission regarding issues raised in Resolution 17(03) Certificate of Compliance and Resolution 18(03) Intention to Bid for Group Contract and agreed to take no further action on the resolutions.

Amended Resolution 14(01) Fair and Equitable EM 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 Groups adopted.

Amended Resolution 54(94) Due Process adopted in lieu of resolutions 52(94) Due Process Exclusion Clause and 54(94) Due Process.

Background Information Prepared by: Craig Price, CAE
Senior Director, Practice Affairs

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 32(21)

SUBMITTED BY: Chris Barsotti, MD, FACEP
Sarah Hoper, MD, JD, FACEP
James C. Mitchiner, MD, MPH, FACEP
Alexandra Nicole Thran, MD, FACEP
Vermont Chapter
American Association of Women Emergency Physicians Section
Diversity Inclusion & Health Equity Section

SUBJECT: Firearm Ban in EDs Excluding Active Duty Law Enforcement

PURPOSE: 1) Directs ACEP to promote and endorse that EDs become "Firearm Free" Zones, with the exception of active-duty law enforcement officers, hospital security, military policy, and federal agents; and 2) endorse and promote screening for firearms in the emergency department as well as promote public education and academic research to decrease workplace violence by decreasing firearm morbidity and mortality.

FISCAL IMPACT: Budgeted staff resources to promote and endorse the concept of EDs becoming firearm-free zones. Promoting public education to decrease workplace violence could involve an unbudgeted and undetermined cost, depending on the scope of the promotion/public relations activity involved.

WHEREAS, Workplace violence against healthcare providers occurs every day and is underreported[1]; and

WHEREAS, The healthcare sector violence is statistically most subject to workplace violence, behind law enforcement; and

WHEREAS, There are no statistically proven methods to reduce workplace violence in the healthcare setting[2]; and

WHEREAS, There are currently no specific OSHA standards for workplace violence[3]; and

WHEREAS, OSHA recommends mitigating workplace violence prevention by taking "appropriate precautions," and establishing a "zero-tolerance towards workplace violence"[4]; and

WHEREAS, ACEP has supported United States House Resolution, 1309 (H.R. 1309): The Workplace Violence Prevention for Health Care and Social Service Workers Act , a bipartisan bill which was passed by the United States House of Representatives; and

WHEREAS, H.R. 1309 was referred by the United States Senate to the Committee on Health, Education, Labor, and Pensions, and did not come up for a vote in the Senate[5]; and

WHEREAS, H.R. 1309 was re-introduced as H.R. 1195 Workplace Violence Prevention for Health Care and Social Service Workers Act[6] and has not come up for a vote in the Senate; and

WHEREAS, ACEP submitted its information paper on workplace violence, "Emergency Department Violence: An Overview and Compilation of Resources"; and

WHEREAS, ACEP and the Emergency Nurses Association (ENA) have launched "No Silence on ED Violence," a new campaign to stop these attacks and protect emergency department professionals and patients;

therefore be it

RESOLVED, That ACEP promote and endorse that Emergency Departments become "Firearm Free" Zones, with the exception of active duty law enforcement officers, hospital security, military police, and federal agents; and be it further

RESOLVED, That ACEP endorse and promote screening for firearms in the emergency department; and be it further

RESOLVED, That ACEP promote public education and academic research to decrease workplace violence by decreasing firearm morbidity and mortality.

References
[1] Phillips, J. P. (2016). Workplace Violence against Health Care Workers in the United States. *New England Journal of Medicine*, *374*(17), 1661–1669. https://doi.org/10.1056/nejmra1501998
[2] Phillips, J. P. (2016). Workplace Violence against Health Care Workers in the United States. *New England Journal of Medicine*, *374*(17), 1661–1669. https://doi.org/10.1056/nejmra1501998
[3] Department of Labor logo UNITED STATESDEPARTMENT OF LABOR. Workplace Violence - Enforcement | Occupational Safety and Health Administration. (n.d.). https://www.osha.gov/workplace-violence/enforcement.
[4] Department of Labor logo UNITED STATESDEPARTMENT OF LABOR. Workplace Violence - Enforcement | Occupational Safety and Health Administration. (n.d.). https://www.osha.gov/workplace-violence/enforcement.
[5] Courtney, J. (2019, November 21). Actions - H.R.1309 - 116th Congress (2019-2020): Workplace Violence Prevention for Health Care and Social Service Workers Act. Congress.gov. https://www.congress.gov/bill/116th-congress/house-bill/1309/all-actions?overview=closed#tabs.
[6] Courtney, J. (2021, April 19). Actions - H.R.1195 - 117th Congress (2021-2022): Workplace Violence Prevention for Health Care and Social Service Workers Act. Congress.gov. https://www.congress.gov/bill/117th-congress/house-bill/1195/all-actions?overview=closed#tabs.

Background

This resolution directs the College to promote and endorse that emergency departments become "Firearm Free" Zones, with the exception of active-duty law enforcement officers, hospital security, military policy and federal agents, and that ACEP endorse and promote screening for firearms in the emergency department as well as promote public education and academic research to decrease workplace violence by decreasing firearm morbidity and mortality.

The federal government and numerous states have enacted laws creating gun-free zones that prohibit the possession of firearms at specific locations. The federal Gun-Free School Zone Act places prohibitions on possessing a firearm within 1,000 feet of a school, and many states have passed laws to further strengthen gun possession restrictions near schools. According to a 2020 report by the RAND Corporation's "Gun Policy in America" project, 39 states have also banned firearms in state court buildings, while a few states also banned guns, under certain circumstances, in bars and restaurants. A few states have banned firearms in hospitals. Mandated gun-free zones are often accompanied by implementation of screening measures such as metal detectors and bag checks.

Proponents of gun-free zones argue that the prohibition reduces accidental and intentional gun violence in these areas by reducing the number of firearms present, while opponents contend that the zones could result in making those areas more vulnerable targets for violent criminals.

Research on the effectiveness of gun-free zones in reducing gun violence is mixed. The Crime Prevention Research Center, an organization that says it is "a research and education organization dedicated to conducting academic quality research on the relationship between laws regulating the ownership or use of guns, crime, and public safety" claims that 94% of mass public shootings from 1950 to June 2019 occurred in gun-free zones. But other research has reached a very different conclusion, including an analysis by the organization called "Everytown for Gun Safety" which claims that only 14 percent of mass shootings took place in gun-free zones. The RAND Gun Policy in America research indicates it has "found no qualifying studies that gun-free zones" increased or decreased "any of the eight outcomes we investigated." The eight outcomes included mass shootings, violent crime, and unintentional injuries and death.

ACEP has taken an active role in trying to address the problem of violence in the emergency department. A 2018 ACEP survey of more than 3,500 emergency physicians showed that nearly half had been physically assaulted at work, with the majority of those assaults occurring within the previous year. 49% of respondents also said that hospitals can do more by adding security guards, cameras, metal detectors and increasing visitor screening.

That year also saw the introduction of federal legislation, the Workplace Violence Prevention for Health Care and Social Service Workers. ACEP worked with lawmakers to ensure the legislation gives appropriate consideration to emergency department needs. The legislation, which would require OSHA to require health care employers to implement violence prevention programs, was passed in the House in 2019, but failed to come up for a vote in the Senate. It was reintroduced in February of this year. ACEP joined with the Emergency Nurses Association (ENA) to issue a joint press release in support of the reintroduced legislation.

This year, ACEP provided input on The Joint Commission's "Workplace Violence Prevention" project and, as a result of that work, TJC announced in June new requirements for accredited hospitals to ensure safer work environments. The new and revised requirements that are scheduled to go 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.

In 2019, ACEP partnered with ENA 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 has additional resources and policies specifically addressing violence in the emergency department. The policy statement "Protection from Violence in the Emergency Department" calls workplace violence "a preventable and significant public health problem" and calls for increased safety measures in all emergency departments. It outlines nine measure hospitals should take to ensure the safety and security of the ED environment. Violence in the ED is one of the 13 topic areas that link from the ACEP website, and the link leads to a page with a wealth of resources entitled "Violence in the Emergency Department: Resources for a Safer Workplace." The site includes links to information papers on the "Risk Assessment and Tools for Identifying Patients at High Risk for Violence and Self-Harm in the ED and "Emergency Department Violence: An Overview and Compilation of Resources."

ACEP policy also addresses the issue of gun violence. The policy statement "Firearm Safety and Injury Prevention" calls for "funding, research, and protocols" to address the public health issue of injury and death from firearms. The policy lists six legislative and regulatory actions that ACEP supports, including funding for firearm injury prevention research, protecting physicians' ability to discuss firearm safety with patients, universal background checks, prohibiting high-risk and prohibited individuals from obtaining firearms, restricting the sale and ownership of weapons and munitions designed for military or law enforcement use, and prohibiting 3-D printing of firearms and their components. The policy statement "Violence-Free Society" also notes that "ACEP believes emergency physicians have a public health responsibility to reduce the prevalence and impact of violence through advocacy, education, legislation, and research initiatives."

In 2018, the Public Health and Injury Prevention Committee developed the information paper "Resources for Emergency Physicians: Reducing Firearm Violence and Improving Firearm Injury Prevention" that provides information on prevention of firearm injuries, including relevant emergency medicine firearm violence and injury prevention programs, prevention practice recommendations, firearm suicide prevention programs, and listings of community-based firearm violence prevention programs by state.

In March 2018, ACEP provided a letter of support for the mission and vision of the American Foundation for Firearm Injury Reduction in Medicine (AFFIRM.) The letter outlined ACEPs support of AFFIRM's efforts to fund medical and public health research of firearm-related violence, injury, and death and development of evidence-based, best practice recommendations for health care providers to prevent and reduce the incidence and health consequences of

firearm-related violence. In January 2019, the Board of Directors approved a $20,000 donation to AFFIRM.

ACEP's legislative and regulatory priorities include working with members of Congress to promote efforts that may prevent firearm-related injuries/deaths and to support public/private initiatives to fund firearm research. The Emergency Medicine Foundation (EMF) has partnered with AFFIRM on several research grants. ACEP members are represented as leaders in AFFRIM, have attended strategic planning meetings, and an ACEP staff member is also a member of their Research Council.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective A – Promote/advocate for efficient, sustainable, and fulfilling clinical practice environments.
- Objective D – Promote quality and patient safety, including continued development and refinement of quality measures and resources.
- Objective F – Develop and implement solutions for workforce issues that promote and sustain quality and patient safety.

Goal 2 – Enhance Membership Value and Member Engagement

- Objective A – Improve the practice environment and member well-being.

Fiscal Impact

Budgeted staff resources to promote and endorse the concept of EDs becoming firearm-free zones. Promoting public education to decrease workplace violence could involve an unbudgeted and undetermined cost, depending on the scope of the promotion/public relations activity involved.

Prior Council Action

The Council has adopted numerous resolutions related to firearms and firearm safety, but none that are specific to EDs becoming "firearm-free zones."

Resolution 19(19) Support of the American Foundation for Firearm Injury Reduction in Medicine (AFFIRM) adopted. Directed ACEP to support a public health approach to firearms-related violence and the prevention of firearm injuries and deaths and to support the mission and vision of AFFIRM to advocate for the allocation of federal and private research dollars to further this agenda.

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 Program adopted. Directed ACEP to promote awareness of hospital-based violence intervention programs and coordinate with relevant shareholders to provide resources to those wishing to establish such programs.

Prior Board Action

Resolution 19(19) Support of the American Foundation for Firearm Injury Reduction in Medicine (AFFIRM) adopted.

October 2019, approved the revised policy statement "Firearm Safety and Injury Prevention;" approved April 2013 with current title, replacing rescinded policy statement titled "Firearm Injury Prevention;" revised and approved October 2012, January 2011; reaffirmed October 2007; originally approved February 2001 replacing 10 separate policy statements on firearms.

April 2019, approved the revised policy statement "Violence-Free Society;" reaffirmed June 2013; revised and approved January 2007; reaffirmed October 2000; originally approved January 1996.

January 2019, approved $20,000 contribution to the American Federation for Firearm Injury Reduction in Medicine (AFFIRM).

June 2018, reviewed the information paper "Resources for Emergency Physicians: Reducing Firearm Violence and Improving Firearm Injury Prevention."

October 2017, Resolution 55(17) Workplace Violence adopted.

May 2016, reviewed the information paper "Emergency Department Violence: An Overview and Compilation of Resources."

April 2016, approved the revised policy statement "Protection from Violence in the Emergency Department;" 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.

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 Program adopted.

Background Information Prepared by: Craig Price, CAE
Senior Director, Practice Affairs

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 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(21)

SUBMITTED BY: California Chapter
DC Chapter
Maryland Chapter
Massachusetts College of Emergency Physicians
New York Chapter
North Carolina College of Emergency Physicians
Vermont Chapter

SUBJECT: Formation of a National Bureau for Firearm Injury Prevention

PURPOSE: Support the creation of a National Bureau for Firearm Injury Prevention that would lead and coordinate a long-term, multidisciplinary campaign to reduce firearm injury and deaths based on proven public health research and practices.

FISCAL IMPACT: Budgeted staff resources.

WHEREAS, The physician motto is to do no harm; and

WHEREAS, Physicians are often placed on the front lines of health crises; and

WHEREAS, Doctors can be encouraged to address firearm injury and death with the same tools used successfully to confront other public health concerns for decades[5,6]; and

WHEREAS, The National Highway Traffic Safety Administration (NHTSA) addressed the problem of motor vehicle death by systematically using a public health approach, promoting and implementing safety technology, supporting research into causes and contributing factors and fostering public awareness of seat belt use[3]; and

WHEREAS, NHTSA coordinated its activities to complement each other, acting synergistically to reduce injuries resulting in a motor vehicle death rate which has fallen by two-thirds[1]; and

WHEREAS, The life-saving potential of seatbelts was realized due to the synergistic use of both legislation that added laws and financial penalties for disobedience, as well as the use of media to increase public awareness of the importance of seat belt wearing; and

WHEREAS, In spite of persistent efforts to reduce firearm injury and death over the past twenty years,[9] deaths from firearm injuries have increased by over 20%[2]; and

WHEREAS, It is necessary to define firearm injury and death as public health crises and use public health methods for reduction that have been proven effective[7]; and

WHEREAS, Health professionals have actively participated in efforts to reduce firearm injury by speaking out against "gag laws,"[6,4] restrictions on firearm injury research funding[5,9]; and

WHEREAS, There have been comprehensive, multidimensional strategies created, that provide an extensive list of proposals designed to reduce firearm injury and death[6,7]; and

WHEREAS, A "call to action" from eight health organizations and the American Bar Association advocating for a series of measures aimed at reducing the health and public health consequences of firearms[4]; and

WHEREAS, Significant reductions in firearm injury can be achieved with the coordinated use of the modalities as was used to increase seatbelt use; and

WHEREAS, The synergistic coordination of multiple modalities is best accomplished through a single entity such as the NHTSA[7]; and

WHEREAS, To be maximally effective at decreasing firearm injury and deaths in the U.S., a National Bureau for Firearm Injury Prevention must be created; and

WHEREAS, A National Bureau for Firearm Injury Prevention would be run by experts in public health, medicine, engineering, communications and law enforcement working together in a transparent and nonpartisan organization charged with: 1) Setting the nation's firearm injury research agenda and developing, testing and implementing firearm safety technologies; 2) Overseeing campaigns to encourage behaviors likely to reduce firearm injuries; 3) Setting out legislative priorities for saving lives due to firearm injury; 4) Directing priorities for enforcing firearm laws in concert with the Bureau of Alcohol, Tobacco, Firearms and Explosives and state law enforcement agencies; and

WHEREAS, The creation of a National Bureau for Firearm Injury Prevention has been adopted as a cornerstone of Doctors For America's policy on firearm injury prevention and a similar position is being considered by multiple professional health groups and grassroots organizations dedicated to firearm injury prevention; therefore be it

RESOLVED, That ACEP support the creation of a National Bureau for Firearm Injury Prevention that would lead and coordinate a long-term, multidisciplinary campaign to reduce firearm injury and deaths based on proven public health research and practices.

References

1. Centers for Disease Control and Prevention (CDC). Achievements in Public Health, 1900-1999 Motor-Vehicle Safety: A 20th Century Public Health Achievement. MMWR May 14, 1999 / 48(18);369-374.
2. CDC National Center for Health Statistics. https://www.cdc.gov/nchs/fastats/injury.htm
3. National Highway Traffic Safety Administration (NHTSA). Seat Belts. https://www.nhtsa.gov/risky-driving/seat-belts
4. Weinberger SE, Hoyt DB, Lawrence HC 3rd, Levin S, Henley DE, Alden ER, Wilkerson D, Benjamin GC, Hubbard WC. Ann Intern Med. Firearm-related injury and death in the United States: a call to action from 8 health professional organizations and the American Bar Association. 2015 Apr 7;16
5. Bauchner H, Rivara FP, Bonow RO et al. Death by Gun Violence—A Public Health Crisis . JAMA Psychiatry. 2017;74(12):1195-1196. doi:10.1001/jamapsychiatry.2017.3616
6. McLean RM, Harris P, Cullen, J, Maier RV et al. Firearm-Related Injury and Death in the United States: A Call to Action From the Nation's Leading Physician and Public Health Professional Organizations Ann Intern Med. 2019; 171:573-579
7. Hemenway, David. "A public health approach to firearms policy" in Mechanic, David; Rogut, Lynn B; Colby, David C; Knickman, James R. eds. *Policy Challenges in Modern Health Care*. New Brunswick, NJ: Rutgers University Press, 2005. pp. 85-98.
8. Hemenway, David; Miller, Matthew. Public health approach to the prevention of gun violence. *New England Journal of Medicine.* 2013; 368:2033-35.
9. Bailey C. More Americans killed by guns since 1968 than in all U.S. wars-combined. NBC News. https://www.nbcnews.com/storyline/las-vegas-shooting/more-americans-killed-guns-1968-all-u-s-wars-combined-n807156. October 4, 2017. Accessed October 5, 2017.

Background

This resolution calls for the College to support the creation of a National Bureau for Firearm Injury Prevention that would lead and coordinate a long-term, multidisciplinary campaign to reduce firearm injury and deaths based on proven public health research and practices.

As the resolution notes, this new body would be run by experts in public health, medicine, engineering,

communications, and law enforcement working together in a transparent and nonpartisan organization charged with:

1) Setting the nation's firearm injury research agenda and developing, testing, and implementing firearm safety technologies;
2) Overseeing campaigns to encourage behaviors likely to reduce firearm injuries;
3) Setting out legislative priorities for saving lives due to firearm injury; and,
4) Directing priorities for enforcing firearm laws in concert with the Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF) and state law enforcement agencies.

The resolution further notes that the creation of a National Bureau of Firearm Injury Prevention is a policy proposal endorsed by Doctors for America (DFA), a coalition of 18,000 physicians and medical students across the country. In addition to firearms violence prevention, DFA's other policy priorities include drug affordability, addressing substance use disorder (SUD), health for all, immigrant health justice, and women's health. According to DFA's website, American Foundation for Firearm Injury Reduction in Medicine (AFFIRM) is listed as a supporting organization for the bureau concept.

ACEP's legislative and regulatory priorities over the years have included working with members of Congress to promote efforts that may prevent firearm-related injuries/deaths and to support public/private initiatives to fund firearm research. ACEP has worked with the AMA and other stakeholders to address firearm injury prevention and research on this issue. To this end, ACEP worked successfully with other physician specialties, health care providers, and other stakeholders to restore federal funding for firearm morbidity and mortality prevention research, with $25 million split between the National Institutes of Health (NIH) and Centers for Disease Control and Prevention (CDC) in December 2019, after a more than 20-year hiatus of federal appropriations for this purpose. ACEP continues to advocate for increased funding for the NIH and CDC to continue and expand this research and joined a March 2021 letter with more than 200 signatories urging Congress to provide $50 million for firearms injury prevention research. ACEP has also met with the National Collaborative on Gun Violence Research (NCGVR), a research collaborative with the mission to fund and disseminate nonpartisan scientific research to provide necessary data to establish fair and effective policies, in a discussion to share ACEP's policy priorities regarding firearms injury prevention.

The College has addressed the issue of firearms multiple times over the years through Council resolutions and policy statements. A compilation of resources for physicians impacted by active shooter mass casualty incidents is available on the ACEP website.

In June 2019, the Board of Directors approved a survey of the ACEP Council on firearms research, safety, and policy. The preliminary report was presented to the Board in October 2019 and at the 2019 Council meeting.

ACEP conducted an all member survey in the fall of 2018. Three of the survey questions were about firearms. The following questions were asked:

- Do you support ACEP's policies on firearms safety and injury prevention (increased access to mental health services, expanded background checks, adequate support and training for the disaster response system, increased funding for research, and restrictions on the sale and ownership of weapons, munitions, and large-capacity magazines designed for military or law enforcement use)?
- Do you support limiting firearms purchases to individuals 21 years or older?
- When mass shootings occur, should ACEP issue public statements advocating for change consistent with the College's policies (referred to above)?

The survey was sent to 32,400 members including medical students and residents with 3,465 responses. Sixty-nine percent of the respondents support the current ACEP policy statement in its entirety with 21.3 % in support of part of the policy. Limiting firearm purchases to individuals 21 years or older was supported by 68.7% of the respondents and not supported by 25.3%. Almost 6% did not know if they supported the age limit or not. When asked about issuing public statements following a mass shooting event advocating for change consistent with the College's policies, 62.5% were in support of making public statements while 28.1% did not support such action.

ACEP' s current policy statement "Firearm Safety and Injury Prevention" was developed by a task force that was appointed in 2013. ACEP policies are reviewed on a 5- to 7-year cycle as part of the policy sunset review process. Committees and section are assigned specific policies for review and recommendations are then made to the Board to reaffirm, revise, rescind, or sunset the policy statement. The policy statement was assigned to the Public Health & Injury Prevention Committee (PHIPC) for review during the 2018-19 committee year. Subsequently, a resolution was submitted to the 2018 Council that called for the revision of the policy, requesting an emphasis on the importance of research in firearm injury and on the relationship of firearm use in suicide attempts; and included additional language restricting the sale of after-market modifications to firearms that increase the lethality of otherwise legal weapons. The Council adopted a substitute resolution that directed the policy statement be revised to reflect the current state of research and legislation. The resolution was assigned to the PHIPC. The committee drafted a revised policy statement that reflected many of the revisions as recommended in the original resolution submitted to the 2018 Council. The Board discussed the revised policy statement in June 2019 and referred it back to the committee for further work. It was revised and approved in October 2019.

The Public Health & Injury Prevention Committee developed an information paper, "Resources for Emergency Physicians: Reducing Firearm Violence and Improving Firearm Injury Prevention" on prevention of firearm injuries including relevant emergency medicine firearm violence and injury prevention programs, prevention practice recommendations, firearm suicide prevention programs as well as listings of community-based firearm violence prevention programs by state. ACEP also partnered with the American Medical Association and the American College of Surgeons to work on issues of common concern to address gun violence through public health research and evidence-based practice.

In March 2018, ACEP provided a letter of support for the mission and vision of the AFFIRM. The letter outlined ACEPs support of AFFIRM's efforts to fund medical and public health research of firearm-related violence, injury, and death as well as development of evidence-based, best practice recommendations for health care providers to prevent and reduce the incidence and health consequences of firearm-related violence. In January 2019, the Board of Directors approved a $20,000 donation to AFFIRM. The Emergency Medicine Foundation (EMF) has partnered with AFFIRM on several research grants.

The Research Committee was assigned an objective in 2014-15 to "Convene a Technical Advisory Group (TAG) of firearm researchers and other stakeholders to develop a research agenda and to consider the use of available research networks (including ACEP's EM-PRN) to perform firearm research." TAG members determined the research agenda would be based on questions relating to suicides, unintentional injuries, mass violence, and peer violence. An article titled "A Consensus-Driven Agenda for Emergency Medicine Firearm Injury Prevention Research" was published in *Annals of Emergency Medicine* in February 2017 outlining this work.

During the 2013-14 committee year, the Research Committee was assigned an objective to make a recommendation to the Board regarding Referred Resolution 19(13) Developing a Research Network to Study Firearm Violence in EDs. In June 2014, the Board approved the following recommendations: 1) ACEP and EMF staff convene a consensus conference of firearm researchers and other stakeholders to develop a research agenda and to consider the use of available research networks (including the proposed EM-PRN) to perform firearm research; 2) ACEP and EMF staff to identify grant opportunities and promote them to emergency medicine researchers; 3) EMF to consider seeking funding for a research grant specifically supporting multi-center firearm research; and 4) ACEP to advance the development of the EM-PRN to create a resource for representative ED-based research on this topic and others.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum, including rural areas.
- Objective D – Promote quality and patient safety, including continued development and refinement of quality measures and resources.

Fiscal Impact

Budgeted staff resources.

Prior Council Action

The Council has adopted numerous resolutions pertaining to firearms and firearm safety, but none that are specific to supporting the creation of a National Bureau for Firearm Injury Prevention.

Amended Resolution 36(19) Research Funding and Legislation to Address Both Firearm Violence and Intimate Partner Violence adopted. Directed ACEP to work with stakeholders to raise awareness and advocate for research funding and legislation to address both firearm violence and intimate partner violence.

Resolution 30(19) High Threat Emergency Casualty Care adopted. Directed ACEP to set as a legislative priority the drafting of and lobbying for legislative language that will enable the development and funding of both National Transportation Safety Board-style "Go Teams" and a database into which gathered information would be entered for research purposes; and, support the development processes of both a National Transportation Safety Board-style "Go Teams" and a database of gathered information for research purposes.

Resolution 19(19) Support of the American Foundation for Firearm Injury Reduction in Medicine (AFFIRM) adopted. Directed ACEP to support a public health approach to firearms-related violence and the prevention of firearm injuries and deaths as enumerated in the 2018 ACEP Position Paper; and that ACEP support the mission and vision of AFFIRM to advocate for the allocation of federal and private research dollars to further this agenda.

Amended Resolution 45(18) Support for Extreme Risk Protection Orders to Minimize Harm adopted. Directed ACEP to support Extreme Risk Protection Orders (ERPO) legislation at the federal level; promote and assist chapters to enact ERPOs by creating a toolkit and other appropriate resources; and encourage and support further research of the effectiveness and ramifications of ERPOs and Gun Violence Restraining Orders (GVROs).

Substitute Resolution 44(18) Firearm Safety and Injury Prevention Policy Statement adopted. Directed ACEP to revise the policy statement, "Firearm Safety and Injury Prevention" to reflect the current state of research and legislation.

Resolution 27(13) Studying Firearm Injuries adopted. Directed ACEP to advocate for funding for research on firearm injury prevention and to work with the AMA and other medical societies to achieve this common cause.

Resolution 19(13) Developing a Research Network to Study Firearm Violence in EDs referred to the Board of Directors. Called for a task force to develop a research network of EDs to study the impact of firearm violence and invite interested stakeholders to participate in the network.

Amended Resolution 31(12) Firearm Violence Prevention adopted. Condemned the recent massacres in Aurora, CO and WI and the daily violence throughout the U.S. and reaffirmed ACEP's commitment against gun violence including advocating for public and private funding to study the health effects of gun violence.

Amended Resolution 41(04) Assault Weapon Ban adopted. ACEP deplores the threat to public safety that is the result of widespread availability of assault weapons and high capacity ammunition devices and urges the Congress and the President to enact and sign into law a comprehensive ban on all sales of assault weapons and high capacity magazines.

Resolution 14(00) Childhood Firearm Injuries referred to the Board of Directors. Directed ACEP to support legislation that requires safety locks on all new guns sold in the USA and support legislation that holds the adult gun owner legally responsible if a child is accidentally injured with the gun.

Resolution 18(97) ACEP Collaboration with Other Medical Specialty Organizations on Firearms Issues adopted. Sought to collaborate with other medical specialty organizations on firearms issues.

Resolution 22(96) National Center for Injury Prevention and Control adopted. Directed ACEP to continue supporting funding for Injury Prevention and Control in the CDC in which firearms research was included.

Amended Resolution 69(95) Firearm Legislation adopted. Sought to limit access to Saturday night specials.

Amended Resolution 48(94) Increased Taxes on Handguns and Ammunition adopted. Advocated for increased taxes on handguns and ammunition with proceeds going to fund the care of victims and/or programs to prevent gun violence and to fund firearm safety education.

Resolution 47(94) Firearm Classification referred to the Board of Directors. Directed ACEP to support legislation classifying firearms into three categories: 1) prohibited; 2) licensed; and 3) unlicensed.

Amended Resolution 46(94) Photo Identification and Qualifications for Firearm Possession adopted. Directed ACEP to support legislation requiring photo identification and specific qualifications for firearm possession.

Substitute Resolution 45(94) Firearm Possession adopted. Supported legislation (as was passed in the crime bill) to make it illegal for persons under 21 and persons convicted of violent crimes, spousal and/or child abuse or subject to a protective order to possess firearms; illegal to transfer firearms to juveniles; and support legislation making it illegal to leave a loaded handgun where it is accessible to a juvenile.

Substitute Resolution 44(94) Firearm Legislation adopted. Support comprehensive legislation to limit federal firearms licenses.

Amended Resolution 43(94) Support of National Safety Regulations for Firearms adopted. Supported national safety regulations for firearms.

Amended Resolution 18(93) Firearm Injury Reporting System adopted. Explore collaboration with existing governmental entities to develop a mandatory firearm injury reporting system.

Amended Resolution 17(93) Firearm Injury Prevention adopted. Consider developing and/or promoting public education materials regarding ownership of firearms and the concurrent risk of injury and death.

Amended Resolution 16(93) Possession of Handguns by Minors adopted. Support federal legislation to prohibit the possession of handguns by minors.

Amended Resolution 11(93) Violence Free Society adopted. Develop a policy statement supporting the concept of a violence free society and increase efforts to educate member about the preventable nature of violence and the important role physicians can play in violence prevention.

Resolution 15(90) Gun Control not adopted. Sought for ACEP to undertake a complete review of all medical, legal, technical, forensic, and other pertinent literature regarding firearm-related violence with emphasis on the effects of firearm availability to the incidence of such violence, and that ACEP withhold public comment on gun control until such study is completed and an informed, unemotional, and unpolarized position on weapons can be formulated.

Amended Resolution 14(89) Ban on Assault Weapons adopted. Support federal and state legislation to regulate as fully automatic weapons are regulated, the sale, possession, or transfer of semi-automatic assault weapons to private citizens and support legislation mandating jail sentences for individuals convicted of the use of a semi-automatic assault weapon in the commission of a crime.

Amended Resolution 13(89) Waiting Period to Purchase Firearms adopted. Support federal and state legislation to require 15-day waiting period for the sale, purchase, or transfer of any firearm to allow time for a background check on the individual and also support legislation mandating significant penalties for possession of a firearm while committing a crime.

Substitute Resolution 16(84) Ban on Handguns adopted. Deplored the loss of life and limb secondary to the improper use of handguns; supported legislation mandating significant penalties for possession of a handgun while committing a crime; support legislation mandating significant penalties for the illegal sale of handguns; support a waiting period for all prospective handgun buyers; supported successful completion of an education program on handgun safe for all prospective handgun buyers; support development of educational programs on the proper use of handguns for existing owners; support requiring screening of prospective handgun buyers for previous criminal records and mental health problems that have led to violent behavior.

Resolution 15(83) Handgun Legislation not adopted. Urged legislative bodies to enact legislation restricting the availability of handguns to the general public and to monitor the results.

Prior Board Action

Amended Resolution 36(19) Research Funding and Legislation to Address Both Firearm Violence and Intimate Partner Violence adopted.

Resolution 30(19) High Threat Emergency Casualty Care adopted.

Resolution 19(19) Support of the American Foundation for Firearm Injury Reduction in Medicine (AFFIRM) adopted.

October 2019, approved the revised policy statement "Firearm Safety and Injury Prevention;" approved April 2013 with current title, replacing rescinded policy statement titled "Firearm Injury Prevention;" revised and approved October 2012, January 2011; reaffirmed October 2007; originally approved February 2001 replacing 10 separate policy statements on firearms.

June 2019, approved sending a survey on firearms research, safety, and policy to the ACEP Council.

April 2019, approved the revised policy statement "Domestic Family Violence;" reaffirmed June 2013; originally approved October 2007 replacing seven rescinded policy statements.

April 2019, approved the revised policy statement "Violence-Free Society;" reaffirmed June 2013, revised and approved January 2007; reaffirmed October 200; originally approved January 1996.

January 2019, approved $20,000 contribution to the American Federation for Firearm Injury Reduction in Medicine (AFFIRM).

Amended Resolution 45(18) Support for Extreme Risk Protection Orders to Minimize Harm adopted.

Substitute Resolution 44(18) Firearm Safety and Injury Prevention Policy Statement adopted.

June 2018, reviewed "Resources for Emergency Physicians: Reducing Firearm Violence and Improving Firearm Injury Prevention"

June 2014, approved the Research Committee's recommendations to convene a consensus conference of firearm researchers and other stakeholders to: 1) develop a research agenda and to consider the use of available research networks (including the proposed EM-PRN) to perform firearm research; 2) identify grant opportunities and promote them to emergency medicine researchers; 3) recommend EMF consider seeking funding for a research grant specifically supporting multi-center firearm research; and 4) advance the development of the EM-PRN so as to create a resource for representative ED-based research on this topic and others.

Resolution 27(13) Studying Firearm Injuries adopted.

December 2013, assigned Referred Resolution 19(13) Developing a Research Network to Study Firearm Violence in EDs to the Research Committee to provide a recommendation to the Board of Directors regarding further action on

the resolution.

Amended Resolution 31(12) Firearm Violence Prevention adopted.

Amended Resolution 41(04) Assault Weapon Ban adopted.

Resolution 18(97) ACEP Collaboration with Other Medical Specialty Organizations on Firearms Issues adopted.

Resolution 22(96) National Center for Injury Prevention and Control adopted.

Amended Resolution 69(95) Firearm Legislation adopted.

Amended Resolution 48(94) Increased Taxes on Handguns and Ammunition adopted.

Resolution 47(94) Firearm Classification referred to the Board of Directors.

Amended Resolution 46(94) Photo Identification and Qualifications for Firearm Possession adopted.

Substitute Resolution 45(94) Firearm Possession adopted.

Substitute Resolution 44(94) Firearm Legislation adopted.

Amended Resolution 43(94) Support of National Safety Regulations for Firearms adopted.

Amended Resolution 18(93) Firearm Injury Reporting System adopted.

Amended Resolution 17(93) Firearm Injury Prevention adopted.

Amended Resolution 16(93) Possession of Handguns by Minors adopted.

Amended Resolution 11(93) Violence Free Society adopted.

Amended Resolution 14(89) Ban on Assault Weapons adopted.

Amended Resolution 13(89) Waiting Period to Purchase Firearms adopted.

Substitute Resolution 16(84) Ban on Handguns adopted.

Background Information Prepared by: Ryan McBride, MPP
Senior Congressional Lobbyist

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 34(21)

SUBMITTED BY: Ohio Chapter ACEP
Pennsylvania College of Emergency Physicians

SUBJECT: Global Budgeting for Emergency Physician Reimbursement in Rural and Underserved Areas

PURPOSE: 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.

FISCAL IMPACT: Budgeted staff resources.

WHEREAS, The ACEP Rural Emergency Care Task Force (2020) outlined challenges, including reimbursement, for the staffing of rural emergency departments (EDs) by board eligible/certified emergency physicians; and

WHEREAS, More rural EDs are closing than opening; and

WHEREAS, Innovation models focused on global budgeting for facility reimbursements to maintain quality and financial viability of rural hospitals currently exist, including the Center for Medicare and Medicaid Services' (CMS's) Pennsylvania Rural Health Model and global budgeting in Maryland and other states; and

WHEREAS, Current innovation models for global budgeting are focused on facility reimbursements and not on professional physician fee reimbursement, with emergency physician reimbursement still largely dependent on patient volumes or subsidies; and

WHEREAS, The ACEP EM Physician Workforce of the Future Report (2021) estimates a looming surplus of emergency physicians, thus creating an opportunity to fill the demand for services of emergency physicians in rural and underserved areas where there is currently a dearth of emergency physicians; therefore be it

RESOLVED, That ACEP engage appropriate stakeholders, including at the federal and state levels, to find innovative staffing, payment, and reimbursement models, including but not limited to potential global budgeting for emergency physician professional services that incentivize and maintain financial viability of the coverage of emergency departments in rural and underserved areas by board eligible/certified emergency physicians.

Resources

1. https://www.healthaffairs.org/do/10.1377/hblog20210610.559255/full/
2. https://innovation.cms.gov/innovation-models/pa-rural-health-model
3. https://www.acep.org/who-we-are/ACEPLately/acep-lately-blog-articles/may-2021/
4. https://www.acep.org/contentassets/c3cef041efd54af48b71946c0cb658f0/final---board-report---2020-rural-emergency-care-task-force-oct-2020---provider-002.mcw-final-edits-002.pdf
5. https://www.acep.org/life-as-a-physician/workforce/
6. Ann Emerg Med. 2020;75(3):370-381
7. Ann Emerg Med. 2021 Apr 27;S0196-0644(21)00333-4

Background

The resolution calls for ACEP to engage appropriate stakeholders, including at the federal and state levels, to find

innovative staffing, payment, and reimbursement models, including but not limited to potential global budgeting for emergency physician professional services that incentivize and maintain financial viability of the coverage of emergency departments in rural and underserved areas by board eligible/certified emergency physicians.

According to a 2020 report by the U.S. Government Accountability Office (GAO), more than 100 rural hospitals have closed since 2013. The report found that among the rural hospitals that closed, they appeared financially distressed in the years prior and had operated under negative total facility margins. The report also found that rural hospital margins have declined over the last several years, and that the percentage of hospitals considered mid-risk or high-risk of financial distress have increased over the past five years. Additionally, there are signs that the impact of the COVID-19 pandemic has only exacerbated these challenges and that more rural hospital closures are on the horizon. As rural facilities continue to face significant uncertainty under traditional fee-for-service reimbursement models, new proposals have been put forward to maintain access to care in rural and underserved communities, such as a "Rural Emergency Hospital" designation or global budgeting models.

Broadly, a global budgeting model guarantees a fixed annual revenue (set in advance) based on an estimate of all inpatient and outpatient items and services. This model is intended to provide a level of predictability regardless of actual numbers of visits, as well as to help limit cost growth and incentivize efficient use of resources. As the resolution notes, at least two states have implemented global budgeting models for rural hospitals.

The Maryland All-Payer Model was a unique all-payer rate-setting system made possible by the state's longstanding Medicare waiver exempting it from both the Inpatient Prospective Payment System (IPPS) and the Outpatient Prospective Payment System (OPPS), affording the state with the ability to set its own rates for these services. All third-party payers paid the same rate as well. Maryland was required to limit all-payer per capita hospital cost growth (including both inpatient and outpatient care) to 3.58 percent, and additionally, the state agreed to limit Medicare growth to a rate lower than the national annual per capita growth rate for 2015-2018. While the model was successful in achieving significant savings and reaching its quality measure targets, the state's ability to sustain the necessary rate of Medicare savings and quality improvements was limited by the model's focus on the hospital setting. As such, CMS worked with Maryland to implement and test a new model, the Maryland Total Cost of Care Model (TCOC), that instead sets a per capita limit on Medicare total cost of care between 2019 and 2023, ultimately concluding in 2026. This model is targeted to achieve more than $1 billion in Medicare savings by the end of the model. Under the terms of the model, the last three model years will be used to determine whether to expand the model test, develop a new model test, or return to the national prospective payment systems.

In Pennsylvania, 18 rural hospitals currently participate in the Pennsylvania Rural Health Model, another program under the Centers for Medicare & Medicaid Services (CMS) Center for Medicare & Medicaid Innovation (CMMI). Critical access hospitals (CAHs) and acute care hospitals in rural areas are eligible to participate in the model. Under this model, both CMS (Medicare and Medicaid) and participating commercial payers pay participating rural hospitals under a global budget that is prospectively set for each participating rural hospital, determined primarily by their historical net revenue for both inpatient and outpatient services from all participating payers. Participating payers then pay the hospitals for those services based on the payer's respective portion of the global budget. The hospitals are also required to redesign care delivery, improve quality, and better meet the needs of their communities. The state and CMS must approve a participating hospital's Rural Hospital Transformation Plan to help ensure that these facilities make meaningful and targeted improvements in quality for their communities.

Another effort to increase access to emergency services in rural areas is the implementation of a new provider designation under Medicare called "Rural Emergency Hospital" (REH). This provision was included in the Consolidated Appropriations Act, 2021 (Public Law 116-260) passed by Congress in late December 2020 and would allow critical access hospitals and small rural hospitals (with fewer than 50 beds) to convert to an REH beginning January 1, 2023. Once established, an REH will not provide any inpatient services, but must be able to provide 24/7 coverage for emergency services. They must also meet other requirements, including, but not limited to, having transfer agreements in place with a level I or II trauma center; adhering to quality measurement reporting requirements to be set by CMS; and following new emergency department conditions of participation (COPs). REHs will receive a five percent reimbursement bump for facility payments that hospitals traditionally receive for outpatient services under the Medicare OPPS and will receive an additional facility payment on top of that. However, while this new provider designation provides higher facility payments for REHs, emergency physicians will not receive higher

payments under the Medicare Physician Fee Schedule (PFS) for providing services in an REH. CMS is currently in the process of writing the regulations and processing comments on the new designation that will be included in the CY20223 OPPS rule.

As the resolution notes, global budgeting models have focused on the hospital/facility side of reimbursement, not on professional physician fee reimbursement that is still largely dependent on patient volumes or subsidies. This is also the case with hospitals under the new REH designation. The resolution suggests that the predictability afforded by a global budgeting model specifically for professional physician fee reimbursement could address this gap, decoupling emergency care from more traditional volume-dependent payment, helping incentivize and maintaining financial viability of coverage of emergency departments in rural and underserved areas by board eligible/certified emergency physicians. Some in favor of this approach propose that in such a system, emergency physicians would be paid at a market-determined fixed rate, whether employed directly by a hospital under a global physician budget or employed by a practice management organization that contracts directly with the facility. Proponents of this model suggest that this would help eliminate the challenges of balancing high vs. low reimbursed visits relative to the resources expended, would help guarantee 24/7/365 coverage of rural EDs, and would also help provide a financial cushion to provide for surge capacity.

Some of the key considerations noted by proponents and observers alike are the need for a well-defined catchment area or the ability to identify an appropriate reference population needed to determine a global budget, as well as if the service area can provide a sufficient number of patients to sustain the model. Some have also noted that given the growth of new value-based payment pathways, rural hospitals may be able to adopt other payment mechanisms (e.g., managed care programs, accountable care organizations, etc.) that are easier to implement while achieving the same ultimate results in care delivery transformation. Another potential challenge may be the willingness for payers to participate in an all-payer global budgeting model and other issues posed by longstanding conflict between hospitals/systems and payers.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum, including rural areas.
- Objective E – Pursue strategies for fair payment and practice sustainability to ensure patient access to care.
- Objective F – Develop and implement solutions for workforce issues that promote and sustain quality and patient safety.

Fiscal Impact

Budgeted staff resources.

Prior Council Action

Resolution 40(19) Advancing Quality Care in Rural Emergency Medicine referred to the Board of Directors. The resolution called for ACEP to work with stakeholder groups to promote emergency medicine delivery models that increase quality and reduce costs in rural settings; identify and promote existing training opportunities to help physicians and non-physicians in rural settings maintain their clinical skills; develop a paper that identifies best practices and funding mechanisms to promote development of emergency medicine electives within emergency medicine residency programs; and encourage research in rural emergency medicine by identifying funding sources to support research and cost savings in rural emergency medicine.

Resolution 62(17) Freestanding Emergency Centers (FECs) as a Care Model for Maintaining Access to Emergency Care in Underserved, Rural, and Federally Declared Disaster Areas of the United States referred to the Board of Directors. The resolution called in part for ACEP to advocate for the creation of a Critical Access Emergency Center Designation where critical access hospitals no longer exist due to natural disasters or cannot be feasibly maintained.

Amended Resolution 16(16) Freestanding Emergency Centers as a Care Model for Maintaining Access to Emergency Care in Underserved and Rural Areas of the U.S. adopted. The resolution called for ACEP to analyze the use of Freestanding Emergency Centers as an alternative care model to maintain access to emergency care in areas where emergency departments in critical access and rural hospitals have closed.

Substitute Resolution 19(08) Second Rural Workforce Task Force referred to the Board of Directors. The resolution called for the appointment of a second rural task force empowered to convene a second Rural Emergency Medicine Summit and develop recommendations for the ACEP Board.

Amended Resolution 37(05) Rural Emergency Medicine Workforce adopted. Directed ACEP to advocate for inclusion of emergency medicine in the National Health Service Corps scholarship program, explore and advocate for various incentives for emergency medicine residency trained physicians to practice in rural or underserved areas, explore funding sources for a new workforce study, and work with other emergency medicine organizations to encourage the development and promotion of rural clerkships/ rotations at medical schools and residency programs.

Substitute Resolution 20(01) Medical Education Debt adopted. The resolution directed ACEP to lobby appropriate state and federal agencies for inclusion of emergency physicians in medical education debt repayment programs, including but not limited to state programs, the National Public Health Service, rural and underserved regional grant programs, and other grants/ scholarship programs.

Amended Substitute Resolution 21(01) Rural Emergency Medicine Departments adopted. Directed ACEP to investigate the root causes related to the difficulty of securing board-certified emergency physician staffing for medically underserved and rural areas; the causes studies should include, but not be limited to, educational, financial, and resident candidate selection factors, and be it further resolved that ACEP investigate methods to improve educational opportunities in rural and underserved environments.

Prior Board Action

January 2021, approved the legislative and regulatory priorities for the First Session of the 117th Congress that include several initiatives related to rural emergency care.

October 2020, filed the report of the Rural Emergency Care Task Force. ACEP's Strategic Plan was updated to include tactics to address recommendations in the report.

January 2020, assigned Referred Resolution 40(19) Advancing Quality Care in Rural Emergency Medicine to the Rural Emergency Task Force to review and provide recommendations to the Board to address rural emergency medicine issues.

August 2018, ACEP supported the Emergency Care Improvement Act that allows for independent freestanding EDs that meet criteria to bill Medicare for a certain amount of facility-side reimbursement, depending on geography and acuity. The legislation contained specific language to protect professional-side reimbursement by Medicare at full physician fee schedule amounts at all acuity levels and to bring the facilities under federal EMTALA requirements.

June 2018, approved the revised policy statement "Resident Training for Practice in Non-Urban Underserved Areas;" reaffirmed April 2012 and October 2006; originally approved June 2000.

January 2018, assigned Referred Resolution 62(17) Freestanding Emergency Centers (FECs) as a Care Model for Maintaining Access to Emergency Care in Underserved, Rural, and Federally Declared Disaster Areas of the United States to the Federal Government Affairs Committee for action.

August 2017, reviewed the information paper "Delivery of Emergency Care in Rural Settings."

June 2017, approved policy statement "Definition of Rural Emergency Medicine."

Amended Resolution 16(16) Freestanding Emergency Centers as a Care Model for Maintaining Access to Emergency Care in Underserved and Rural Areas of the U.S. adopted.

June 2015, accepted for information the report of the Rural Emergency Medicine Task Force.

June 2009, took no further action on Referred Substitute Resolution 19(08) Second Rural Workforce Task Force because the intent of the resolution would be met by the Future of Emergency Medicine Summit.

October 2005, adopted Amended Resolution 37(05) Rural Emergency Medicine Workforce.

September 2004, approved continuing the work of the Rural Task Force to complete their assigned tasks.

September 2003, approved the recommendations from the Rural Emergency Medicine Summit.

February 2003, approved the development of a Rural Emergency Medicine Summit.

November 2002, approved convening a Rural Workforce Summit to identify specific needs of physicians practicing in rural emergency departments, explore solutions to staffing rural EDs, and make recommendations as to ACEP's role in this effort.

Substitute Resolution 20(01) Medical Education Debt adopted.

Amended Substitute Resolution 21(01) Rural Emergency Medicine Departments adopted.

Background Information Prepared by: Ryan McBride, MPP
Senior Congressional Lobbyist

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 35(21)

SUBMITTED BY: Rural Emergency Medicine Section

SUBJECT: Preserving Rural Emergency Care in Rural Critical Access Hospitals and Rural Emergency Hospitals

PURPOSE: 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.

FISCAL IMPACT: Budgeted staff resources.

WHEREAS, Rural emergency departments provide access to essential care for millions of Americans yet are under constant threat of closure due to financial constraints. The majority of unprofitable hospitals in the United States are rural hospitals, with 180 rural hospitals closing since 2005[1-3]; and

WHEREAS, Major challenges facing rural hospitals include uncompensated care and inadequate Medicare and Medicaid reimbursement to cover the costs of care for an underserved and underinsured population[2,4]; and

WHEREAS, Rural critical access hospital (CAH) closure leaves rural communities without access to rural emergency care, transformation of rural CAHs to rural emergency hospitals (REHs) – facilities that provide outpatient services and 24/7 emergency services – may provide a way to preserve access to emergency care and outpatient services[4-5]; and

WHEREAS, The optimal funding model for rural CAHs and REHs remains uncertain and is an active area of health services research[2-4]; and

WHEREAS, Tremendous growth in high deductible health care policies has had a disproportionate impact on rural hospitals. Typically, all the initial care at the rural hospital is subject to the patient's high deductible, and is therefore unpaid or underpaid, while the subsequent care at the referral hospital is typically in excess of the deductible and therefore paid in full by the insurer[6]; therefore be it

RESOLVED, That ACEP support the rural critical access hospital program including the conversion of struggling rural critical access hospitals to rural emergency hospitals and state and federal governments should increase rural hospital access to low-cost capital to support the conversion of these facilities and preserve access to emergency care[1-5]; and be it further

RESOLVED, That ACEP support rural health services research, including financial analyses of rural hospitals to better define the optimal funding model for rural critical access hospitals and rural emergency hospitals[1-4]; and be it further

RESOLVED, That ACEP support cost-based reimbursement for rural critical access hospitals and rural emergency hospitals at a minimum of 101% of patient care, including emergency care, to enable rural critical access hospitals to provide a safety net for rural patients and cost-based reimbursement should be increased beyond this

101% minimum according to the proportion of Medicare, Medicaid, and uninsured patients seen in the emergency department[1-4]; and be it further

RESOLVED, That ACEP support changes in Center for Medicare and Medicaid Services regulation that would allow rural off-campus emergency departments and rural emergency hospitals to collect the facility fee as well as the professional fee, as this essential for rural emergency hospital financial viability[4]; and be it further

RESOLVED, That ACEP advocate for insurance plans to aggregate all institutional and professional billing related to an episode of care and send one unified bill to the patient for their portion to shift the burden of collecting from the patient with a high-deductible insurance plan to the insurance company and allow for more equitable payments to both the rural and referral hospitals for initial stabilization in a rural area and definitive care at a tertiary center.[6]

References

1. Rural Hospital Closures Database. Cecil Sheps Center for Health Services Research The University of North Carolina Chapel Hill.https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/
2. Thomas et al. Health System Challenges for Critical Access Hospitals: Findings from a National Survey of CAH Executives. NC Rural Health Research Program Findings Brief. February 2021. https://www.shepscenter.unc.edu/wp-content/uploads/dlm_uploads/2021/02/Health-System-Challenges-for-Critical-Access-Hospitals-Findings-from-a-National-Survey.pdf.
3. Thomas et al. Alternative to Rural Hospital Closure: Findings from a National Survey of CAH Executives. NC Rural Health Research Program Findings Brief. February 2021. https://www.shepscenter.unc.edu/product/alternatives-to-hospital-closure-findings-from-a-national-survey-of-cah-executives/
4. Dunc Williams J, Song PH, Pink GH. Estimated Costs of Rural Free Standing Emergency Departments. https://www.shepscenter.unc.edu/product/estimated-costs-of-rural-freestanding-emergency-departments/
5. American Hospitals Association. Detailed Summary of Health Provision in Consolidated Appropriations Act, 2021. https://www.aha.org/system/files/media/file/2020/12/detailed-summary-health-provisions-consolidated-appropriations-act-2021-bulletin-12-22-20.pdf
6. Hawryluk, Markian. “High-Deductible Plans Jeopardize Financial Health of Patients and Rural Hospitals.” Kaiser Health News, 10 Jan. 2020, khn.org/news/high-deductible-plans-jeopardize-financial-health-of-patients-and-rural-hospitals/.

Background

This resolution calls on ACEP to take a number of actions to increase access to emergency services in rural areas and support rural hospitals and emergency departments. Specifically, it requests that ACEP support the conversion of certain rural hospitals, like critical access hospitals, into rural emergency hospitals. Further, it calls on ACEP to support rural health services research to better understand the optimal funding mechanism for rural hospitals. Finally, it requests that ACEP work with on the legislative and regulatory fronts, as well as to reach out to private payors, to improve the payment and billing structures and processes for rural facilities.

In order to increase access to emergency services in rural areas, Congress included a provision in the Consolidated Appropriations Act (enacted last December) that would allow critical access hospitals and small rural hospitals (those with less to than 50 beds) to convert to rural emergency hospitals (REHs) starting on January 1, 2023. REHs, once established, will not provide any inpatient services, but must be able to provide emergency services 24 hours a day/7 days a week and have a physician, nurse practitioner, clinical nurse specialist, or physician assistant available at all times. Further, they must meet other requirements, including, but not limited to: having a transfer agreement in place with a level I or level II trauma center; adhering to quality measurement reporting requirements that will be set by the Centers for Medicare & Medicaid Services (CMS); and following new emergency department (ED) conditions of participation (COPs). With respect to payment, REHs will receive a five percent bump up to the facility payments that hospitals traditionally receive for outpatient services under the Medicare outpatient prospective payment system (OPPS). They will also receive an additional facility payment on top of that. It is important to note that although there will be higher facility payments for REHs, clinicians will not receive any higher payments under the Medicare physician fee schedule if they provide services in REHs.

To get REHs up and running by 2023, CMS must create all the requirements associated with the new facility-type through regulations. ACEP leadership held a meeting with CMS staff who are in charge of creating the new REH

Medicare designation in June 2021 to provide our initial feedback. Specifically, we requested that although REHs can legally be staffed by non-physician practitioners, we strongly believe that all care provided in REHs should be supervised by a board-certified emergency physician, even remotely via telehealth. ACEP also had a Congressional meeting on this before any regulations were released.

In the Calendar Year (CY) 2022 OPPS proposed rule, released in July 2021, CMS issued a large request for information (RFI) to help inform future policies. The RFI included questions on the following topics: 1) Type and Scope of Services Offered by REHs; 2) Health and Safety Standards, Including Licensure and Conditions of Participation; 3) Health Equity; 4) Collaboration and Care Coordination; 5) Quality Measurement; 6) Payment Methodology; and 7) Enrollment Process. In all, there are 29 questions in the RFI. As of August 2021, when this background section was written, ACEP was in the process of developing a comprehensive response.

In all, ACEP has expressed support for this new designation of REHs, and even worked with Congress on the legislative language that was ultimately included in the Consolidated Appropriations Act. As stated earlier, ACEP has been proactive in reaching out to CMS to help construct various REH requirements. Once REHs get up and running in 2023, ACEP will likely play a role in helping to educate hospitals, like critical access hospitals, about the possible benefits of converting to this new facility-type.

Related to the resolveds around billing and reimbursement, it is important to note that any structural changes to how Medicare reimburses critical access hospitals and REHs would require legislation from Congress and could not be achieved through regulatory means. As referenced above, the Consolidated Appropriations Act set the specific payment methodology for REHs. REHs will not be paid on a cost-basis in Medicare, but rather their payments are based off the OPPS payment rate plus a five percent bump up. With respect to critical access hospitals, Medicare pays for most inpatient and outpatient services provided to patients at 101% of reasonable costs. Clinicians practicing in critical access hospitals can either reassign their billing rights to the hospital or bill Medicare directly for their services under the physician fee schedule (PFS). If clinicians reassign their billing rights, Medicare reimburses physician professional services at a rate of 115% of the Medicare PFS allowable amount.

The last resolved requests that ACEP advocate for insurance plans to send a unified bill to patients that includes both the facility and professional fees for each episode of care. While ACEP has not engaged on this specific advocacy effort before, during the debates in Congress on surprise medical billing, ACEP did discuss with lawmakers that emergency care is billed in two separate components and that patients must sort through costs included in at least two different bills, each of which may have different cost-sharing obligations associated with it. We recommended that health plans be responsible for collecting cost-sharing from patients and distributing that amount directly to clinicians and facilities. When making that request, we noted the difficulty many emergency departments and physician groups had collecting the full cost-sharing amount from patients.

ACEP Strategic Plan Reference

This resolution aligns with the following objective.

,
Goal 1 – Improve the Delivery System for Acute Care

- Objective B- Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum, including rural areas.

Fiscal Impact

Budgeted staff resources.

Prior Council Action

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.

Amended Resolution 29(18) Insurance Collection of Patient Financial Responsibility adopted. Directed ACEP to advocate for federal laws to require insurance companies to pay the reported professional fees directly to the provider, collect deductibles or co-payments from its covered beneficiary, and develop an information paper or legislative toolkit to assist members in advocating for applicable changes to state insurance laws.

Resolution 62(17) Freestanding Emergency Centers (FECs) as a Care Model for Maintaining Access to Emergency Care in Underserved, Rural, and Federally Declared Disaster Areas of the United States referred to the Board of Directors. The resolution called in part for ACEP to advocate for the creation of a Critical Access Emergency Center Designation where critical access hospitals no longer exist due to natural disasters or cannot be feasibly maintained.

Amended Resolution 17(16) Insurance Collection of Beneficiary Deductibles referred to the Board of Directors. The resolution requested ACEP to advocate for health insurance companies to provide full payment to physicians and leave collection of beneficiary deductibles to insurance companies. Additionally, submit a resolution to the AMA seeking the same policy at the national level

Amended Resolution 16(16) Freestanding Emergency Centers as a Care Model for Maintaining Access to Emergency Care in Underserved and Rural Areas of the U.S. adopted. The resolution called for ACEP to analyze the use of Freestanding Emergency Centers as an alternative care model to maintain access to emergency care in areas where emergency departments in critical access and rural hospitals have closed.

Substitute Resolution 19(08) Second Rural Workforce Task Force referred to the Board of Directors. The resolution called for the appointment of a second rural task force empowered to convene a second Rural Emergency Medicine Summit and develop recommendations for the ACEP Board.

Amended Resolution 37(05) Rural Emergency Medicine Workforce adopted. Directed ACEP to advocate for inclusion of emergency medicine in the National Health Service Corps scholarship program, explore and advocate for various incentives for emergency medicine residency trained physicians to practice in rural or underserved areas, explore funding sources for a new workforce study, and work with other emergency medicine organizations to encourage the development and promotion of rural clerkships/ rotations at medical schools and residency programs.

Substitute Resolution 20(01) Medical Education Debt adopted. The resolution directed ACEP to lobby appropriate state and federal agencies for inclusion of emergency physicians in medical education debt repayment programs, including but not limited to state programs, the National Public Health Service, rural and underserved regional grant programs, and other grants/ scholarship programs.

Amended Substitute Resolution 21(01) Rural Emergency Medicine Departments adopted. Directed ACEP to investigate the root causes related to the difficulty of securing board-certified emergency physician staffing for medically underserved and rural areas; the causes studies should include, but not be limited to, educational, financial, and resident candidate selection factors, and be it further resolved that ACEP investigate methods to improve educational opportunities in rural and underserved environments.

Prior Board Action

January 2021, approved the legislative and regulatory priorities for the First Session of the 117th Congress that include several initiatives related to rural emergency care.

October 2020, filed the report of the Rural Emergency Care Task Force. ACEP's Strategic Plan was updated to include tactics to address recommendations in the report.

January 2020, assigned Referred Resolution 40(19) Advancing Quality Care in Rural Emergency Medicine to the Rural Emergency Task Force to review and provide recommendations to the Board to address rural emergency medicine issues.

Amended Resolution 29(18) Insurance Collection of Patient Financial Responsibility adopted.
August 2018, ACEP supported the Emergency Care Improvement Act that allows for independent freestanding EDs that meet criteria to bill Medicare for a certain amount of facility-side reimbursement, depending on geography and acuity. The legislation contained specific language to protect professional-side reimbursement by Medicare at full physician fee schedule amounts at all acuity levels and to bring the facilities under federal EMTALA requirements.

August 2017, reviewed the information paper "Delivery of Emergency Care in Rural Settings."

June 2017, approved policy statement "Definition of Rural Emergency Medicine."

October 2017, approved taking no further action on Referred Amended Resolution 17(16) Insurance Collection of Beneficiary Deductibles given the scope of work on initiatives related to the repeal and/or replacement of the Affordable Care Act.

Amended Resolution 16(16) Freestanding Emergency Centers as a Care Model for Maintaining Access to Emergency Care in Underserved and Rural Areas of the U.S. adopted.

June 2015, accepted for information the report of the Rural Emergency Medicine Task Force.

June 2009, took no further action on Referred Substitute Resolution 19(08) Second Rural Workforce Task Force because the intent of the resolution would be met by the Future of Emergency Medicine Summit.

October 2005, adopted Amended Resolution 37(05) Rural Emergency Medicine Workforce.

September 2004, approved continuing the work of the Rural Task Force to complete their assigned tasks.
September 2003, approved the recommendations from the Rural Emergency Medicine Summit

February 2003, approved the development of a Rural Emergency Medicine Summit.

November 2002, approved convening a Rural Workforce Summit to identify specific needs of physicians practicing in rural emergency departments, explore solutions to staffing rural EDs, and make recommendations as to ACEP's role in this effort.

Substitute Resolution 20(01) Medical Education Debt adopted.

Amended Substitute Resolution 21(01) Rural Emergency Medicine Departments adopted.

Background Information Prepared by: Jeffrey Davis
Regulatory and External Affairs Director

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 36(21)

SUBMITTED BY: New York Chapter

SUBJECT: Mitigating the Unintended Consequences of the CURES Act

PURPOSE: Work with stakeholders to highlight patient safety issues affecting emergency department patients related to the CURES Act implementation and develop a policy statement advocating for release of records only after the treating physician and team have had sufficient opportunity to review results and discuss with the patient.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, The 2020 CURES Act, implemented in April 2021, mandated immediate release of patient records and results to the patient via patient portals or other means; and

WHEREAS, The spirit of the CURES Act was to prevent "information blocking," e.g., to avail patients of important clinical information promptly, but failed to consider the consequences of releasing STAT results on diagnostic tests ordered in the ED, sometimes even prior to a physician having an opportunity to see the patient; and

WHEREAS, The immediate release of such records exposes lay patients to unfiltered information they are likely unable to interpret independently; and

WHEREAS, Patients awaiting to be seen by an ED physician or awaiting final disposition may access results during their visit which may inappropriately distress them, or perhaps worse, reassure them and lead them to elope or sign themselves out of the ED; and

WHEREAS, The CURES Act itself provides a Preventing Harm Exception, which stipulates that "it will not be information blocking for an actor to engage in practices that are reasonable and necessary to prevent harm to a patient or another person, provided certain conditions are met"[1]; and

WHEREAS, The CURES Act recognizes that "the public interest in protecting patients and other persons against unreasonable risks of harm can justify practices that are likely to interfere with access, exchange, or use of" electronic health information[2]; therefore be it

RESOLVED, That ACEP work with appropriate stakeholders to highlight patient safety issues that may disproportionately impact the emergency department population related to implementation of the CURES Act; and be it further

RESOLVED, That ACEP develop a policy statement advocating for release of records only after the treating physician and team have had sufficient opportunity and time to review those results and discuss them with the patient.

References

[1] https://www.healthit.gov/cures/sites/default/files/cures/2020-03/InformationBlockingExceptions.pdf
[2] https://www.healthit.gov/cures/sites/default/files/cures/2020-03/InformationBlockingExceptions.pdf

Background

The resolution calls for the College to work with appropriate stakeholders to highlight patient safety issues that may disproportionately impact the emergency department population related to the implementation of the CURES Act, and to develop a policy statement advocating for the release of records only after the treating physician and team have had sufficient opportunity and time to review those results and discuss them with the patient.

The "21st Century Cures Act" (P.L. 114-255) was broad legislation signed into law in 2016 that addressed a wide variety of topics including streamlining the drug and medical device approval process, mental health, and provisions concerning the interoperability and sharing of electronic health records (EHRs). Congress took action on the EHR interoperability issues after well-documented complaints about EHR products that were deliberately designed not to exchange health information and hospitals that refused to share patient data with other providers. From the perspective of the emergency department, a lack of interoperability and the presence of data blocking creates an extremely challenging environment for emergency physicians attempting to provide comprehensive care to patients and make potentially life or death decisions. ACEP supported the legislation and advocated for its passage in Congress.

In February 2019, the Office of the National Coordinator (ONC) for Health Information Technology issued a long-awaited proposed rule to implement certain provisions of the 21st Century Cures Act to promote interoperability. ACEP provided a detailed response to the rule on May 31, 2019, which among other issues highlighted concerns about the additional burden placed on providers under these provisions such as investing in and adopting new technologies to understanding the new definitions and exceptions around information blocking.

The resolution outlines concerns about the data sharing/blocking provisions of this rule that require immediate release of patient records and results via patient portals. The authors note that while the spirit of these provisions were to prevent "information blocking," they have resulted in unintended consequences that may affect patient safety as they require the immediate release of records that, prior to physician/health care team review and discussion with the patient, could inappropriately distress the patient or alternatively provide them with inappropriate reassurance that causes them to leave the ED.

The ACEP response to the 2019 ONC rule noted some aspects of these concerns, including how the complexity of the information blocking provisions and how they intersect with longstanding HIPAA regulations could affect a clinician's decision to either not share information or overshare information, as well as the burdensome documentation requirements regarding their decision-making process for qualifying information blocking exceptions or sub-exceptions. It also noted a lack of clarity regarding the "preventing harm" exceptions and the burden of proof that falls upon providers who want to use this exception.

The ambiguous and sometimes conflicting guidance released by ONC has led hospital systems to interpret the data blocking provisions differently, and further, health care systems to have some discretion on how to operationalize these requirements – so application of these rules often varies from system to system, or even by region or state. Many hospitals err on the side of caution against any potential data blocking, opting to release all patient information immediately. Others interpret the guidance differently, such as limiting sharing of ED information until after discharge and co-signed by the attending physician, releasing inpatient records after discharge and co-signed by the attending physician (with release after 5 days if not co-signed by the attending), and ambulatory care records essentially released in real-time (with disclaimers). While the Department of Health and Human Services (HHS) has not yet instituted penalties to physicians or providers for not complying with the requirements of the rule, given the wide discretion or variance in implementation of the rules, emergency physicians are rightly concerned about the fear of consequences or liability for not sharing data, especially when the actual policies are determined at system/local/state level. ACEP has asked CMS to clarify the guidance and consider that waiting to release records until after discharge *not* be considered data blocking, but to date has not received a response on this issue.

On March 25, 2021, ACEP met with ONC leadership, including the Chief Medical Officer, to discuss specific issues including the implementation of these requirements. In response to an ONC request during the meeting for specific feedback on how the requirements affect emergency physicians, ACEP conducted a poll of members (received 134

responses) on the data sharing requirements. The largest issue flagged by respondents concerned the timing of data sharing. More than two-thirds of respondents stated that lab results are shared immediately with patients once available, with many noting this has caused patient confusion, anger, and sadness for patients who received distressing results prior being able to discuss with their physician. Others noted examples where patients either misread or misinterpreted clinical notes and lab results, causing physicians to have to spend significant time and effort correcting those misconceptions and consoling or reassuring patients. Respondents also noted another unique challenge for emergency physicians in that most EPs do not have a pre-existing relationship with patients, potentially adding another layer of confusion or adverse consequences when patients receive information immediately (even before discharge from the ED). ACEP continues working with the relevant agencies to resolve these issues.

Fiscal Impact

Budgeted committee and staff resources.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

Prior Council Action

Amended Resolution 21(15) Healthcare Information Exchanges adopted. Directed ACEP to create a minimum standard of information to be contained in Healthcare Information Exchanges (HIE), promote standardized requirements in development, identify recommended standards for ED summaries, and work with stakeholders to identify and promote standards that allow for notification in the ED EHR of applicable HIE data.

Substitute Resolution 21(14) ED Mental Health Information Exchange adopted. The resolution directed ACEP to research the feasibility of identifying and risk-stratifying patients at high risk for violence, devise strategies to help emergency physicians work with stakeholders to mitigate patients' risk of self-directed or interpersonal harm, and investigate the feasibility and functionality of sharing patient information under HIPAA for such purposes and explore similar precedents currently in use.

Amended Resolution 29(13) Support of Health Information Exchanges adopted. Directed ACEP to investigate and support health information exchanges, work with stakeholders to promote the development, implementation, and utilization of a national HIE, and develop an information paper exploring a national HIE.

Resolution 22(07) Information Systems for Emergency Care – ACEP Policy adopted. Directed ACEP to update and establish policies regarding the need and utility of information systems for emergency care and produce a paper on the issue.

Prior Board Action

April 2021, approved the revised policy statement, "Health Information Technology for Emergency Care;" replacing rescinded policies "Emergency Care Electronic Data Collection and Exchange," "Health Information Technology Standards," and "Patient Information Systems;" revised June 2015, August 2008 with current title replacing "Internet Access;" rescinded August 2008, February 2003; originally approved October 1998 titled "Internet Access."

Amended Resolution 21(15) Healthcare Information Exchanges adopted.

October 2014, reviewed the information paper, Health Information Exchange in Emergency Medicine.

Substitute Resolution 21(14) ED Mental Health Information Exchange adopted.

Amended Resolution 29(13) Support of Health Information Exchanges adopted.

Resolution 22(07) Information Systems for Emergency Care – ACEP Policy adopted

Background Information Prepared by: Ryan McBride, MPP
Senior Congressional Lobbyist

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 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(21)

SUBMITTED BY: Louisiana Chapter

SUBJECT: Physician Pay Ratio

PURPOSE: 1) Support legislation to establish a Minimum Emergency Physician Pay Ratio (MEPPR) that all Contract Management Groups (CMGs) and employers are required to pay individual emergency physicians based on what is collected on the billings for the services provided by that individual emergency physician, before collection costs; 2) support that when a nominal compensation amount is stated to compensate the emergency physician, that amount must meet or exceed an established MEPPR; and 3) support legislation to establish a MEPPR that all CMGs and employers are required to pay individual emergency physicians a reasonable, prorated percentage of any other revenue that the CMG or employer receives as a direct or indirect result of the individual, or group of individuals, emergency physicians, providing his/her/their services with a suggested starting point: 0.80-0.85 (80-85%).

FISCAL IMPACT: Budgeted staff resources.

WHEREAS, Many are concerned that Contract Management Groups (CMGs) yield too much control and power in emergency medicine and take advantage of individual emergency physicians; and

WHEREAS, CMGs can use their size and control to inhibit a true free [market?] from existing; and

WHEREAS, Many CMGs do not clearly and fully disclose billing and collection information to the physicians who work for them as employees or independent contractors; and

WHEREAS, CMGs typical[ly?] set the pay, or have significant power over the compensation that emergency physicians receive for providing physician professional services in emergency departments, freestanding emergency centers and other facilities, for which the CMGs code, bill and collect under the name of the emergency physician but the CMG actually collects and/or controls the collections; and

WHEREAS, CMGs can and often collect revenue, or take expenses from the collections generated from individual emergency physician professional services for scheduling, coding, billing, medical malpractice, etc.; and

WHEREAS, CMGs often collect revenues in the form of subsidies from hospitals or governmental programs because the CMG employed individual emergency physicians cover the emergency department or provide care to the indigent or uninsured patients, or for other reasons as a direct or indirect result of individual emergency physicians providing professional services, or the CMGs receive benefits, directly or indirectly, because in[*no space] dividual emergency physicians provide emergency medicine services, (i.e., allowed to provide other service lines such as hospitalist, radiologic, anesthesiologists, orthopedic contracts, etc., billing assistance, consulting services, educational offerings, etc.); and

WHEREAS, CMGs pay emergency physicians only a fraction of the amounts they receive or collect as a direct or indirect result of the emergency physician services; and

WHEREAS, While CMGs can offer some value to emergency physicians, many question whether the amount charged, or held by the CMGs for their “services” are fair or reasonable; and

WHEREAS, Requiring CMGs to pay a Minimum Emergency Physician Pay Ratio (MEPPR), a percentage of all monies received related to the individual emergency physician’s services i.e. what is collected from billings, and

revenue generated from non-emergency physician billing but from other revenues generated by the CMG as a direct or indirect result of individual emergency physician services, similar to how insurance companies are required to pay out a minimum Medical Loss Ratio (MLR), or a percentage of the premiums collected under the Affordable Care Act for medical care and benefits to policyholders; and

WHEREAS, Many emergency physicians are compensated at a nominal pay rate that may be significantly less than what they are generating and the compensation to emergency physicians should be compensated the greater of the stated nominal pay or the MEPPR; and

WHEREAS, If a MEPPR were paid to individual emergency physicians for the value they bring to emergency medicine and patient care, it would incentivize CMGs to be as efficient as possible i.e. eliminating services that do not bring a good return on value to the individual emergency physician or patient care; and

WHEREAS, A MEPPR would incentivize CMGs to better represent the interests of the individual emergency physicians they allegedly claim they are helping; and

WHEREAS, Requiring a MEPPR would not likely cause the cost of healthcare to increase as if the CMGs tried to raise nominal costs to keep the same percentage of a higher total amount to increase total nominal profits, competitors would be able to better compete on price for contracts; therefore be it

RESOLVED, That ACEP support legislation to establish a Minimum Emergency Physician Pay Ratio that all Contract Management Groups and employers are required to pay individual emergency physicians based on what is collected on the billings for the services provided by that individual emergency physician, before collection costs; and be it further

RESOLVED, That ACEP support that when a nominal compensation amount is stated to compensate the emergency physician, the amount must meet or exceed an established Minimum Emergency Physician Pay Ratio; and be it further

RESOLVED, That ACEP support legislation to establish a Minimum Emergency Physician Pay Ratio that all Contract Management Groups and employers are required to pay individual emergency physicians a reasonable, prorated percentage of any other revenue that the contract management group or employer receives as a direct or indirect result of the individual, or group of individual, emergency physicians, providing his/her/their services with a suggested starting point: 0.80-0.85 (80-85%).

Background

The resolution directs the College to support legislation to establish a Minimum Emergency Physician Pay Ratio (MEPPR) that all Contract Management Groups (CMGs) and employers are required to pay individual emergency physicians based on what is collected on the billings for the services provided by that individual emergency physician before collection costs. It also calls for ACEP to support that when a nominal compensation amount is stated to compensate the emergency physician, that amount must meet or exceed an established Minimum Emergency Physician Pay Ratio. Finally, it calls for ACEP to support legislation to establish a Minimum Emergency Physician Pay Ratio that all Contract Management Groups and employers are required to pay individual emergency physicians a reasonable, prorated percentage of any other revenue that the contract management group or employer receives as a direct or indirect result of the individual, or group of individuals, emergency physicians, providing his/her/their services with a suggested starting point: 0.80-0.85 (80-85%).

The resolution states concerns that CMGs exert too much control over the markets, and that such groups pay emergency physicians a fraction of what the group receives either directly or indirectly from the physician's services. It also states that while CMGs may provide some value to emergency physicians, some question whether or not these arrangements are fair or reasonable. To address these issues, the resolution puts forward a "MEPPR" as a tool to require CMGs to pay a set percentage of revenues to contracted emergency physicians.

As explained in the resolution, a MEPPR is envisioned as a percentage of all monies received related to the individual emergency physician's services, such as what is collected from billings as well as revenue generated from non-emergency physician billing but from other revenues generated by the CMG as a direct or indirect result of an individual emergency physician's services. The authors liken this compensation structure to the Medical Loss Ratio (MLR), a financial measurement implemented through the Affordable Care Act (ACA) that requires insurers to use a certain percentage (generally 80/20, though there are different rates for some insurance markets or states) of every premium dollar to pay for a beneficiary's clinical services and quality improvement activities, with the remainder spent on administrative costs, marketing, profits, salaries, agent commissions, and other overhead costs. If insurers do not meet their MLR targets for a given year, they are required to pay a rebate to beneficiaries on part of the premiums paid.

ACEP policy statements "Compensation Arrangements for Emergency Physicians" and "Emergency Physician Contractual Relationships" lay out the College's existing policies regarding fair and appropriate contractual relationships. ACEP also provides a policy resource and education paper (PREP) that lays out additional background and the foundation of the "Emergency Physician Contractual Relationships" policy statement, further detailing the ideal components of contracts involving emergency physicians.

ACEP's policy statement "Compensation Arrangements for Emergency Physicians" recognizes that emergency physicians practice under a variety of compensation arrangements, e.g., independent contractor, fee for service, salary, hourly compensation, percentage of gross or net billing, or a combination of these. ACEP policy is not prescriptive in terms of how compensation methods or practice arrangements are provided, and states that regardless of these, emergency physicians are entitled to fair and equitable compensation, taking into account their experience, clinical and administrative services provided, added value to the practice, market conditions, and other appropriate circumstances or factors. ACEP strongly encourages each emergency physician to carefully evaluate and understand the health care delivery system such that they are engaging in a suitable compensation arrangement. Additionally, ACEP strongly urges transparency in disclosure of both the revenue and expenses associated with emergency medicine practice, including administration and management services, so that each emergency physician can make an informed decision in determining what is a fair compensation package for them.

The resolution also notes concerns about transparency regarding disclosure of billing or collections information by CMGs. ACEP policy also states that emergency physicians are entitled to and should be provided detailed itemized reports of all billings and collections in their name on at least a semi-annual basis regardless of whether or not billing and collection is assigned to another entity within the limits of state and federal law and have the right to audit such billings, at any time without retribution, and that emergency physicians shall not be asked to waive access to this information.

The "Emergency Physician Contractual Relationships" policy statement reinforces that ACEP does not endorse any single type of contractual arrangement between emergency physician and the contracting vendor and endorses the principle that the interests of patients are best served when emergency physicians practice in a stable, fair, equitable, and supportive environment.

ACEP's "Antitrust" policy statement states in part:

"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 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."
"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."

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective A – Promote/advocate for efficient, sustainable, and fulfilling clinical practice environments.
- Objective E – Pursue strategies for fair payment and practice sustainability to ensure access patient access to care.

Goal 2 – Enhance Membership Value and Member Engagement

- Objective A – Improve the practice environment and member well-being.

Fiscal Impact

Budgeted staff resources.

Prior Council Action

The Council has adopted many resolutions regarding emergency physician compensation, but none that address a minimum emergency physician pay ratio.

Amended Resolution 30(20) Protection and Transparency adopted. Directed the College to establish policy that encourages all employers, persons, or entities who contract for emergency physician services to provide information on a semi-annual basis to non-federal physicians for any and all compensation or benefit, cash, and payment-in-kind, received by the employer or CMG as a result of the physician providing his or her services without any requirement of the physician requesting it.

Amended Resolution 29(20) Billing and Collections Transparency in Emergency Medicine first two resolveds adopted and the last 3 resolveds were referred to the Board of Directors. The first two resolveds directed the College to make specific revisions to the policy statements "Emergency Physician Contractual Relationships" and "Emergency Physician Rights and Responsibilities." The last three resolveds requested that ACEP: 1) adopt a new policy statement prohibiting members from denying another emergency physician access to monthly detailed information about billing and collections for their services; 2) petition state or federal legislative and regulatory bodies to require revenue cycle management entities to provide every emergency physician it bills or collects for with a detailed itemized statement of billing and remittances for medical services they provide on at least a monthly basis; and 3) adopt a new policy statement prohibiting any entity that fails to meet this standard from advertising, exhibiting, sponsoring, or otherwise being associated with ACEP

Prior Board Action

April 2021, approved the revised policy statement "Compensation Arrangements for Emergency Physicians;" revised and approved April 2015, April 2002, June 1997; reaffirmed October 2008, April 1992; originally approved June 1988.

April 2021, approved the revised policy statement "Emergency Physician Contractual Relationships;" revised and approved June 2018, October 2012, January 2006, March 1999, and August 1993 with the current title; originally approved October 1984 titled, "Contractual Relationships between Emergency Physicians and Hospitals."

Amended Resolution 30(20) Protection and Transparency adopted.

Amended Resolution 29(20) Billing and Collections Transparency in Emergency Medicine first two resolveds adopted.

January 2019, reaffirmed the policy statement "Antitrust;" reaffirmed June 2013, October 2007; revised and approved October 2001; originally approved June 1996 replacing a policy statement with the same title approved April 1994.

July 2018, reviewed the Policy Resource & Education Paper (PREP) "Emergency Physician Contractual Relationships" as an adjunct to the policy statement "Emergency Physician Contractual Relationships."

Background Information Prepared by: Ryan McBride, MPP
Senior Congressional Lobbyist

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 38(21)

SUBMITTED BY: Kevin E. McVaney, MD
Stephen J. Wolf, MD, FACEP
Colorado Chapter

SUBJECT: Prehospital Oversight and Management of Patients Experiencing Hyperactive Delirium with Severe Agitation

PURPOSE: Advocate at the state and national levels: 1) ABEM-certified providers serve as the highest-level medical experts on the management of hyperactive delirium with severe agitation; 2) against any non-ABEM-certified specialty's assertion to having greater expertise on the management of hyperactive delirium in the prehospital setting; 3) against any non-ABEM-certified specialty's medical oversight of prehospital medical direction on the management of hyperactive delirium with severe agitation; 4) on all issues pertaining to the prehospital management of hyperactive delirium with severe agitation in partnership with NAEMSP.

FISCAL IMPACT: Budgeted committee/task force and staff resources.

WHEREAS, Medical direction of prehospital services is largely in the scope of emergency medicine and solely board certified by the American Board of Emergency Medicine (ABEM); and

WHEREAS, Hyperactive delirium with severe agitation is a critical patient and prehospital provider safety issue in the prehospital setting; and

WHEREAS, Pharmacologic therapeutic interventions for hyperactive delirium with severe agitation – i.e., benzodiazepines (e.g., midazolam), antipsychotics (e.g., haloperidol), and dissociative sedatives (e.g., ketamine) – are frequently required for the appropriate and safe medical management of patients experiencing hyperactive delirium with severe agitation; and

WHEREAS, Use and administration of the above stated therapeutic interventions are fully in the scope of practice of emergency medicine for the management of a variety of patient conditions, including hyperactive delirium with severe agitation; and

WHEREAS, Recent societal and political concerns have led to regulatory reviews and scrutiny of prehospital medical direction and protocols for the management of hyperactive delirium with severe agitation; and

WHEREAS, In some instances, regulators and other specialty organizations have sought to place greater emphasis on the medical expertise and opinions of non-ABEM-certified providers on this topic; and

WHEREAS, In some instances, regulators have proposed mandating non-ABEM-certified medical experts to participate in regulatory oversite of prehospital medical practice; therefore be it

RESOLVED, That ACEP advocate, at both state and national levels, that ABEM-certified providers serve as the highest level of medical experts on the matter of management of patients with hyperactive delirium with severe agitation in the prehospital and emergency medical settings; and be it further

RESOLVED, That ACEP play an active role, at both state and national levels, in advocating against any non-ABEM-certified specialty's assertion to having greater expertise in the acute therapeutic (i.e., pharmacologic and non-pharmacologic) management of patients with hyperactive delirium in the prehospital setting; and be it further

RESOLVED, That ACEP oppose any non-ABEM-certified specialty's medical oversight, in part or in whole, of prehospital medical direction, particularly when pertaining to the management of hyperactive delirium with severe agitation; and be it further

RESOLVED, That ACEP partner with the National Association of EMS Physicians (NAEMSP) to work with state and national regulators and legislators on all issues pertaining to the prehospital management of hyperactive delirium with severe agitation.

Background

This resolution requests ACEP to advocate at the state and national levels to recognize ABEM-certified providers as the highest-level medical experts on the management of hyperactive delirium with severe agitation in the prehospital and emergency department setting, and to advocate against any non-ABEM-certified specialty's assertion to having greater expertise or medical oversight of prehospital or emergency department medical direction on the management of hyperactive delirium with severe agitation. The resolution also requests ACEP to partner with the National Association of EMS Physicians (NAEMSP) to work with state and national regulators on all issues pertaining to the prehospital management of hyperactive delirium with severe agitation.

Since 2009, ACEP has made efforts to study the existence of excited delirium as a disease entity and has worked to synthesize the most current information available regarding the recognition, evaluation, and management of patients presenting with excited delirium.[1] Most recently, due to the increasingly charged nature of the term "excited delirium syndrome," ACEP has chosen to use the term "hyperactive delirium with severe agitation" when referring to patients exhibiting agitated or combative behavior associated with a delirious state where the individual is not capable of interacting with other individuals or the environment.[2] The term "hyperactive delirium with severe agitation" is more descriptive of the identified mental status and level of activity exhibited by patients of interest, and expands upon the term "hyperactive delirium," which is the term commonly used in recent research for delirium associated with increased neuromuscular activity, often accompanied by agitation.[2]

ACEP first addressed excited delirium syndrome with the 2009 task force report titled *Excited Delirium Task Force White Paper Report on Excited Delirium Syndrome*. This 20-member task force, consisting primarily of emergency physicians, provided a review of the history, epidemiology, clinical perspectives, potential pathophysiology, diagnostic characteristics, differential diagnoses, and clinical treatment of excited delirium syndrome.

In 2020, urgent questions surrounding the initial management of excited delirium was raised by ACEP membership, the scientific community, community leaders, media, and governmental agencies. In response, ACEP leadership assembled a 10-member task force to address the progress made since 2009 in the recognition, evaluation, and management of patients demonstrating dangerous degrees of agitation. To incorporate the perspectives from multiple specialties, a 17-member multispecialty review panel reviewed the document's text and recommendations. In June 2021, the ACEP Board of Directors approved the document titled *ACEP Task Force Report on Hyperactive Delirium with Severe Agitation in Emergency Settings*.

The approval of the *ACEP Task Force Report on Hyperactive Delirium with Severe Agitation in Emergency Settings* followed the American Medical Association's adoption of a policy earlier in the month opposing "excited delirium" as a medical diagnosis and underscoring the importance of emergency physician-led oversight of medical emergencies in the field.[3,4]

ACEP has a long history of working with NAEMSP on joint projects and policy statements and there are no known obstacles or barriers to collaboration on this issue.

References

1. Debard ML, Adler J, Bozeman W, et al. Excited Delirium Task Force White Paper Report on Excited Delirium Syndrome. September 2009. https://www.acep.org/globalassets/uploads/uploaded-files/acep/clinical-and-practice-management/ems-and-disaster-

preparedness/ems-resources/acep-excited-delirium-white-paper-final-form.pdf
2. Hatten BW, Bonney C, Dunne RB, et al. ACEP Task Force Report on Hyperactive Delirium with Severe Agitation in Emergency Settings. June 2021. https://www.acep.org/by-medical-focus/hyperactive-delirium/
3. American Medical Association Council on Science and Public Health. Use of Drugs to Chemically Restrain Agitation Individuals Outside of Hospital Settings. June 2021. https://www.ama-assn.org/system/files/2021-05/j21-handbook-addendum-ref-cmte-e.pdf.
4. American Medical Association. Press Release: New AMA policy opposes "excited delirium" diagnosis. June 2021. https://www.ama-assn.org/press-center/press-releases/new-ama-policy-opposes-excited-delirium-diagnosis.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care
- Objective A – Promote/advocate for efficient, sustainable, and fulfilling clinical practice environments.
- Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum.
- Objective C – Promote the value of emergency medicine and emergency physicians as essential components of the health care system.

Goal 2 – Enhance Membership Value and Member Engagement
- Objective F – Provide and promote leadership development among emergency medicine organizations and strengthen liaison relationships.

Fiscal Impact

Budgeted committee/task force and staff resources.

Prior Council Action

Amended Resolution 21(08) Excited Delirium. Directed the College to establish a multidisciplinary group to study "excited delirium" and make clinical recommendations.

Prior Board Action

June 2021, approved "ACEP Task Force Report on Hyperactive Delirium with Severe Agitation in Emergency Settings."

October 2009, approved "White Paper Report on Excited Delirium Syndrome." The report was distributed to the 2009 Council.

Amended Resolution 21(08) "Excited Delirium" adopted.

Background Information Prepared by: Travis Schulz, MLS, AHIP
Clinical Practice Manager

Rick Murray, EMT-P
EMS & Disaster Preparedness Director

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 39(21)

SUBMITTED BY: Ohio Chapter
Pennsylvania College of Emergency Physicians

SUBJECT: Recommit to Lessening Opioid Deaths in America

PURPOSE: 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.

FISCAL IMPACT: Budgeted staff resources.

WHEREAS, ACEP and all 53 of the chapters have been fighting the opioid epidemic since 2012; and

WHEREAS, Most states and the District of Columbia have developed prescription drug monitoring programs; and

WHEREAS, ACEP promotes that emergency physicians develop programs to initiate buprenorphine in the emergency department linked to ongoing care to assist patients to obtain treatment; and

WHEREAS, ACEP promotes prescribing naloxone for all patients and families who are at risk for opioid use disorder; and

WHEREAS, Federal agents in El Paso, Texas report a staggering 4,000% increase in fentanyl seizures over the last three years, rising from 1 pound in 2018 to 41 pounds during the 2021 fiscal year; and

WHEREAS, As of April 2021, Customs and Border Patrol had seized 6,494 pounds of fentanyl this year, compared to 4,776 pounds in all of 2020; and

WHEREAS, Fentanyl strongly contributed to the stark rise in overdoses that killed more than 90,000 Americans during the 12-month period ending September 2020; and

WHEREAS, More than twice as many people died from overdoses than from COVID-19 in San Francisco last year; and

WHEREAS, One kilogram of fentanyl has the potential to kill 500,000 people; therefore be it

RESOLVED, That ACEP recommit to the goal of reducing overdose deaths in this country by working with Customs and Border Patrol, the Drug Enforcement Agency, state legislatures on the southern border, federal legislatures, and any other relevant stakeholders; and be it further

RESOLVED, That ACEP continue to advocate for governmental actions to decrease the supply of fentanyl and other illegal drugs entering our country by whatever means necessary and to highlight the continued increase in overdoses and overdose deaths.

Background

The resolution calls for the College to recommit to the goal of reducing overdose deaths in the U.S. by working with U.S. Customs and Border Protection (CBP), the Drug Enforcement Agency (DEA), state legislatures on the southern border, federal legislatures, and any other relevant stakeholders. (Technical note: the resolution writes this as "Customs and Border Patrol," the U.S. Border Patrol is a subsidiary organization under the purview of U.S. Customs and Border Protection – for purposes of this background information, staff assumes "Customs and Border Protection" to reflect the authors' intent given the agency's broader purview.) The resolution also directs ACEP to continue to advocate for governmental actions to decrease the supply of fentanyl and other illegal drugs entering the country by whatever means necessary and to highlight the continued increase in overdoses and overdose deaths.

The use of, and addiction to, various opioids, both prescription medication and illegal substances, has become a serious global health problem. It is estimated that more than two million people in the United States suffer from a substance abuse disorder related to prescription opioids and another 500,000 are addicted to heroin. In 2020, the Centers for Disease Control and Prevention (CDC) reported more than 93,000 opioid deaths, the highest number on record and a nearly 30 percent increase from 2019. This increase was driven primarily by illicitly manufactured fentanyl and synthetic opioids, and also thought to be exacerbated by the COVID-19 pandemic. The opioid crisis also has additional impacts on public health, such as significant increases in the incidence of infectious diseases often associated with injection drug use, including acute hepatitis C virus (HCV), HIV, and other bloodborne infections. The CDC noted that over from 2010-2016, HCV cases more than tripled.

Given the impact of opioid use disorder (OUD) on ED patients, emergency physicians have unique knowledge, experience, and opportunities to help patients with OUD or other substance use disorders (SUDs). The treatment of opioid use disorder in the ED has been associated with increased rates of outpatient treatment linkage and decreased drug use when compared to patients referred to the ED. The ED has also been increasingly recognized as a venue for the identification and initiation of treatment for opioid use disorder. To this end, over the past several years the College has developed a robust set of OUD treatment resources and materials for emergency physicians and has taken a leading role in comprehensive federal and state advocacy efforts to address the opioid crisis.

Since 2012, ACEP has promoted the use of non-opioid analgesics to treat pain and has engaged in addressing prescribing patterns in the ED. This has included the development of the Management of Acute Pain (MAP) in the Emergency Department Point of Care Tool. However, ED physicians are responsible for less than 5% of total opioid prescribing nationwide, and changing prescribing patterns does little for our patients already suffering from opioid use disorder. The Department of Health and Human Services (HHS) has recognized the emergency department as one of the first places individuals with a substance use disorder will seek treatment.

During the 115th Congress, the College successfully advocated to include two ACEP-developed and -led bills in the SUPPORT for Patients and Communities Act (Public Law 115-271), a comprehensive bipartisan opioid package that provided federal resources for prevention, recovery, and treatment efforts. The two bills included in this package were the Alternatives to Opioids (ALTO) in the Emergency Department Act, establishing a grant program to help emergency departments implement their own ALTO programs based upon the successful ALTO program developed by current ACEP President Mark Rosenberg, DO, MBA, FACEP; and the Preventing Overdoses While in Emergency Rooms (POWER) Act that established a program to develop best practices for ED-initiated medication assisted treatment (MAT) programs to provide a "warm handoff," helping emergency physicians initiate OUD treatment for patients who have overdosed and directly connect them with more appropriate longer-term treatment options in their communities. In March 2018 as these bills were being considered in the House, Dr. Rosenberg testified before the Energy and Commerce Committee in support of the ALTO and POWER bills. And later, in recognition of the College's successful efforts, ACEP received an invitation to the White House signing ceremony for the legislation in October 2018, with former ACEP Executive Director Dean Wilkerson attending the ceremony on behalf of the College.

The ALTO program recently received a $3 million increase in the House of Representatives Labor, Health and Human Services, Education, and Related Agencies (L/HHS) appropriations bill, and in July 2021, ACEP helped facilitate introduction of legislation to reauthorize the ALTO program through 2026.

Also during the 115th Congress, ACEP helped develop legislation, the "Sharing Health Information to Ensure Lifesaving Drug Safety (SHIELDS) Act," to close the gap in the U.S. Department of Defense's (DoD's) reporting of prescriptions, including opioids, to state prescription drug monitoring programs (PDMPs). In a matter of a few short months, ACEP was able to bring this issue to Congress' attention, help develop legislation, and secure enactment of this bill as part of the fiscal year 2019 National Defense Authorization Act (NDAA). Previously, prescribing data for service members and their families was not available to emergency physicians and other providers when they sought care at non-military treatment facilities.

In 2017, the HHS Secretary declared the opioid crisis and public health emergency, which in turn spurred the ACEP Pain Management & Addiction Medicine Section to develop an updated EM-focused DATA 2000 X-Waiver training, followed by a guideline on the initiation of medication for OUD for appropriate ED patients. ACEP also continues to advocate for policy changes that lower regulatory barriers to initiating Medication-Assisted Treatment (MAT) in the ED, and support expansion of outpatient and inpatient opioid treatment programs. Additionally, ACEP has launched the Pain and Addiction Care in the Emergency Department (PACED) accreditation program.

In 2016, Congress approved the bipartisan Comprehensive Addiction and Recovery Act (CARA; P.L. 114-198) that included several important ACEP-supported provisions, including: expedited training of military medics who become civilian emergency medical technicians (EMTs); improved access to opioid overdose reversal treatments, including grants to purchase and distribute naloxone to first responders, and expand physician co-prescribing of naloxone in conjunction with opioid prescriptions for patients at elevated risk of overdose; reauthorized grants to help states establish, implement, and improve PDMPs; increased disposal sites for unwanted prescription medications; among many others.

ACEP has also supported multiple bills over the last several years to extend temporary orders by the Drug Enforcement Agency (DEA) to keep fentanyl-related substances and analogues in Schedule I of the Controlled Substances Act (CSA), giving Congress and the DEA this much-needed immediate authority as they develop a more permanent solution. The most recent extension of these temporary orders was signed into law in May 2021, and ACEP continues to urge Congress and the DEA to implement an effective and permanent mechanism to address this particular challenge.

Among ACEP's current federal legislative priorities are continued efforts to increase access to MAT. Recently, ACEP helped secure the successful passage of legislation in late 2020, the "Easy Medication Access and Treatment for Opioid Addiction (Easy MAT) Act," to allow non-waivered emergency physicians to dispense from the ED up to a three-day supply of buprenorphine at one time to a patient suffering from acute withdrawal symptoms. Previously, patients were required to return to the ED within the 72-hour window to receive additional doses as they awaited long-term treatment. Additionally, ACEP continues to work to eliminate of the "X-waiver" requirement required for health care practitioners to dispense certain narcotic drugs, including buprenorphine, for maintenance or detoxification treatment for OUD. In January 2021, the Trump Administration issued guidance to provide a broad exemption to the X-waiver requirement; however, this effort was reversed shortly after by the new Biden Administration with the reasoning that the Administration does not have the authority to relax these requirements. As Health and Human Services (HHS) Secretary Xavier Becerra noted during his confirmation hearings in Congress, the Administration supports the effort to increase access to buprenorphine, but reiterated that the Administration does not have the authority to eliminate the policy and that an act of Congress is required. This issue was also one of the advocacy items for ACEP's 2021 Leadership and Advocacy Conference (LAC).

On the regulatory front, ACEP met with the head of the Substance Abuse and Mental Health Services Administration (SAMHSA), Assistant Secretary for Mental Health and Substance Use Dr. Elinore McCance-Katz, on May 15, 2019. During the meeting with Dr. McCance-Katz, ACEP discussed issues that are extremely important to emergency physicians and our patients, including the ability to administer buprenorphine in the ED for patients with opioid use disorder and how to improve care for patients with mental health illnesses. ACEP mentioned the resources and tools that we have created to help our physicians and patients, highlighting the EM-specific DATA 2000/Medications for Addiction Treatment waiver training course that is now being offered to our members, as well as new web-based and mobile device applications around opioids and the management and treatment of suicidal patients. One of SAMHSA's major goals is to boost the community resources that are available to help clinicians across specialties treat patients

with substance abuse disorders and mental illnesses. ACEP expressed our commitment to helping SAMHSA achieve the goal and identified opportunities to work together going forward.

On August 29, 2019, ACEP responded to an HHS request for information on ensuring appropriate access to opioid treatments. In the response, HHS is urged to do what is in their authority to reduce barriers to the treatment of patients with OUD. ACEP also issued a press release highlighting the major points contained in the letter.

In addition to advocating for Congress to remove the X-waiver and pushing for regulatory changes to the "three-day rule," ACEP also:

- Offers an emergency-medicine specific X-waiver training course;
- Provides clinical tools for emergency physicians to improve decision making and clinical practices; and
- Operates the EQUAL Network Opioid Initiative, which engages emergency clinicians and leverages emergency departments to improve clinical outcomes.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum, including rural areas.
- Objective C – Promote the value of emergency medicine and emergency physicians as essential components of the health care system.

Fiscal Impact

Budgeted staff resources.

Prior Council Action

Amended Resolution 34(19) Opposing Naloxone Addition to the Prescription Drug Monitoring Program adopted. Directed ACEP to oppose legislation to add naloxone to the PDMP and work with chapters in developing strategies and supporting materials to stop such legislation.

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 Pain Management & Addiction Medicine Section to develop a guideline on the initiation of medication for OUD for appropriate ED patients, advocate for policy changes that lower regulatory barriers to initiating MAT in the ED, and support expansion of outpatient and inpatient opioid treatment programs.

Amended Resolution 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 followup.

Amended Resolution 23(16) Medical Medication Assisted Therapy for Patients with Substance Use Disorders in the ED adopted. The resolution directed ACEP to provide education to emergency physicians on ED-initiated treatment of patients with substance use disorders and support through advocacy the availability and access to novel induction programs such as buprenorphine from the ED.

Resolution 21(16) Best Practices for Harm Reduction Strategies adopted. Directed ACEP to set a standard for linking patients with a Substance Use Disorder to an appropriate potential treatment resource after receiving medical care from the ED.

Amended Resolution 42(14) Reverse an Overdose, Save a Life adopted. The resolution directed ACEP to advocate and support Naloxone use by first responders, availability of Naloxone Over the Counter (OTC), and support research of the effectiveness of ED-initiated overdose education.

Amended Resolution 44(13) Prescription Drug Overdose Deaths adopted. Directed ACEP to appoint a task force to review solutions to decrease death rates from prescription drug overdoses, provide best practice solutions to impact the epidemic of prescription drug overdoses with the goal of reducing the number of prescription overdose deaths.

Amended Resolution 17(12) Ensuring ED Patient Access to Adequate and Appropriate Pain Treatment adopted. The resolution supports chapter autonomy to establish guidelines or protocols for ED pain management, development of evidence-based, coordinated pain treatment guidelines, opposes non-evidence-based limits on prescribing opiates, and work with government and regulatory bodies on the creation of evidence supported guidelines for responsible emergency prescribing.

Resolution 16(12) Development of Guidelines for the Treatment of Chronic Pain not adopted. Directed ACEP to support state autonomy to establish guidelines for treatment of patients with chronic pain who present to the ED requesting significant doses of narcotic pain medications or other controlled substances, including the establishment of referral networks to existing pain treatment centers.

Prior Board Action

February 2020, approved changing the name of the ED Pain & Addiction Management Accreditation Program to Pain & Addiction Care in the ED (PACED).

Amended Resolution 34(19) Opposing Naloxone Addition to the Prescription Drug Monitoring Program adopted.

Substitute Resolution 23(19) Expanding Emergency Physician Utilization and Ability to Prescribe Buprenorphine adopted.

June 2019, approved the governance charter, revised accreditation criteria, and funding for the ED Pain & Addiction Management Accreditation Program.

April 2019, reviewed the draft criteria for the ED Pan Management Accreditation Program.'

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.

September 2018, approved creation of the Emergency Department Pain & Addiction Management Accreditation Program.

February 2018, revised and approved the policy statement "Ensuring Emergency Department Patient Access to Appropriate Pain Treatment;" originally approved October 2012.

April 2017, approved the revised policy statement "Optimizing the Treatment of Acute Pain in the Emergency Department;" originally approved June 2009 with the title "Optimizing the Treatment of Pain in Patients with Acute Presentations." This is a joint policy statement with the American Academy of Emergency Nurse Practitioners, the Emergency Nurses Association, and the Society for Academic Emergency Medicine.

Amended Resolution 23(16) Medical Medication Assisted Therapy for Patients with Substance Use Disorders in the ED adopted.

Resolution 21(16) Best Practices for Harm Reduction Strategies adopted.

June 2016, approved the revised policy statement "Naloxone Access and Utilization for Suspected Opioid Overdoses;" originally approved October 2015.

October 2015, approved the policy statement "Naloxone Prescriptions by Emergency Physicians."

Amended Resolution 42(14) Reverse an Overdose, Save a Life adopted.

Amended Resolution 44(13) Prescription Drug Overdose Deaths adopted.

Amended Resolution 17(12) Ensuring ED Patient Access to Adequate and Appropriate Pain Treatment adopted.

June 2012, approved the Clinical Policy: Critical Issues in the Prescribing of Opioids for Adult Patients in the Emergency Department.

Background Information Prepared by: Ryan McBride, MPP
Senior Congressional Lobbyist

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 40(21)

SUBMITTED BY: Missouri Chapter
Ohio Chapter
Pennsylvania College of Emergency Physicians

SUBJECT: Reimbursement for Naloxone Distributed from Emergency Departments

PURPOSE: Advocate for state and federal laws requiring payers to reimburse EDs, hospitals, and other healthcare facilities for naloxone distributed but not administered to patients at risk for suffering an overdose event.

FISCAL IMPACT: Budgeted committee and staff resources to draft model legislation and federal and state advocacy initiatives.

WHEREAS, Bystander naloxone has been demonstrated to reduce mortality from opioid overdose while also being cost-effective[1,2]; and

WHEREAS, Despite the availability in many pharmacies and community organizations through standing orders and other local, state, and federally funded programs, most patients who are treated in an emergency department (ED) do not obtain naloxone within a month of their index ED visit[3]; and

WHEREAS, Emergency department initiated naloxone distribution programs are feasible and associated with increased community naloxone availability; and

WHEREAS, Medications provided to patients in the emergency department for use at home are not reimbursed by insurers or managed care organizations; and

WHEREAS, The Centers for Medicare and Medicaid Services (CMS) and most insurance companies provide coverage, often without co-pay, for prescription naloxone; and

WHEREAS, In 2021, CMS approved payment for distribution of opioid antagonist medications, specifically naloxone, under Opioid Treatment Provider medication agreements[4]; and

WHEREAS, Several states, including Colorado, are considering or have enacted laws requiring insurers and managed care organizations within that state to reimburse healthcare facilities for naloxone distributed to patients for future overdose reversals, if needed[5]; therefore be it

RESOLVED, That ACEP advocate for state and federal laws requiring payers to reimburse emergency departments, hospitals, and other healthcare facilities for naloxone distributed but not administered to patients at risk for suffering an overdose event.

References

1. Walley AY et al. Opioid overdose rates and implementation of overdose education and nasal naloxone distribution in Massachusetts: interrupted time series analysis. BMJ. 2013 Jan 30; 346:f174.
2. Coffin PO, Sullivan SD. Cost-effectiveness of distributing naloxone to heroin users for lay overdose reversal. Ann Intern Med 2013;158:1–9.
3. Kilaru AS, Liu M, Gupta R, Perrone J, Delgado MK, Meisel ZF, Lowenstein M. Naloxone prescriptions following emergency department encounters for opioid use disorder, overdose, or withdrawal. Am J Emerg Med. 2021 Mar 24;47:154-157. doi: 10.1016/j.ajem.2021.03.056. Epub ahead of print. PMID: 33812332.
4. Opioid Treatment Programs (OTP) | CMS Accessed 6/11/2021
5. Harm Reduction Substance Use Disorders | Colorado General Assembly Accessed 6/11/2021

Background

This resolution directs the College to advocate for state and federal laws requiring payers to reimburse emergency departments, hospitals, and other healthcare facilities for naloxone distributed but not administered to patients at risk for suffering an overdose event.

Since 2012, ACEP has promoted the use of non-opioid analgesics to treat pain and has engaged in addressing prescribing patterns in the ED. However, ED physicians are responsible for less than 5% of total opioid prescribing nationwide, and changing prescribing patterns does little for our patients already suffering from opioid use disorder. The Department of Health and Human Services (DHHS) has recognized the emergency department as one of the first places individuals with a substance use disorder will seek treatment. In 2017, DHHS declared the opioid crisis a public health emergency, which in turn spurred the ACEP Pain Management & Addiction Medicine Section to develop a guideline on the initiation of medication for Opioid Use Disorder (OUD) for appropriate ED patients, advocate for policy changes that lower regulatory barriers to initiating Medication-Assisted Treatment (MAT) in the ED, and support expansion of outpatient and inpatient opioid treatment programs.

The treatment of opioid use disorder in the ED has been associated with increased rates of outpatient treatment linkage and decreased drug use when compared to patients referred to the ED. The ED has also been increasingly recognized as a venue for the identification and initiation of treatment for opioid use disorder.[1] ACEP is preparing clinical guidance for standardizing naloxone education and prescribing in the ED so emergency physicians can submit appropriate documentation for reimbursement.

At the federal level, ACEP has asked agencies for additional reimbursement for naloxone. In the Calendar Year (CY) 2021 Physician Fee Schedule, the Centers for Medicare & Medicaid Services (CMS) instituted a policy allowing opioid treatment programs (OTPs) to offer naloxone to Medicare beneficiaries as part of a new benefit that CMS established to provide treatment to patients with OUD. This benefit only applies to services delivered by OTPs. In our comments on the regulation, ACEP stated that we believe some services allowable under the benefit, such as the administration of naloxone, should also be paid for when delivered in the ED. Specifically, we requested that CMS allow EDs to get reimbursed for administering naloxone and emergency physicians and other clinicians working in EDs to get compensated for the time that is spent counseling patients on how to appropriately use naloxone at home.

Reimbursement for naloxone distribution at the state level depends on a patchwork of hospital, insurer, pharmacy, state, and federal policies and regulations. Some communities have already established a naloxone distribution program in which local hospitals and their emergency departments participate, however this is largely on a voluntary basis without adequate reimbursement for the emergency physician's work. Certain state Medicaid programs make it possible for emergency physicians to bill the patient's insurance for naloxone and the education provided to the patient. Private insurers have been willing to pay for naloxone prescriptions through participating pharmacies, however advocacy efforts reveal that most insurers believe patients should shoulder much of the costs for naloxone.

The complexities of gaining adequate reimbursement for naloxone distribution in the ED at the state and federal level also apply to coding and billing principles. Professional service codes are determined based on the "complexity and intensity of work performed by an emergency physician and include the cognitive effort expended by the physician." The facility or technical coding guidelines reflect the "volume and intensity of resources utilized by the facility to provide patient care." Unlike professional ED Evaluation and Management (E/M) billing, the Centers for Medicaid and Medicare Services (CMS) does not have any standard guidelines for facility level coding. These coding and billing complexities make it difficult to capture the complexity and intensity of the ED encounter when distribution of naloxone is not the primary reason why a patient is seeking treatment.

Given the high prevalence of unmet substance abuse needs among ED patients, and increasing frequency of drug related ED visits, emergency physicians have an opportunity to prevent opioid overdose deaths. ED naloxone distribution is one way to provide a lifesaving intervention to patients at risk for opioid overdose.

---

[1] Consensus Recommendations on the Treatment of Opioid Use Disorder in the Emergency Department. Hawk, Kathryn et al. Annals of Emergency Medicine, Volume 78, Issue 3, 434 – 442

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective E – Pursue strategies for fair payment and practice sustainability to ensure patient access to care.
  - Tactic 9 – Create and promote resources on fair payment issues for the membership.

Fiscal Impact

Budgeted committee and staff resources to draft model legislation and federal and state advocacy initiatives.

Prior Council Action

Substitute Resolution 23(19) Expanding Emergency Physician Utilization and Ability to Prescribe Buprenorphine adopted. Directed ACEP to work directly with the DEA and SAMHSA to minimize barriers emergency physicians to enact meaningful therapy for patients; advocate to the DEA and SAMHSA for ED-specific requirements and curriculum to reach the greatest number of patients safely and without onerous barriers; and continue advocating for the removal of the DEA X-waiver requirement for emergency physicians who prescribe a bridging course of buprenorphine for opioid use disorder from an ED setting.

Amended Resolution 47(18) Supporting Medication for Opioid Use Disorder adopted. Directed ACEP to work with Pain Management & Addiction Medicine Section to develop a guideline on the initiation of medication for OUD for appropriate ED patients, advocate for policy changes that lower regulatory barriers to initiating MAT in the ED, and support expansion of outpatient and inpatient opioid treatment programs.

Amended Resolution 23(16) Medical Medication Assisted Therapy for Patients with Substance Use Disorders in the ED adopted. The resolution directed ACEP to provide education to emergency physicians on ED-initiated treatment of patients with substance use disorders and support through advocacy the availability and access to novel induction programs such as buprenorphine from the ED.

Resolution 21(16) Best Practices for Harm Reduction Strategies adopted. Directed ACEP to set a standard for linking patients with a Substance Use Disorder to an appropriate potential treatment resource after receiving medical care from the ED.

Amended Resolution 42(14) Reverse an Overdose, Save a Life adopted. The resolution directed ACEP to advocate and support Naloxone use by first responders, availability of Naloxone Over the Counter (OTC), and support research of the effectiveness of ED-initiated overdose education.

Amended Resolution 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.

Resolution 39(13) Naloxone Prescriptions in the ED not adopted. Called for ACEP to support and advise 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.

Resolution 38(13) Naloxone as an Over the Counter (OTC) Drug not adopted. Called for ACEP to adopt a policy in support of Naloxone becoming available as an OTC drug and promote education and safeguards for its use.

Prior Board Action

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.

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.

February 2018, approved the revised policy statement "Ensuring Emergency Department Patient Access to Appropriate Pain Treatment;" originally approved October 2012.

April 2017, approved the revised policy statement "Optimizing the Treatment of Acute Pain in the Emergency Department;" originally approved June 2009 with the title "Optimizing the Treatment of Pain in Patients with Acute Presentations." This is a joint policy statement with the American Academy of Emergency Nurse Practitioners, the Emergency Nurses Association, and the Society for Academic Emergency Medicine.

Amended Resolution 23(16) Medical Medication Assisted Therapy for Patients with Substance Use Disorders in the ED adopted.

Resolution 21(16) Best Practices for Harm Reduction Strategies adopted.

June 2016, approved the revised policy statement "Naloxone Access and Utilization for Suspected Opioid Overdoses;" originally approved October 2015.

October 2015, approved the policy statement "Naloxone Prescriptions by Emergency Physicians."

Amended Resolution 42(14) Reverse an Overdose, Save a Life adopted.

Amended Resolution 39(14) Naloxone Prescriptions by Emergency Physicians adopted.

June 2012, approved the Clinical Policy: Critical Issues in the Prescribing of Opioids for Adult Patients in the Emergency Department.

Background Information Prepared by: Adam Krushinskie, MPA
Reimbursement Manager

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 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(21)

SUBMITTED BY: Donald E. Stader, MD, FACEP
Nathan M. Novotny
John Spartz
Emergency Medicine Residents' Association
Colorado Chapter
New Jersey Chapter
Massachusetts College of Emergency Physicians
Pain Management & Addiction Medicine Section
Social Emergency Medicine Section

SUBJECT: Take Home Naloxone Programs in Emergency Departments

PURPOSE: 1) Amend ACEP's policy statement "Naloxone Prescriptions by Emergency Physicians" to include endorsement for Take Home Naloxone programs. 2) Seek to increase distribution of naloxone from the ED. 3) Promote Take Home Naloxone programs as a best practice for patients at risk of opioid overdose. 4) Advocate for regulatory and payment reform for reimbursement to hospitals and EDs for naloxone dispensed directly to patients. 5) Promote educating emergency physicians about strategies to implement Take Home Naloxone programs in their ED.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, According to the Centers for Disease Control and Prevention, there have been 841,000 drug overdose deaths in the United States from 1999-2019[1] with 70% of overdoses involving an opioid in 2019[2]; and

WHEREAS, Deaths attributed to overdoses involving prescription opioids, synthetic opioids or heroin have increased six-fold from 1999-2019[1]; and

WHEREAS, Contamination of stimulants (e.g., cocaine, methamphetamine, etc.) with synthetic opioids has significantly increased in the past decade, increasing overdose by unintentional ingestion of synthetic opioids in opioid-naive individuals[30-32]; and

WHEREAS, Emergency department (ED) visits among people aged ≥11 years for opioid overdoses in the United States increased 29.7% overall from July 2016–September 2017[3] and opioid overdose deaths increased by 6% from 2018-2019[4]; and

WHEREAS, Available data indicate that the COVID-19 pandemic has caused opioid-related overdoses to further increase from 2020 until present [5-7]; and

WHEREAS, Research shows that people who have one overdose are more likely to have another[8] and a commission report from Delaware found that 52% of people who died of an overdose were seen in an emergency department within three months of a non-fatal opioid-involved overdose[9]; and

WHEREAS, Existing data indicates that layperson administration of naloxone is effective in preventing death and increasing the recovery rates from opioid-related overdose[10,11]; and

WHEREAS, Community members most likely to administer naloxone to reverse opioid overdoses are people who actively use drugs[12]; and

WHEREAS, Barriers such as cost, lack of insurance coverage and patient refusal lead to dismal fill rates of naloxone, including in three studies which demonstrated that approximately 1% of naloxone of ED prescriptions were filled[13,14,33]; and

WHEREAS, People who use drugs are less likely to access a pharmacy for naloxone for fear of consequences, shame, and stigma[15-17]; and

WHEREAS, Virtually all existing data on Take Home Naloxone (THN) programs demonstrate that they are markedly effective in reducing opioid-involved overdose deaths[18-23]; and

WHEREAS, One study indicates that at least two-thirds of patients using opioids indicated that they would accept naloxone given as part of a THN program[24]; and

WHEREAS, It has thus been suggested that THN programs in the ED would increase the number of people who carry naloxone and therefore the number of lives that could be saved by naloxone in an overdose; and

WHEREAS, Multiple probabilistic analyses have projected that THN programs would be cost-effective even by conservative estimates[25-27]; and

WHEREAS, Many hospitals have difficulty with reimbursement for THN and hence are dependent on grant funding or donated naloxone, thereby limiting the willingness of many hospitals and ability of many emergency physicians to adopt this proven harm reduction intervention[28,29]; and

WHEREAS, Educational measures by ACEP have predominantly targeted increasing co-prescribing and use of standing orders, a tactic that has been shown to be largely ineffective; therefore be it

RESOLVED, That ACEP amend the current policy statement "Naloxone Prescriptions by Emergency Physicians" to include endorsement for Take Home Naloxone programs in emergency departments; and be it further

RESOLVED, That ACEP seek to increase the distribution of naloxone from the emergency department by researching and advocating for a standardized, lower barrier, and cost-effective take-home model for naloxone for at risk patients; and be it further

RESOLVED, That ACEP promote Take Home Naloxone programs as a best practice for patients at risk of opioid overdose and work toward increasing the number of Take Home Naloxone programs in emergency departments, partnering with other like-minded organizations, and promoting take home naloxone as a best practice; and be it further

RESOLVED, That ACEP advocate for regulatory and payment reform that would facilitate reimbursement to hospitals and emergency departments for naloxone dispensed directly to patients as part of Take Home Naloxone programs, thus removing financial disincentives for hospitals to have Take Home Naloxone programs; and be it further

RESOLVED, That ACEP promote educating emergency physicians about strategies to implement Take Home Naloxone programs in their emergency department.

References

1. Centers for Disease Control and Prevention. CDC WONDER. Last Reviewed December 22, 2020. https://wonder.cdc.gov/
2. Mattson CL, Tanz L, Quinn K, Kariisa M, Patel P, Davis N. Trends and Geographic Patterns in Drug and Synthetic Opioid Overdose Deaths — United States 2013–2019. *MMWR Morb Mortal Wkly Rep*. 2021;70. doi:10.15585/mmwr.mm7006a4
3. Vivolo-Kantor AM, Seth P, Gladden RM, et al. Vital Signs: Trends in Emergency Department Visits for Suspected Opioid Overdoses — United States, July 2016–September 2017. MMWR Morb Mortal Wkly Rep 2018;67:279–285. DOI: http://dx.doi.org/10.15585/mmwr.mm6709e1
4. Centers for Disease Control and Prevention. Understanding the Epidemic. Last Reviewed March 17, 2021. https://www.cdc.gov/drugoverdose/epidemic/index.html

5. Haley DF, Saitz R. The Opioid Epidemic During the COVID-19 Pandemic. JAMA. 2020;324(16):1615-1617. doi:10.1001/jama.2020.18543
6. Slavova S, Rock P, Bush HM, Quesinberry D, Walsh SL. Signal of increased opioid overdose during COVID-19 from emergency medical services data. Drug Alcohol Depend. 2020;214:108176. doi:10.1016/j.drugalcdep.2020.108176
7. Ochalek TA, Cumpston KL, Wills BK, Gal TS, Moeller FG. Nonfatal Opioid Overdoses at an Urban Emergency Department During the COVID-19 Pandemic. JAMA. 2020;324(16):1673-1674. doi:10.1001/jama.2020.17477
8. Suffoletto B, Zeigler A. Risk and protective factors for repeated overdose after opioid overdose survival. Drug Alcohol Depend. 2020;209:107890. doi:10.1016/j.drugalcdep.2020.107890
9. June 2019 Commission Report. Delaware Drug Overdose Fatality Review Commission. 2019. https://attorneygeneral.delaware.gov/wp-content/uploads/sites/50/2019/07/2019-Delaware-Drug-Overdose-Fatality-Review-Commission-Report-Final.pdf
10. Giglio RE, Li G, DiMaggio CJ. Effectiveness of bystander naloxone administration and overdose education programs: a meta-analysis. Inj Epidemiol. 2015;2(1):10. doi:10.1186/s40621-015-0041-8
11. Walley AY, Xuan Z, Hackman HH, et al. Opioid overdose rates and implementation of overdose education and nasal naloxone distribution in Massachusetts: interrupted time series analysis. BMJ. 2013;346:f174. Published 2013 Jan 30. doi:10.1136/bmj.f174
12. Rowe C, Santos GM, Vittinghoff E, Wheeler E, Davidson P, Coffin PO. Predictors of participant engagement and naloxone utilization in a community-based naloxone distribution program. Addiction. 2015;110(8):1301-1310. doi:10.1111/add.12961
13. Spivey CA, Wilder A, Chisholm-Burns MA, Stallworth S, Wheeler J. Evaluation of naloxone access, pricing, and barriers to dispensing in Tennessee retail community pharmacies. J Am Pharm Assoc (2003). 2020;60(5):694-701.e1. doi:10.1016/j.japh.2020.01.030
14. Ruff AL, Seiler K, Brady P, Fendrick AM. Naloxone fill rates after opioid overdose. J Addict Med Ther Sci. 2019;5(1):001-002. DOI: 10.17352/2455-3484.000027
15. Davis CS, Carr D. Over the counter naloxone needed to save lives in the United States. Prev Med. 2020;130:105932. doi:10.1016/j.ypmed.2019.105932
16. Green TC, Case P, Fiske H, et al. Perpetuating stigma or reducing risk? Perspectives from naloxone consumers and pharmacists on pharmacy-based naloxone in 2 states. J Am Pharm Assoc (2003). 2017;57(2S):S19-S27.e4. doi:10.1016/j.japh.2017.01.013
17. Corrigan PW, Nieweglowski K. Stigma and the public health agenda for the opioid crisis in America. Int J Drug Policy. 2018;59:44-49. doi:10.1016/j.drugpo.2018.06.015
18. Maxwell S, Bigg D, Stanczykiewicz K, Carlberg-Racich S. Prescribing naloxone to actively injecting heroin users: a program to reduce heroin overdose deaths. J Addict Dis. 2006;25(3):89-96. doi:10.1300/J069v25n03_11
19. Bird SM, McAuley A, Perry S, Hunter C. Effectiveness of Scotland's National Naloxone Programme for reducing opioid-related deaths: a before (2006-10) versus after (2011-13) comparison. Addiction. 2016;111(5):883-891. doi:10.1111/add.13265
20. Noveloso B, Singh J, Coombs S. Are take-home naloxone programs effective in reducing mortality from heroin use in patients with a history of heroin overdose?. Evidence-Based Practice. 2020;23(4)27-28. doi: 10.1097/EBP.0000000000000625
21. McDonald R, Strang J. Are take-home naloxone programmes effective? Systematic review utilizing application of the Bradford Hill criteria. Addiction. 2016;111(7):1177-1187. doi:10.1111/add.1332
22. Parmar MK, Strang J, Choo L, Meade AM, Bird SM. Randomized controlled pilot trial of naloxone-on-release to prevent post-prison opioid overdose deaths. Addiction. 2017;112(3):502-515. doi:10.1111/add.13668
23. Chimbar L, Moleta Y. Naloxone Effectiveness: A Systematic Review. J Addict Nurs. 2018;29(3):167-171. doi:10.1097/JAN.0000000000000230
24. Kestler A, Buxton J, Meckling G, et al. Factors Associated With Participation in an Emergency Department-Based Take-Home Naloxone Program for At-Risk Opioid Users. Ann Emerg Med. 2017;69(3):340-346. doi:10.1016/j.annemergmed.2016.07.027
25. Coffin PO, Sullivan SD. Cost-effectiveness of distributing naloxone to heroin users for lay overdose reversal in Russian cities. J Med Econ. 2013;16(8):1051-1060. doi:10.3111/13696998.2013.811080
26. Langham S, Wright A, Kenworthy J, Grieve R, Dunlop WCN. Cost-Effectiveness of Take-Home Naloxone for the Prevention of Overdose Fatalities among Heroin Users in the United Kingdom. Value Health. 2018;21(4):407-415. doi:10.1016/j.jval.2017.07.014
27. Coffin PO, Sullivan SD. Cost-effectiveness of distributing naloxone to heroin users for lay overdose reversal [published correction appears in Ann Intern Med. 2017 May 2;166(9):687]. Ann Intern Med. 2013;158(1):1-9. doi:10.7326/0003-4819-158-1-201301010-00003
28. Eswaran V, Allen KC, Bottari DC, et al. Take-Home Naloxone Program Implementation: Lessons Learned From Seven Chicago-Area Hospitals. Ann Emerg Med. 2020;76(3):318-327. doi:10.1016/j.annemergmed.2020.02.013
29. Kim HS, Aks SE. Take-Home Naloxone and the Need for a Publicly Funded Naloxone Supply. J Addict Med. Published online February 1, 2021. doi:10.1097/ADM.0000000000000821
30. LaRue L, Twillman RK, Dawson E, et al. Rate of Fentanyl Positivity Among Urine Drug Test Results Positive for Cocaine or Methamphetamine [published correction appears in JAMA Netw Open. 2019 Oct 2;2(10):e1916040]. JAMA Netw Open. 2019;2(4):e192851. Published 2019 Apr 5. doi:10.1001/jamanetworkopen.2019.2851
31. Ciccarone D. The rise of illicit fentanyls, stimulants and the fourth wave of the opioid overdose crisis. Curr Opin Psychiatry. 2021;34(4):344-350. doi:10.1097/YCO.0000000000000717
32. Jones CM, Bekheet F, Park JN, Alexander GC. The Evolving Overdose Epidemic: Synthetic Opioids and Rising Stimulant-Related Harms. Epidemiol Rev. 2020;42(1):154-166. doi:10.1093/epirev/mxaa011
33. Kilaru AS, Liu M, Gupta R, et al. Naloxone prescriptions following emergency department encounters for opioid use disorder, overdose, or withdrawal [published online ahead of print, 2021 Mar 24]. Am J Emerg Med. 2021;47:154-157. doi:10.1016/j.ajem.2021.03.056

Background

This resolution calls on ACEP to amend the policy statement “Naloxone Prescriptions by Emergency Physicians” to include endorsement for Take Home Naloxone programs; seek to increase distribution of naloxone from the ED; promote Take Home Naloxone programs as a best practice for patients at risk of opioid abuse; advocate for regulatory

and payment reform for reimbursement to hospitals and emergency departments for naloxone dispensed directly to patients; and promote educating emergency physicians about strategies to implement Take Home Naloxone programs in their ED.

Since 2012, ACEP has promoted the use of non-opioid analgesics to treat pain and has engaged in addressing prescribing patterns in the ED. This has included the development of the Management of Acute Pain (MAP) in the Emergency Department Point of Care Tool. However, ED physicians are responsible for less than 5% of total opioid prescribing nationwide, and changing prescribing patterns does little for our patients already suffering from opioid use disorder. The Department of Health and Human Services (HHS) has recognized the emergency department as one of the first places individuals with a substance use disorder will seek treatment.

In 2017, the HHS Secretary declared the opioid crisis and public health emergency, which in turn spurred the ACEP Pain Management & Addiction Medicine Section to develop an updated EM-focused DATA 2000 X-Waiver training, followed by a guideline on the initiation of medication for OUD for appropriate ED patients. ACEP also continues to advocate for policy changes that lower regulatory barriers to initiating Medication-Assisted Treatment (MAT) in the ED, and support expansion of outpatient and inpatient opioid treatment programs. Additionally, ACEP has launched the Pain and Addiction Care in the Emergency Department (PACED) accreditation program.

The opioid overdose epidemic continues to claim tens of thousands of lives in the United States each year despite an aggressive, multifaceted approach. Increased ED visits and deaths during the COVID-19 pandemic have magnified the need to invest in care for people with substance use disorders. The Centers for Disease Control and Prevention (CDC) reported more than 81,000 drug overdose deaths in the 12 months ending in May 2020, which is the highest number ever recorded in a 12-month period in the United States. Further, over 70 percent of the nearly 71,000 drug overdose deaths in 2019 involved an opioid. The treatment of opioid use disorder in the ED has been associated with increased rates of outpatient treatment linkage and decreased drug use when compared to patients referred to the ED. The ED has also been increasingly recognized as a venue for the identification and initiation of treatment for opioid use disorder.

At the federal level, ACEP has asked agencies for additional reimbursement for naloxone. In the Calendar Year (CY) 2021 Physician Fee Schedule, the Centers for Medicare & Medicaid Services (CMS) instituted a policy allowing opioid treatment programs (OTPs) to offer naloxone to Medicare beneficiaries as part of a new benefit that CMS established to provide treatment to patients with OUD. This benefit only applies to services delivered by OTPs. In our comments on the regulation, ACEP stated that we believe some services allowable under the benefit, such as the administration of naloxone, should also be paid for when delivered in the ED. Specifically, we requested that CMS allow EDs to get reimbursed for administering naloxone, and emergency physicians and other clinicians working in EDs to get compensated for the time that is spent counseling patients on how to appropriately use naloxone at home.

Reimbursement for naloxone distribution at the state level depends on a patchwork of hospital, insurer, pharmacy, state, and federal policies and regulations. Some communities have already established a naloxone distribution program in which local hospitals and their emergency departments participate, however this is largely on a voluntary basis without adequate reimbursement for the emergency physician's work. Certain state Medicaid programs make it possible for emergency physicians to bill the patient's insurance for naloxone and the education provided to the patient. Private insurers have been willing to pay for naloxone prescriptions through participating pharmacies, however advocacy efforts reveal that most insurers believe patients should shoulder much of the costs for naloxone.

The complexities of gaining adequate reimbursement for naloxone distribution in the ED at the state and federal level also apply to coding and billing principles. Professional service codes are determined based on the "complexity and intensity of work performed by an emergency physician and include the cognitive effort expended by the physician." The facility or technical coding guidelines reflect the "volume and intensity of resources utilized by the facility to provide patient care." Unlike professional ED Evaluation and Management (E/M) billing, CMS does not have any standard guidelines for facility level coding. These coding and billing complexities make it difficult to capture the complexity and intensity of the ED encounter when distribution of naloxone is not the primary reason a patient is seeking treatment.

Given the high prevalence of unmet substance abuse needs among ED patients, and increasing frequency of drug related ED visits, emergency physicians have an opportunity to prevent opioid overdose deaths. ED naloxone distribution is one way to provide a lifesaving intervention to patients at risk for opioid overdose.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum, including rural areas.
- Objective C – Promote the value of emergency medicine and emergency physicians as essential components of the health care system.
- Objective E – Pursue strategies for fair payment and practice sustainability to ensure patient access to care.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Substitute Resolution 23(19) Expanding Emergency Physician Utilization and Ability to Prescribe Buprenorphine adopted. Directed ACEP to work directly with the DEA and SAMHSA to minimize barriers for emergency physicians to enact meaningful therapy for patients in a time of opioid crisis; advocate to the DEA and SAMHSA for ED-specific requirements and curriculum to reach the greatest number of patients safely and without onerous barriers; and continue to advocate for the removal of the DEA X-waiver requirement for emergency physicians who prescribe a bridging course of buprenorphine for opioid use disorder from an ED setting.

Amended Resolution 47(18) Supporting Medication for Opioid Use Disorder adopted. Directed ACEP to work with Pain Management & Addiction Medicine Section to develop a guideline on the initiation of medication for OUD for appropriate ED patients, advocate for policy changes that lower regulatory barriers to initiating MAT in the ED, and support expansion of outpatient and inpatient opioid treatment programs.

Amended Resolution 23(16) Medical Medication Assisted Therapy for Patients with Substance Use Disorders in the ED adopted. The resolution directed ACEP to provide education to emergency physicians on ED-initiated treatment of patients with substance use disorders and support through advocacy the availability and access to novel induction programs such as buprenorphine from the ED.

Resolution 21(16) Best Practices for Harm Reduction Strategies adopted. Directed ACEP to set a standard for linking patients with a Substance Use Disorder to an appropriate potential treatment resource after receiving medical care from the ED.

Amended Resolution 42(14) Reverse an Overdose, Save a Life adopted. The resolution directed ACEP to advocate and support Naloxone use by first responders, availability of Naloxone Over the Counter (OTC), and support research of the effectiveness of ED-initiated overdose education.

Amended Resolution 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.

Resolution 39(13) Naloxone Prescriptions in the ED not adopted. The resolution called for supporting and advising 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.

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.

Amended Resolution 17(12) Ensuring ED Patient Access to Adequate and Appropriate Pain Treatment adopted. The resolution supports chapter autonomy to establish guidelines or protocols for ED pain management, development of evidence-based, coordinated pain treatment guidelines, opposes non-evidence-based limits on prescribing opiates, and work with government and regulatory bodies on the creation of evidence supported guidelines for responsible emergency prescribing.

Resolution 16(12) Development of Guidelines for the Treatment of Chronic Pain not adopted. Directed ACEP to support state autonomy to establish guidelines for treatment of patients with chronic pain who present to the ED requesting significant doses of narcotic pain medications or other controlled substances, including the establishment of referral networks to existing pain treatment centers.

Prior Board Action

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

Amended Resolution 23(19) Expanding Emergency Physician Utilization and Ability to Prescribe Buprenorphine adopted.

Amended resolution 47(18) Supporting Medication for Opioid Use Disorder adopted.

February 2018, approved the revised policy statement "Ensuring Emergency Department Patient Access to Appropriate Pain Treatment;" originally approved October 2012 titled "Ensuring Emergency Department Access to Adequate and Appropriate Pain Treatment."

April 2017, approved the revised policy statement "Optimizing the Treatment of Acute Pain in the Emergency Department;" originally approved June 2009 with the title "Optimizing the Treatment of Pain in Patients with Acute Presentations." This is a joint policy statement with the American Academy of Emergency Nurse Practitioners, the Emergency Nurses Association, and the Society for Academic Emergency Medicine.

Amended Resolution 23(16) Medical Medication Assisted Therapy for Patients with Substance Use Disorders in the ED adopted.

Resolution 21(16) Best Practices for Harm Reduction Strategies adopted.

June 2016, approved the revised policy statement "Naloxone Access and Utilization for Suspected Opioid Overdoses;" originally approved October 2015.

October 2015, approved the policy statement "Naloxone Prescriptions by Emergency Physicians."

Amended Resolution 42(14) Reverse an Overdose, Save a Life adopted.

Amended Resolution 39(14) Naloxone Prescriptions by Emergency Physicians adopted.

Amended Resolution 17(12) Ensuring ED Patient Access to Adequate and Appropriate Pain Treatment adopted.

June 2012, approved the Clinical Policy: Critical Issues in the Prescribing of Opioids for Adult Patients in the Emergency Department.

Background Information Prepared by: Jeffrey Davis
Regulatory and External Affairs Director

Sam Shahid, MBBS, MPH
Practice Management Manager

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2021 Council Meeting
Reference Committee Members

Reference Committee C – Emergency Medicine Practice
Resolutions 42-59

L. Carlos Zapata, MD, FACEP (NY) Chair
Purva Grover, MD, FACEP (OH)
Jonathan Hansen, MD, FACEP (MD)
Jeffrey Linzer, MD, FACEP (GA)
Eric Maur, MD, FACEP (NC)
Sandra Williams, DO, FACEP (TX)

Travis Schulz, MLS, AHIP
Kaeli Vandertulip, MBA, MSLS, AHIP

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 42(21)

SUBMITTED BY: Laura Janneck, MD, FACEP
Nikkole Turgeon, BS
Disaster Medicine Section
Diversity, Inclusion, & Health Equity Section
International Emergency Medicine Section
Social Emergency Medicine Section
Young Physicians Section

SUBJECT: Administration of COVID-19 Vaccines in the Emergency Department

PURPOSE: Advocate for the administration of vaccines against COVID-19 to qualified patients that present to the ED and support development of best practices addressing vaccine hesitancy and allow for capacity building and integration of COVID-19 vaccination programs in the ED.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, COVID-19 continues to threaten the public health of communities across the United States and around the world; and

WHEREAS, New more contagious variants are experience resurgences in various communities; and

WHEREAS, Vaccination against COVID-19 is the most effective means of controlling the epidemic at a public health level[1]; and

WHEREAS, Vaccination against COVID-19 is highly effective for reducing individual risk of infection[1]; and

WHEREAS, Populations served in emergency departments are often underserved by the larger healthcare system and may have reduced access to COVID-19 vaccinations; and

WHEREAS, There are lower vaccination rates among historically marginalized communities, such as Black and Hispanic people, leaving them at increased risk for coronavirus, potentially leading to widening disparities going forward[2]; and

WHEREAS, Emergency departments often serve as safety nets for vulnerable patient populations and have played a key role many prior public health interventions[3]; and,

WHEREAS, Clinical encounters in the emergency department offer opportunity to discuss patients' questions and concerns about vaccination; and

WHEREAS, Emergency department vaccine distribution initiatives can play a critical role in mitigating the COVID-19 pandemic[4]; therefore be it

RESOLVED, That ACEP advocate for the administration of vaccines against COVID-19 to qualified patients that present to the emergency department (ED); and be it further

RESOLVED, That ACEP support the development of best practices for discussing COVID-19 vaccines with patients, clinical decision making around when to administer the vaccine, building capacity to administer vaccines to emergency department patients, and integrating ED vaccination programs into larger community vaccination efforts.

References

1. Centers for Disease Control and Prevention // Key Things to Know About COVID-19 Vaccines https://www.cdc.gov/coronavirus/2019-ncov/vaccines/keythingstoknow.html?s_cid=10493:cdc%20covid%20vaccine:sem.ga:p:RG:GM:gen:PTN:FY21 Accessed July 19th, 2021.
2. Kaiser Family Foundation. Latest data on COVID-19 vaccinations by race/ethnicity. Published July 8th, 2021. https://www.kff.org/coronavirus-covid-19/issue-brief/latest-data-on-covid-19-vaccinations-race-ethnicity/ Accessed July 19th, 2021.
3. Bernstein SL, D'Onofrio G. Public health in the emergency department: Academic Emergency Medicine consensus conference executive summary. Acad Emerg Med. 2009 Nov;16(11):1037-9. doi: 10.1111/j.1553-2712.2009.00548.x. PMID: 20053218.
4. ACEP // ACEP Toolkit for COVID-19 Emergency Department (ED) Vaccination Programs https://www.acep.org/contentassets/0d59136e8d4f48e19019a3874c0c5f80/acep-ed-covid-vaccine-toolkit.4.19.pdf Accessed July 19th, 2021.

Background

This resolution calls for ACEP to advocate for the administration of vaccines against COVID-19 to qualified patients that present to the ED and support the development of best practices addressing vaccine hesitancy and allow for capacity building and integration of COVID-19 vaccination programs in the ED.

Emergency departments see more than 150 million patients per year, some of whom have limited access to primary care. Therefore, EDs serve as a critical access juncture for those who may or may not have access to primary care or have other established linkages to the health care system and care. Patients coming to the ED may or may not have found the opportunity to get vaccinated and/or are hesitant. While emergency departments provide emergent care and traditionally do not address public health needs, there is some precedence for EDs giving vaccines (e.g., tetanus) and engaging in public health initiatives (e.g. offering HIV screening). ACEP supports emergency department based COVID vaccine programs and offers its members tools and resources to be vaccine advocates. Emergency physicians know that the option to get a vaccine in the ED can be an important opportunity to protect patients and promote public health and safety. As emergency physicians, ACEP members can help increase the number of people who are vaccinated. ACEP encourages its members to consider working with their emergency departments and institutions to provide vaccines to appropriate patients.

ACEP supports and advocates for ED-based COVID-19 vaccination programs and has developed and continues to update and adapt education, tools, and resources for its members to enable them to establish COVID-19 vaccination programs out of their EDs, hospitals, and institutions.

In 2020, ACEP received a federal grant from the CDC: “Frontline National Partnership to Control and Prevent Infectious Disease Threats.” Funding from this grant has been utilized to combat the COVID-19 pandemic but creating resources, tools, best practices and maintain an online resource centers, advocating and creating awareness, targeted towards both physicians and the public, and host virtual learning opportunities, live and on demand.

There are multiple open access resources that are currently available to ACEP members and anyone who is interested:

- COVID-19 Vaccination Toolkit
- COVID-19 ED Vaccination Program Resource center
- ACEP Toolkit for COVID-19 Emergency Department (ED) Vaccination Programs
- COVID-19 Vaccination Smart Phrases Now in Several Languages
- ACEP Field Guide Chapter on Vaccinations and Prevention
- COVID-19 Vaccine Resource Center
- Webinar: COVID-19 Vaccinations in the Emergency Department (on demand)

ACEP has also developed numerous resources addressing vaccine hesitancy:

- Patient Poster and Flyer from ACEP's Diversity and Inclusion Section

- Webinar: This Is Our Shot: How EM Docs Can Empower Patients to End the Pandemic (on demand)
- ACEP's Public COVID-19 Vaccine Information Center
- The Language of COVID-19 Vaccine Acceptance

We have had more than 100 members access the webinars and the number of EDs providing COVID-19 Vaccination continues to increase. ACEP continues to advocate for COVID-19 vaccinations (including prioritization of emergency physicians for the COVID-19 Booster):

- ACMT/AAEM/ACEP Joint Statement in Support of COVID-19 Vaccine
- ACEP support of the Joint Statement in Support of COVID-19 Vaccine Mandates for All Workers in Health and Long-Term Care
- Vaccine related Press Releases:
  - ACEP Urges FDA to Prioritize Emergency Physicians for COVID-19 Booster (August 13, 2021
  - Emergency Physicians Increase their Calls for Concerns around COVID-19 Delta Variant and Support Mandate to Vaccinate Healthcare Workers (July 28, 2021)
  - Emergency Physicians Encourage Vaccines and Vigilance in Face of New COVID Surge (July 21, 2021)

ACEP Now articles:
- COVID-19 Vaccine Hesitancy Info and Tips (May 18, 2021)
- Opinion: Let's Give Vaccination Programs a Shot (February 24, 2021)

Annals of Emergency Medicine publications:
- Research Forum Special Edition: COVID 2021 Abstracts
  - Implementation of an Ed-Based COVID-19 Vaccine Program. Maloney, G. et al. Annals of Emergency Medicine, Volume 78, Issue 2, S34
  - COVID-19 Vaccine Hesitancy Among Emergency Department Patients and Caregivers in New York City. Guzman, C. et al. Annals of Emergency Medicine, Volume 78, Issue 2, S12
  - Implementation of a COVID-19 Vaccine Emergency Department Education Program for Underserved Communities: A Pilot Quality Improvement Project. Bischof, J.J. et al. Annals of Emergency Medicine, Volume 78, Issue 2, S13
  - Perceptions of the COVID-19 Vaccine Amongst Health Care Workers in a Southeast Michigan Hospital: A Cross-Sectional Survey. Choi, T. et al. Annals of Emergency Medicine, Volume 78, Issue 2, S34 - S35
- The Rapid Evaluation of COVID-19 Vaccination in Emergency Departments for Underserved Patients Study. Rodriguez, Robert M.Nichol, Graham et al.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care
- Objective C – Promote the value of emergency medicine and emergency physicians as essential components of the health care system.
- Objective H – Position ACEP as a leader in emergency preparedness and response.

Fiscal Impact

Budgeted committee and staff resources and funding from a CDC grant.

Prior Council Action

None

Prior Board Action

None

Background Information Prepared by: Sam Shahid, MBBS, MPH
Practice Management Manager

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 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(21)

SUBMITTED BY: Paul D. Kivela, MD, MBA, FACEP
California Chapter

SUBJECT: Autonomous "Shared Governance" Due Process

PURPOSE: Directs ACEP to adopt and promote a practice of "shared governance based due process."

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Increasing numbers of emergency physicians are not owners of the medical practices and are either in independent contractor or employed status; and

WHEREAS, Many physicians were arbitrarily or punitively furloughed during the COVID-19 pandemic; and

WHEREAS, There are multiple examples during COVID that emergency physicians were not able to speak up about quality or their own personal safety without risk of losing their jobs; and

WHEREAS, The legal owners and/or decision makers of whom staffs are often not practicing physicians; and

WHEREAS, ACEP has made this a priority item by helping to sponsor federal legislation on due process; and

WHEREAS, The corporate practice of medicine doctrine encapsulates the principle that physicians must make decisions autonomously and although its application varies in the roughly 30 states that follow it, the basic idea is that a business corporation may not practice medicine or employ physicians or other clinical personnel to provide professional medical services; and

WHEREAS, Many emergency physicians have contracts that require them to forego their due process rights afforded other specialties; and

WHEREAS, Many medical groups/employers engage in a process of simply not scheduling a physician or arbitrarily removing them from a schedule instead of granting them a hearing; and

WHEREAS, It has been reported that some corporate entities are replacing emergency physicians with lower cost providers such as nurse practitioners and/or physicians assistants; and

WHEREAS, With an expected incoming surplus of emergency physicians, corporate entities may resort to replacing hire compensated experienced emergency physicians with lower cost providers; and

WHEREAS, Typical due process hearing are expensive and potentially punitive to the individual physician by being reportable to the National Practitioner Data Bank; and

WHEREAS, It is common sense that the practicing physicians at a contract have better insight to the standards of care in that community than administrators; and

WHEREAS, There is a similar paradigm in nursing where shared governance is a professional practice model that promotes nursing empowerment and shared decision making by making staff nurses accountable for decisions that impact policies, procedures, and processes at the point of care; therefore be it

RESOLVED, That ACEP adopt and promote a practice of "shared governance based due process" that has the following general qualities and that it applies to:

1. Employees of a hospital or health system.
2. Independent contractors or employees of a large group with a MSO
3. Independent contractors or employees of a small group

Definitions

1. Individual Physician (IP) requesting due process.
2. Management Service Organization (MSO) or individual or entity that makes decisions, negotiates contracts, or provides management. services. This can also apply to administrative physicians in small group or deans/chairs/administrative faculty.
3. Practicing physicians in Physician Group (PPG) would be the entity deciding that outcome of the IP and be limited to the physicians practicing in the group at that hospital in that department. Their vote would be based on number of clinical hours worked in the past six months. Groups could establish some type of seniority multiplier based on years worked or full votes to each full-time clinical physician based on a minimum hours such as 80/hours a month.

The hospital, health system, medical group, or MSO would still arrange and sign contracts with individual physicians (IP). However, in the event a hospital administration, MSO, or health system requests the immediate removal of an IP, or removes them from the schedule, or fails to schedule them for their usual numbers of shifts, the IP would have the opportunity to have a hearing before the PPG. The PPG would then determine if the IP should be immediately terminated or removed from the schedule. The proceedings/vote would be confidential, but results would be reported to the MSO. If the MSO or IP disagrees with the decision, the MSO or IP could still initiate a hospital medical staff due process complaint (if available to them), arbitration process, or legal remedy.

Background

The resolution directs the College to adopt and promote a practice of "shared governance based due process" as detailed in the resolved clause.

The shared governance (SG) concept is not uncommon among nursing staff in the hospital setting. According to an article from the Association for Nursing Professional Development (ANPD) entitled "Shared Governance: What it Is and Is Not," "shared governance is a structure and process for partnership, equity, accountability, and ownership. It puts the responsibility, authority, and accountability for practice-related decisions into the hands of the individuals who will operationalize the decision."

Some research suggests that the shared governance model has increased nurse job satisfaction and quality of care. A 2016 study in the Journal of Nursing Administration ("Nurse Engagement in Shared Governance and Patient and Nurse Outcomes") concluded that "Improving nurse engagement in SG may serve as a transformational leadership strategy to improve the patient experience—an outcome directly tied to reimbursement. Of additional financial interest to hospital administrators, greater involvement of nurses in SG is also associated with outcomes related to nurse retention and nurse-reported quality and safety of patient care."

While this structure empowers nurses to have meaningful input into decisions impacting their point-of-care practices, there are limitations on how much governance is shared. The ANPD article notes that "all involved in shared governance must have clarity that there are structures, processes, and outcomes that leadership will continue to have responsibility for, such as regulatory requirements, immediate safety concerns, performance management, and operations decisions such as hiring, salary, staffing, etc. Decisions related to practice are the ones that should be decided in a shared decision-making model."

Developing a shared governance model for physician group practices to include processes that ensure due process protections may be an extension of the typical shared governance model seen in the nursing community. The author of

the resolution provided these additional details about how such a program would work and pros and cons of the concept:

> "Nothing in this proposed solution would prevent the hospital or other entity from referring the IP to the hospital peer review, hospital-based due process, or outside third party or suspending an impaired physician or someone that provides an immediate danger to patient care. Administrative accusations would be transparent (not be subject to any confidentiality) and not be subject to any protections if done in bad faith."
>
> PROS:
> 1. Inexpensive and rapid
> 2. Not reportable to NPDB unless involves quality of care issue
> 3. Rests control to the actual doctors working the clinical shifts
> 4. Gives some innate whistleblower protections by establishing group protection
> 5. Protects physicians from impulsive and punitive moves by administration
>
> CONS:
> 1. Gives some legal protections and at the same time accountability to administration and practicing physicians
> 2. Administration/MSO can still initiate clauses of contract or not renew an IP or terminate the group
> 3. Might only give IP as little as 90 days-notice (based on contract) or as short as posted scheduled shifts. Nothing stops future non-scheduling unless number of shifts/hours written into contract."

ACEP has been working actively to improve due process protections for emergency physicians. In 2018, ACEP and seven other emergency medicine organizations signed a letter to then CMS Administrator Seema Verma. The letter noted that "Whether employed by hospitals or contracted groups, emergency physicians are often deprived of their due process rights via inclusion of a 'waiver of due process rights' clause in employment contracts. The letter requested CMS to guarantee physician due process rights by making them unwaivable and irrevocable. Also in 2018, ACEP and the other emergency medicine organizations supported the introduction of legislation that would prohibit the mandatory waiver of due process rights which many emergency physicians are forced to comply with as a condition of employment. An ACEP press release issued after introduction of the legislation quoted then president Dr. Paul Kivela, who stated "This is an important safeguard that will ensure all emergency physicians have access to a fair due process procedure."

The bill was introduced again in the 116th Congress as H.R. 6910, the "ER Hero and Patient Safety Act." A letter from then ACEP President Dr. William Jaquis was sent to the bi-partisan cosponsors of the new bill, Congressmen Raul Ruiz and Roger Marshall, reaffirming ACEP's support for legislation to ensure every emergency physician has due process rights. The letter notes, "The threat of termination or the actual termination of physicians without the right of a fair hearing prevents emergency physicians from fully advocating for their patients for fear of retribution. For these reasons, ACEP believes that all emergency physician contracts should include a due process clause regardless of whether those physicians are directly employed by a hospital or they provide emergency medical services at a hospital through a group or individual contract." ACEP is working to reintroduce the bill again in the current 117th Congress.

During the pandemic, emergency physicians have faced new threats to their employment. In a statement issued by ACEP, Dr. Jaquis stated, "Emergency physicians are prepared to handle virtually anything thrown at us as we seek to treat and heal our patients, however, we should not be forced to put our own lives at risk and have our jobs threatened simply for wearing our own supplied protective equipment."

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 policy statement has an accompanying Policy Resource and Education Paper (PREP), which states in part: "The core issue behind language in emergency medicine contracts having to do with termination of the physician's ability to practice is that of due process. Due process refers to the right to have a fair hearing, including input from the affected physician, prior to any decision being made about termination of the ability to practice (specifically the loss of hospital medical staff privileges). The concept of due process is felt to support the independence of a physician in advocating for patients without undue influence from extrinsic forces and preserves the sanctity of the physician-patient relationship. These forces may include non-medical concerns, such as financial, marketing, or political interests."

ACEP's policy statement "Emergency Physician Rights and Responsibilities" addresses the due process issue with revised language adopted in April 2021 that now states in part:

> "8. Emergency physicians are entitled to due process before any adverse final action with respect to employment or contract status, the effect of which would be the loss or limitation of medical staff privileges or their ability to see patients. Emergency physicians' medical and/or clinical staff privileges should not be reduced, terminated, or otherwise restricted except for grounds related to their competency, health status, limits placed by professional practice boards or state law."

ACEP staff is developing a questionnaire to be distributed 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. The questionnaire includes an attestation that the entities fully adhere to several ACEP policy statements as they pertain to the emergency physicians in their group, including "Emergency Physician Rights and Responsibilities" and "Emergency Physician Contractual Relationships."

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Member Engagement

- Objective H – Strengthen job security and opportunity for individual members at all stages of their careers.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Amended Resolution 44(20) Due Process in Emergency Medicine referred to the Board of Directors. The resolution called for the College to 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. The resolution further called for wording changes in the policy statement "Emergency Physician Rights and Responsibilities" and the adoption of a new policy requiring any entity that wants to advertise, exhibit, or provide other sponsorship of any ACEP activity to remove all restrictions on due process for emergency physicians.

Resolution 45(13) Revision of "AMA Principles for Physician Employment" referred to the Board of Directors. The resolution called for ACEP to work to amend the AMA Principles for Physician Employment to state that no physician employment agreement should limit a physician's right to due process as a member of the medical staff if terminated. The AMA Section Council on Emergency Medicine recommended that the AMA Organized Medical

Staff Section (OMSS) review the information and potentially submit a resolution to the AMA Interim Meeting in November 2014. However, AMA staff reported that the AMA amended the Principles for Physician Employment in June 2014 to address the issue of automatic termination of staff privileges following termination of an employment agreement (sections 3e and 5f) based on a report from the OMSS Governing Council that outlined the rationale for the amended language.

Resolution 29(11) Due Process for Emergency Physicians adopted. Called for ACEP to review and update the policy statement “Emergency Physician Contractual Relationships” regarding due process and distribute the updated policy to the American Hospital Association, the American College of Health Care Executives and other entities.

Amended Resolution 30(11) Emergency Physician Contracts and Medical Staff Activities/Membership adopted. Called for 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 17(03) Certificate of Compliance referred. 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.”

Amended Resolution 14(02) Emergency Physician Rights and Self-Disclosure defeated. The resolution called for ACEP to require exhibitors, advertisers, grant providers and sponsors who employ emergency physicians as medical care providers to disclose to their program audience their level of compliance with ACEP policies addressing due process and other emergency physician rights outlined in the policy statements “Emergency Physician Rights and Responsibilities,” Emergency Physician Contractual Relationships,” “Agreements Restricting the Practice of Emergency Medicine,” and “Compensation Arrangements for Emergency Physicians.” It would require that those claiming to be in substantial compliance with the policies must be able to support the claims by producing documentation for review, and those whose self-disclosure is determined through due process to be false would be prohibited from sponsoring, exhibiting, or advertising with ACEP.

Amended Resolution 14(01) Fair and Equitable EM Practice Environments adopted. The resolution called for 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 report back to the Council, 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.

Substitute Resolution 10(01) Commercial Sponsorships adopted. The substitute resolution called for ACEP to continue initiatives to develop and implement policies on self-disclosure by sponsors, grant providers, advertisers, and exhibitors at ACEP meetings regarding their compliance with ACEP physicians’ rights policies.

Amended Resolution 20(00) Due Process in Contracts Between Physicians and Hospitals, Health Systems, and Contract Groups adopted. Called for ACEP to endorse the right to have due process provisions in contracts between physicians, health systems, health plans and contract groups.

Resolution 59(95) Due Process for Emergency Physicians referred to the Board of Directors. The resolution called for ACEP to support, and incorporate into educational and advocacy efforts, promotion of the concepts of due process in all employment arrangements for emergency physicians, that any emergency physician being terminated has the right to receive the reasons for such termination and to formally respond to those reasons prior to the effective date of the termination.

Amended resolution 54(94) Due Process adopted in lieu of resolutions 52(94) Due Process Exclusion Clause and 54(94) Due Process. The amended resolution called for the College to study the issue of peer review and due process exclusion clauses in emergency physician contracts and report back to the Council.

Resolution 52(94) Due Process Exclusion Clauses not adopted. This resolution called for ACEP to lobby to ban peer review and due process exclusion clauses from emergency physician contracts. Amended Resolution 54(94) was adopted in lieu of 52(94).

Resolution 38(90) Due Process Rights of Hospital Based Physicians not adopted. This resolution called for ACEP to work with TJC to develop standards to protect due process rights of hospital-based physicians.

Prior Board Action

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 Rights and Responsibilities;" revised and approved October 2015, April 2008, July 2001; originally approved September 2000.

April 2021, approved the revised policy statement "Emergency Physician Contractual Relationships;" revised and approved June 2018, October 2012, January 2006, March 1999, and August 1993 with the current title; originally approved October 1984 titled "Contractual Relationships between Emergency Physicians and Hospitals."

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.

September 2018, approved the policy statement "Due Process for Physician Medical Directors of Emergency Medical Services."

January 2017, approved the revised policy statement "Code of Ethics for Emergency Physicians;" revised and approved June 2016, June 2008; reaffirmed October 2001; revised and approved June 1997 with the current title; originally approved January 1991 titled "Ethics Manual."

Resolution 29(11) Due Process for Emergency Physicians adopted.

Amended Resolution 30(11) Emergency Physician Contracts and Medical Staff Activities/Membership adopted.

September 2004, approved a report to the Council with a letter from the Federal Trade Commission regarding issues raised in Resolution 17(03) Certificate of Compliance and Resolution 18(03) Intention to Bid for Group Contract and agreed to take no further action on the resolutions.

Amended Resolution 14(01) Fair and Equitable EM 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 Groups adopted.

Amended Resolution 54(94) Due Process adopted.

Background Information Prepared by: Craig Price, CAE
Senior Director, Practice Affairs

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 44(21)

SUBMITTED BY: Lauren Apgar, DO
Leslie Gailloud
Logan Jardine, MD, MPH
Hannah Janeway, MD
Diversity, Inclusion, & Health Section
Social Emergency Medicine Section
Young Physicians Section

SUBJECT: Caring for Transgender and Gender Diverse Patients in the Emergency Department

PURPOSE: 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.

FISCAL IMPACT: Budgeted committee, section, and staff resources.

WHEREAS, Transgender (TGD) is a gender identity that is different from the sex assigned at birth and gender diverse (e.g., non-binary, gender queer, gender non-conforming, agender, gender fluid, two spirit) is used by people who do not identify exclusively as male or female[1]; and

WHERAS, TGD patients experience higher rates of suicide, substance use disorder, poverty, homelessness, HIV, unemployment, victimization, and are less likely to have health insurance than heterosexual or LGB individuals[2,3,4,5]; and

WHEREAS, The emergency department serves as a safety-net for many vulnerable populations; and

WHEREAS, TGD patients have negative experiences in the emergency department related to their gender identity[2,3,4]; and

WHEREAS, TGD patients often avoid seeking emergency medical care due to past negative experiences or due to fear of discrimination and bias related to their gender identity[2,3,4]; and

WHEREAS, There is limited graduate and post-graduate medical education on the appropriate treatment of TGD patients[6,7]; and

WHEREAS, There are limited continuing medical education courses and resources on how to care for patients presenting the emergency department; therefore be it

RESOLVED, That ACEP promote the equitable, culturally competent, and knowledgeable treatment of transgender and gender diverse patients receiving care in the emergency department; and be it further

RESOLVED, That ACEP compile information on the unique needs and best practices related to care of transgender and gender diverse patients in the emergency department; and be it further

RESOLVED, That ACEP encourage hospitals to provide adequate and appropriate education, training, and resources to all emergency department physicians on the needs and best practices related to care of transgender and gender diverse patients; and be it further

RESOLVED, That ACEP encourage emergency departments to foster and develop practices and policies that uphold supportive and inclusive environments and remove structural barriers to care.

References

1. Apa.org. 2015. Key Terms and Concepts in Understanding Gender Diversity and Sexual Orientation Among Students. [online] Available at: <https://www.apa.org/pi/lgbt/programs/safe-supportive/lgbt/key-terms.pdf> [Accessed 20 July 2021].
2. Bauer et. al. Reported Emergency Department Avoidance, Use and Experiences of Transgender Persons in Ontario, Canada: Results from a Respondent- Driven Sampling Survey, Ann Emerg Med. 2014;63:713-720
3. Chisolm-Straker M, Jardine L, Bennouna C, Morency-Brassard N, Coy L, Egemba MO, Shearer PL. Transgender and Gender Nonconforming in Emergency Departments: A Qualitative Report of Patient Experiences. Transgend Health. 2017 Feb 1;2(1):8-16. doi: 10.1089/trgh.2016.0026. PMID: 28861544; PMCID: PMC5367487.
4. James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). The Report of the 2015 U.S. Transgender Survey. Washington, DC: National Center for Transgender Equality
5. James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). The Report of the 2015 U.S. Transgender Survey. Washington, DC: National Center for Transgender Equality
6. Moll J, Krieger P, Moreno-Walton L, Lee B, Slaven E, James T, Hill D, Podolsky S, Corbin T, Heron SL. The prevalence of lesbian, gay, bisexual, and transgender health education and training in emergency medicine residency programs: what do we know? Acad Emerg Med. 2014 May;21(5):608-11. doi: 10.1111/acem.12368. PMID: 24842513.
7. Obedin-Maliver J, Goldsmith ES, Stewart L, White W, Tran E, Brenman S, Wells M, Fetterman DM, Garcia G, Lunn MR. Lesbian, gay, bisexual, and transgender-related content in undergraduate medical education. JAMA. 2011 Sep 7;306(9):971-7. doi: 10.1001/jama.2011.1255. PMID: 21900137.
8. Lech, Christie A. EMRA Transgender Care Guide. Emergency Medicine Residents' Association, 2018.
9. Janeway H, Coli CJ. Emergency care for transgender and gender-diverse children and adolescents. Pediatr Emerg Med Pract. 2020 Sep;17(9):1-20. Epub 2020 Sep 2. PMID: 32805092.
10. "AACAP Statement Responding to Efforts to Ban Evidence-Based Care for Transgender and Gender Diverse Youth." Aacap.org, The American Academy of Child & Adolescent Psychiatry , 8 Nov. 2019, www.aacap.org/AACAP/Latest_News/AACAP_Statement_Responding_to_Efforts-to_ban_Evidence-Based_Care_for_Transgender_and_Gender_Diverse.aspx.
11. "AAMC Statement on Gender-Affirming Health Care for Transgender Youth." AAMC, Association of American Medical Colleges, 9 Apr. 2021, www.aamc.org/news-insights/press-releases/aamc-statement-gender-affirming-health-care-transgender-youth.
12. Rafferty J; COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH; COMMITTEE ON ADOLESCENCE; SECTION ON LESBIAN, GAY, BISEXUAL, AND TRANSGENDER HEALTH AND WELLNESS. Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents. Pediatrics. 2018 Oct;142(4):e20182162. doi: 10.1542/peds.2018-2162. Epub 2018 Sep 17. PMID: 30224363.

Background

This resolution asks 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.

The March 2014 issue of *ACEP Now* article *"Transgender Patients in the ED"* brings to light the negative experiences and discrimination transgender patients experience due to the biases of health care providers. It outlines the importance of thoughtful communication with this patient population and the need to continue to educate through evidence-based guidelines to ensure quality care is given to address the unique needs of this specific patient population.

ACEP's course Emergency Care for Transgender Patients focuses on caring for transgender patients. The Emergency Medicine Residents' Association has created the Transgender Care Guide that provides basic medical knowledge and terminology and is directed to residents. This resolution requests that ACEP develop comprehensive resources for attending physicians and include a review of recent literature while ensuring the focus of education is directed specifically on post-operation care.

ACEP has received two grants opportunities that are focused on developing non-CME digital resources in the area of diversity and health equity. As a part of a webinar series, supported by Bristol-Myers Squibb, ACEP will host a webinar panel session, scheduled for Fall 2021, that will discuss the needs of the transgender community. The recording will then be available as enduring content and will be promoted to members as a learning opportunity.

AstraZenenca has also provided support to ACEP to create a series of non-CME micro education mirroring the same topics of the webinar series. Micro education is a new digital resource that ACEP is developing as another medium to educate members by creating short, 60-90 second videos highlighting the clinical pearls developed through other educational pieces, such as webinars, CME activities, point of care tools, policies, etc. The webinar developed on transgender care will be converted into micro education content that will be available on the ACEP website and social media channels.

ACEP's policy statement " Non- Discrimination and Harassment" advocates for tolerance and respect for the dignity for all individuals and opposes all forms of discrimination against and harassment of patients and emergency medicine staff on the basis of an individual's race, age, religion, creed, color, ancestry, citizenship, national or ethnic origin, language preference, immigration status, disability, medical condition, military or veteran status, social or socioeconomic status or condition, sex, gender identity or expression, sexual orientation, or any other classification protected by local, state, or federal law.

The information paper "Disparities in Emergency Care" includes three recommendations that directly supports the need for continued education related to cultural competence, clinical decision-making, and knowledge gaps among physicians that lack post-graduate education in emergency medicine:

1. Promote the evidence-based teaching of cultural competency.
2. Emphasize the use of clinical decision tools that standardize the approach to risk stratification and potentially reduce subjective bias.
3. Explore initiatives that address the "knowledge disparity" between rural and urban providers of emergency services, including providers who do not have post-graduate training in emergency medicine

ACEP's policy statement "Cultural Awareness and Emergency Care" supports that cultural awareness is essential to the training of healthcare professionals in providing quality patient care. It also confirms ACEP's position that resources be made available to emergency departments and emergency physicians to ensure they properly respond to the needs of all patients regardless of background.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective G – Promote/facilitate diversity and inclusion and cultural sensitivity within emergency medicine

Fiscal Impact

Budgeted committee, section, and staff resources.

Prior Council Action

Substitute Resolution 41(05) Non-Discrimination adopted. The resolution expressed ACEP's opposition to all forms of discrimination against patients on the basis of gender, race, age, creed, color, national or ethnic origin, religion, disability, or sexual orientation and against employment discrimination in emergency medicine on the same principles as well as physical or mental impairment that does not pose a threat to the quality of patient care.

Prior Board Action

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."

October 2017, reviewed the information paper "Disparities in Emergency Care."

Substitute Resolution 41(05) Sexual Orientation Non-Discrimination adopted.

Background Information Prepared by: Riane Gay, MPA, CAE
Director, Corporate Development

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 45(21)

SUBMITTED BY: Quality Improvement & Patient Safety Section
Rural Emergency Medicine Section
Massachusetts College of Emergency Physicians
Rhode Island Chapter
Wisconsin Chapter

SUBJECT: ED Performance Measures Data for Small, Rural, and Critical Access Hospital EDs

PURPOSE: Define the essential operational and quality metrics that could be used for managing small, rural, or critical access hospitals and to provide regional performance measure data to the emergency departments (EDs) within these facilities in the form of free, basic, annual reports.

FISCAL IMPACT: Unbudgeted costs for additional staff and investment building the new quality measures (range $50,000 to $100,000 per measure) and into the Clinical Emergency Department Data Registry cloud infrastructure and reporting capabilities.

WHEREAS, ACEP has long championed a data-driven approach to ED management and quality improvement[1-5]; and

WHEREAS, Emergency physicians in leadership roles (i.e., medical director or patient safety officer) are commonly tasked by hospital administration with continuously improving ED efficiency and quality; and

WHEREAS, Basic performance measure data is an essential tool for operating a modern ED and fostering a departmental culture of continuous quality improvement[7-8]; and

WHEREAS, Department-level funding for efficiency and quality improvement projects is contingent upon provision of regional performance measure statistics in order to show a gap in practice standards and define improvement goals; and

WHEREAS, Multiple organizations (some affiliated with ACEP) provide subscription-based services for ED performance measure data, such as the Emergency Department Benchmarking Alliance (EDBA), Clinical Emergency Data Registry (CEDR), Centers for Medicare & Medicaid Services (CMS), etc.; and

WHEREAS, There is a precedent for ACEP sharing limited ED performance measure data publicly (*ACEPNow* articles, CEDR webinars, Rural Emergency Quality Series, previous Quality Improvement & Patient Safety Section performance measure section grant, etc.); and

WHEREAS, Small, rural, and critical access EDs are an integral part of health care delivery in the United States[6]; and

WHEREAS, Small, rural, and critical access hospital ED physician administrators commonly lack access to subscription-based regional performance measure data due to financial constraints; and

WHEREAS, Releasing an ACEP-curated, limited subset of basic ED performance measure data on an annual basis has the potential to address the data gap for small, rural, and critical access hospital EDs and also advertise the value of CEDR and other subscription-based performance measure services; therefore be it

RESOLVED, That ACEP define the essential operational and quality metrics appropriate for managing a

small, rural, or critical access ED; and be it further

RESOLVED, That ACEP provide regional performance measure data on operational and quality metrics to small, rural, and critical access hospital emergency departments in the form of a free, basic, annual report.

References

1. Strauss, R. and Mayer, T., Strauss and Mayer's emergency department management.
2. Qualified Clinical Data Registry (QCDR) & Clinical Emergency Data Registry (CEDR) Overview https://www.acep.org/globalassets/sites/cedr/cedr-overview.pdf Accessed 05.09.21
3. ACEP Emergency Department Director's Academy Curriculum. https://www.acep.org/edda/GeneralInfo/GeneralInformation/ Accessed 05.09.21
4. EQUAL and Rural Emergency Quality Series. https://www.acep.org/administration/quality/equal/emergency-quality-network-e-qual/list2/ Accessed 05.09.21
5. Quality Driven Emergency Care. https://www.acep.org/administration/quality/ Accessed 05.09.21
6. Bennett, Christopher L., et al. "National study of the emergency physician workforce, 2020." Annals of Emergency Medicine 76.6 (2020): 695-708.
7. Karpiel, Martin S. "Benchmarking facilitates process improvement in the emergency department." Healthcare Financial Management 54.5 (2000): 54-54.
8. Yiadom MYAB, Napoli A, Granovsky M, Parker RB, Pilgrim R, Pines JM, Schuur J, Augustine J, Jouriles N, Welch S. Managing and Measuring Emergency Department Care: Results of the Fourth Emergency Department Benchmarking Definitions Summit. Acad Emerg Med. 2020 Jul;27(7):600-611. doi: 10.1111/acem.13978. Epub 2020 May 8. PMID: 32248605.

Background

The resolution calls on ACEP to define essential operational and quality metrics that could be used for managing small, rural, or critical access hospitals and to provide these facilities with regional performance data on these metrics in the form of free, basic, annual reports.

The resolution indicates that data is unavailable to under-resourced EDs, including small, rural, and critical access hospital EDs, that under-resourced EDs and critical access EDs are often located in low-income or predominantly non-white zip codes, and that if ACEP does not actively work to close the operations and data-gap, then ACEP runs the risk of that gap exacerbating the existing stark health disparity outcomes. ACEP staff, the Quality & Patient Safety Committee (QPSC) & CEDR Committee, collaborate to identify key quality care gaps ideal for measurement at the ED-levels. Together with committee-selected measure subject matter experts, specifications are developed for measure concept. Each specification is then rigorously analyzed against the CEDR database for reliability, feasibility, and usability. The analyses are then presented to QPSC for review, which includes assessments of value to emergency medicine, accuracy, attributability to clinicians and hardships for community, rural, critical access, and safety-net sites. This thorough vetting of measures takes six months to one year internally. Because CMS mandates a minimum of one year of performance data before measures can be nominated for approval (two years if we are developing a concept a part of the Merit-based Incentive Payment System (MIPS)-Value Pathways system), the vetting process must start two-three years in advance of expected measure approval. ACEP staff and both committees continue to collaborate and prioritize new measures with focus on value to smaller, rural sites.

While CEDR has onboarded some small, rural, and critical access ED sites (~10% of CEDR customer sites), the data set is extremely limited to accomplish this task. ACEP would need to invest millions of dollars into site and data acquisition, site on-boarding, data mapping, data refinement, dashboard build-out and delivery, and yearly maintenance of small, rural, and critical access sites. CEDR currently does have customers in rural areas and does help emergency physicians and groups who work in these EDs to meet the requirements of the MIPS. However, this resolution calls on CEDR to broadly expand its data collection and sharing capabilities. Furthermore, the pool of current measures focuses on quality care gaps for which many smaller sites would normally transfer to other specialized facilities (e.g., septic shock, CTPA, thrombectomy). This reduces the value for smaller sites as it limits reportable measures to those which are not outcomes-based. Broadening the number of applicable measures for new rural sites to report on would at best occur on a two-to-three-year delay. The resolution's goal of "of free, basic, annual reports" may be out of scope for CEDR and would likely require expansion of CEDR's functionality and size and/or would require ACEP to explore new streamlined, cost-appropriate solutions.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum, including rural areas.

Fiscal Impact

Unbudgeted costs for additional staff and invest into Quality Measure development (range $50,000 to $100,000 per measure) and Clinical Emergency Department Data Registry cloud infrastructure and reporting capabilities.

Prior Council Action

Resolution 40(19) Advancing Quality Care in Rural Emergency Medicine referred to the Board of Directors. The resolution called for ACEP to work with stakeholder groups to promote emergency medicine delivery models that increase quality and reduce costs in rural settings; identify and promote existing training opportunities to help physicians and non-physicians in rural settings maintain their clinical skills; develop a paper that identifies best practices and funding mechanisms to promote development of emergency medicine electives within emergency medicine residency programs; and encourage research in rural emergency medicine by identifying funding sources to support research and cost savings in rural emergency medicine.

Resolution 62(17) Freestanding Emergency Centers (FECs) as a Care Model for Maintaining Access to Emergency Care in Underserved, Rural, and Federally Declared Disaster Areas of the United States referred to the Board of Directors. The resolution called in part for ACEP to advocate for the creation of a Critical Access Emergency Center Designation where critical access hospitals no longer exist due to natural disasters or cannot be feasibly maintained.

Amended Resolution 16(16) Freestanding Emergency Centers as a Care Model for Maintaining Access to Emergency Care in Underserved and Rural Areas of the U.S. adopted. The resolution called for ACEP to analyze the use of Freestanding Emergency Centers as an alternative care model to maintain access to emergency care in areas where emergency departments in critical access and rural hospitals have closed.

Substitute Resolution 19(08) Second Rural Workforce Task Force referred to the Board of Directors. The resolution called for the appointment of a second rural task force empowered to convene a second Rural Emergency Medicine Summit and develop recommendations for the ACEP Board.

Amended Resolution 37(05) Rural Emergency Medicine Workforce adopted. Directed ACEP to advocate for inclusion of emergency medicine in the National Health Service Corps scholarship program, explore and advocate for various incentives for emergency medicine residency trained physicians to practice in rural or underserved areas, explore funding sources for a new workforce study, and work with other emergency medicine organizations to encourage the development and promotion of rural clerkships/ rotations at medical schools and residency programs.

Substitute Resolution 20(01) Medical Education Debt adopted. The resolution directed ACEP to lobby appropriate state and federal agencies for inclusion of emergency physicians in medical education debt repayment programs, including but not limited to state programs, the National Public Health Service, rural and underserved regional grant programs, and other grants/ scholarship programs.

Amended Substitute Resolution 21(01) Rural Emergency Medicine Departments adopted. Directed ACEP to investigate the root causes related to the difficulty of securing board-certified emergency physician staffing for medically underserved and rural areas; the causes studies should include, but not be limited to, educational, financial, and resident candidate selection factors, and be it further resolved that ACEP investigate methods to improve educational opportunities in rural and underserved environments.

Prior Board Action

January 2021, approved the legislative and regulatory priorities for the First Session of the 117th Congress that include several initiatives related to rural emergency care.

October 2020, filed the report of the Rural Emergency Care Task Force. ACEP's Strategic Plan was updated to include tactics to address recommendations in the report.

January 2020, assigned Referred Resolution 40(19) Advancing Quality Care in Rural Emergency Medicine to the Rural Emergency Task Force to review and provide recommendations to the Board to address rural emergency medicine issues.

January 2018, assigned Referred Resolution 62(17) Freestanding Emergency Centers (FECs) as a Care Model for Maintaining Access to Emergency Care in Underserved, Rural, and Federally Declared Disaster Areas of the United States to the Federal Government Affairs Committee for action.

August 2017, reviewed the information paper "Delivery of Emergency Care in Rural Settings."

June 2017, approved policy statement "Definition of Rural Emergency Medicine."

Amended Resolution 16(16) Freestanding Emergency Centers as a Care Model for Maintaining Access to Emergency Care in Underserved and Rural Areas of the U.S. adopted.

June 2015, accepted for information the report of the Rural Emergency Medicine Task Force.

June 2009, took no further action on Referred Substitute Resolution 19(08) Second Rural Workforce Task Force because the intent of the resolution would be met by the Future of Emergency Medicine Summit.

October 2005, adopted Amended Resolution 37(05) Rural Emergency Medicine Workforce.

September 2004, approved continuing the work of the Rural Task Force to complete their assigned tasks.

September 2003, approved the recommendations from the Rural Emergency Medicine Summit

February 2003, approved the development of a Rural Emergency Medicine Summit.

November 2002, approved convening a Rural Workforce Summit to identify specific needs of physicians practicing in rural emergency departments, explore solutions to staffing rural EDs, and make recommendations as to ACEP's role in this effort.

Substitute Resolution 20(01) Medical Education Debt adopted.

Amended Substitute Resolution 21(01) Rural Emergency Medicine Departments adopted.

Background Information Prepared by: Pawan Goyal, MD, MHA, FHIMSS
Senior Vice President, Quality

Bill Malcolm, PMP
Clinical Emergency Data Registry Program Director

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 46(21)

SUBMITTED BY: Stephen Epstein, MD, MPP, FACEP
Jay Mullen, MD, FACEP

SUBJECT: Effects of EM Practice Ownership on the Costs and Quality of Emergency Care

PURPOSE: Study the impact of emergency medicine practice ownership models on the cost and quality of emergency care.

FISCAL IMPACT: Estimated $200,000 to retain a research firm to conduct the research, based on Milliman's bid of $300,000 - $350,000 to conduct a broader range of research, including that called for in this resolution.

WHEREAS, ACEP is currently engaged in determining the ownership of emergency medicine practices throughout the nation; and

WHEREAS, Emergency medicine practice ownership models may impact both the cost and quality of emergency care; therefore be it

RESOLVED, That ACEP study the impact of emergency medicine practice ownership models on the cost and quality of emergency care.

Background

This resolution calls for ACEP to study the impact of emergency medicine practice ownership models on the cost and quality of emergency care.

In October 2019, the Council and the Board of Directors adopted Amended Resolution 58(19) Role of Private Equity in Emergency Medicine:

> RESOLVED, That ACEP study and report annually the market penetration of non-physician ownership, namely private equity, insurance company ownership, hospital ownership, and corporate non-physician ownership and management of emergency groups; and be it further
>
> RESOLVED, That ACEP study and report the effects on individual physicians, ACEP advocacy efforts, of the actions of private equity groups, insurance company ownership, hospital ownership, corporate non-physician ownership and management of emergency physician groups; and be it further
>
> RESOLVED, That ACEP advocate to preserve access to emergency care for patients and protect the careers of emergency physicians in the event of contract transitions, bankruptcy, etc. or other adverse events of their employer/ management company; and be it further
>
> RESOLVED, That ACEP partner with the American Medical Association, other interested national medical specialty societies, and other appropriate bodies to determine the circumstances under which corporate or private equity investment could lead or has led to market efforts that increases the cost of health care to consumers without a commensurate increase in access or quality; and be it further
>
> RESOLVED, That should there be circumstances under which corporate or private equity investment in health care could lead or has led to negative market effects that ACEP work with other interested parties to advocate for corrections to the market.

ACEP created a task force to lead the research aspects of the resolution and the task force began meeting in March

2020. The early work focused on the scope of the research project and the development of an RFP. While the task force was not specifically asked to address the third and fifth resolved statements in Resolution 58(19), there was strong support that pertinent research into possible market effects of different ownership models, particularly as they relate to cost of care and quality of care, should be sought to try to understand the impact, if any, that different models have on the public as well as physicians. The RFP outlined the following goals and objectives:

- Describe various practice models of emergency physicians and their prevalence across the country.
- Describe the pros/cons of each practice model from the standpoint of the physician and the practice and/or hospital.
- Describe any economic impacts to patients or the health care system unique to any practice model.
- Describe the growth and market forces (such as coordination of care, improved profit, decreased cost) leading to changes in ownership of emergency medicine groups.
- Describe how these changes in ownership impact physicians and cost and quality of patient care.
- Discuss how the group management landscape has been impacted by initial ramifications of the COVID-19 pandemic.

The RFP was sent to 12 research consulting firms that were identified as potentially interested and capable of managing the project, as well as to members of the ACEP Research Committee and Research Section. Seven proposals were submitted in response to the RFP. At the recommendation of the task force, the Board approved retaining Milliman, Inc. to conduct the research. While Milliman's bid for the total project was $300,000 to $350,000, the final agreement with Milliman entailed a two-phase approach. Phase 1 called for Milliman to investigate and report on data sources that could provide meaningful data to inform the various research elements sought in the initial proposal and for Milliman to provide a high-level market scan of emergency medicine ownership models. The cost of Phase 1 was $75,000. A decision on whether to proceed with Phase 2, and if so, to what extent, would be made by the Board after its review of the Phase 1 report.

Milliman presented a preliminary report on Phase 1 and options for Phase 2 research to the Board at its January 2021 meeting. Feedback from the Board during the meeting included direction that any Phase 2 work should focus on the impact different group ownership models have on physician compensation and satisfaction. In its final Phase 1 report to the Board in April 2021, Milliman informed the Board that its search for public and proprietary data sources yielded only aggregated or de-identified data that could not provide identifying information on group ownership. Milliman recommended a member survey to ask emergency physicians about the ownership of their groups as well as questions related to their job satisfaction and compensation. It was subsequently determined that such survey questions could be included in ACEP's previously planned member survey to glean that information and that ACEP would not proceed with Phase 2 of the Milliman engagement.

While unable to identify existing data that would provide meaningful group ownership information, Milliman expressed high confidence in its ability to obtain sufficient data to measure impacts on quality of care and cost of care by different ownership models (assuming ownership model was known.) Milliman expressed low and medium confidence in its ability to demonstrate different models' impacts on physician compensation and physician satisfaction, respectively. While the questions on the ACEP member survey addressed job satisfaction and compensation, no additional activity has been undertaken to collect data related to impacts on cost of care or quality of care.

ACEP is undertaking efforts to try to obtain more information about ownership of emergency physician groups. In addition to the questions on the member survey, ACEP is developing a questionnaire to be distributed 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, including ownership. ACEP leadership has also approached AMA leadership about considering a broader effort to improve transparency of physician ownership information throughout the house of medicine. There is also an effort underway by a member of the task force to try to obtain information on ownership of groups through an exploration and matching of various data including tax identification numbers and national provider identifier numbers. However, it is currently unclear when or if these efforts may provide sufficient data on ownership that would allow for meaningful research into the impacts of different ownership models on the cost and quality of emergency care.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective A – Promote/advocate for efficient, sustainable, and fulfilling clinical practice environments.
- Objective D – Promote quality and patient safety, including continued development and refinement of quality measures and resources.

Fiscal Impact

Estimated $200,000 to retain a research firm to conduct the research, based on Milliman's bid of $300,000 – $350,000 to conduct a broader range of research, including that called for in this resolution.

Prior Council Action

Amended Resolution 58(19) Role of Private Equity in Emergency Medicine adopted.

Prior Board Action

April 2021, received the final report on Phase I of the Emergency Medicine Group Ownership Research Project. Determined not to utilize Milliman for Phase 2 of the project and proceed with a survey to obtain data about ownership models and their impact on physician compensation and satisfaction.

January 2021, received a preliminary report on Phase 1 and options for Phase 2 research of the Emergency Medicine Group Ownership Research Project.

September 2020, approved a budget modification of $75,000, funded from operations, for Phase 1 of the Emergency Medicine Group Ownership Research Project and revise the report to the Council regarding Amended Resolution 58(19) Role of Private Equity in Emergency Medicine to include this information and what will be accomplished in Phase 1 of the research project and include providing a report to the Finance Committee and the Council with the findings from Phase 1.

August 2020, approved moving forward with retaining Milliman to perform the research and analysis of the market penetration of various emergency medicine group ownership models and, to the extent possible, identify the impacts of different models on physicians, quality of care, and cost of care.

Amended Resolution 58(19) Role of Private Equity in Emergency Medicine adopted.

Background Information Prepared by: Craig Price, CAE
Senior Director, Practice Affairs

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 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(21)

SUBMITTED BY: Megan Dougherty, MD, FACEP
Sarah Hoper, MD, JD, FACEP
Iowa Chapter
Vermont Chapter
American Association of Women Emergency Physicians Section

SUBJECT: Family and Medical Leave

PURPOSE: 1) advocate for paid family leave, including but not limited to supporting the American Medical Association's effort to study the effects of Family Medical Leave Act expansion including paid parental leave (AMA Policy H-405.954); 2) conduct an environmental survey and develop a paper on best practices regarding maternity, paternity, and family leave for emergency physicians; and 3) develop a policy statement in support of paid family leave outside of the language in ACEP's "Family and Medical Leave" policy statement revised in 2019.

FISCAL IMPACT: Budgeted committee and staff resources. Unbudgeted and unknown costs for conducting an environmental survey. The cost will be based on the resources needed.

WHEREAS, The ACEP Council in 2017 adopted a resolution for ACEP to create a policy on paid parental leave and a white paper addressing different ways to pay for paid parental leave, but instead the ACEP "Family and Medical Leave" policy statement was revised and no language in regards to paid parental leave was included and an information paper has not been produced[1]; and

WHEREAS, The United States is one of six out of 193 countries in the United Nations that does not mandate paid maternity leave[2] and 50 countries provide six months or more of paid leave[3]; and

WHEREAS, 40% of American workers do not meet the requirements for 12 weeks of unpaid leave provided by the Family Medical Leave Act (FMLA) because they have not worked 1,250 hours in the past year or they do not work for an employer with more than 50 employees[4]; and

WHEREAS, Only 12% of workers in the private sector get paid maternity leave through their employers[5]; and

WHEREAS, 23% of surveyed women reported taking 2 weeks or less of maternity leave because they could not afford more[6,7]; and

WHEREAS, Women with 12 weeks of paid leave are more likely to breastfeed for six months,[8] women with 12 weeks or more of paid maternity leave have lower rates of post – partum depression,[9] and paid maternity leave is associated with lower infant mortality rates;[10] and

WHEREAS, Fathers that take paternity leave have higher satisfaction with parenting,[11] are more engaged in the care of their children nine months after birth,[12,13,14] children with engaged fathers have fewer behavioral and mental health problems,[15] and longer paternity leave with fathers caring for young children is associated with higher cognitive test scores[14,16]; and

WHEREAS, Some academic emergency medicine programs provide paid maternity and paternity leave of differing number of weeks or days; and

WHEREAS, A few private emergency medicine practice groups have developed innovative ways to help with paid maternity and paternity leave that should be shared with other groups; and

WHEREAS, Despite the Equal Pay Act of 1963 prohibiting discrimination on account of sex, there is still an approximately $20,000 wage gap between men and women in medicine even when adjusted for factors that may impact compensation; and

WHEREAS, Offering only paid maternity and not paternity leave may increase the wage gap; and

WHEREAS, Unlike previous generations, most family caregivers today work at a paying job in addition to caring for ill family members[16]; and

WHEREAS, If employed caregivers lack the supports and protections needed to manage their dual responsibilities, some make changes to their work life including giving up work entirely, reducing work hours, or taking a less demanding job[17]; and

WHEREAS, Although paid family leave is primarily directed at helping workers balance caregiving responsibilities, effects extend to the workers' financial security and labor force attachment, health (of caregivers and receivers) and productivity related to turnover and absenteeism[18]; therefore be it

RESOLVED, That ACEP advocate for paid family leave, including but not limited to supporting the American Medical Association's effort to study the effects of Family Medical Leave Act expansion including paid parental leave (AMA Policy H-405.954); and be it further

RESOLVED, That ACEP conduct an environmental survey and develop a paper on best practices regarding maternity, paternity, and family leave for emergency physicians; and be it further

RESOLVED, That ACEP develop a policy statement in support of paid family leave outside of the language in ACEP's "Family and Medical Leave" policy statement revised in 2019.

References

[1]ACEP Family and Medical Leave Policy Statement Revised June 2019.
[2]UNData. Maternity Leave. http://data.un.org/DocumentData.aspx?id=344
[3]Deahl, Jessica. Countries Around the World Beat the U.S. on Paid Parental Leave. NPR- All Things Considered. http://www.npr.org/2016/10/06/495839588/countries-around-the-world-beat-the-u-s-on-paid-parental-leave
[4]Dept of Labor. FMLA is Working. https://www.dol.gov/whd/fmla/survey/FMLA_Survey_factsheet.pdf
[5]Dept of Labor Factsheet: Paid Family and Medical Leave. https://www.dol.gov/wb/paidleave/PDF/PaidLeave.pdf
[6] Wang W, Parker K, Taylor P. Breadwinner Mom. Pew Research Center. http://www.pewsocialtrends.org/2013/05/29/breadwinner-moms/
[7] Dept of Labor Factsheet: Paid Family and Medical Leave. https://www.dol.gov/wb/paidleave/PDF/PaidLeave.pdf
[8] Mirkovic, K *et al.* Paid Maternity Leave and Breastfeeding Outcomes. Birth. Vol 43, Issue 3, September 2016, 233-239.
[9] Dagher, R *et al.* Maternity Leave Duration and Postpartum Physical Health: Implications for Leave Policies. Journal of Health Politics, Policy and Law, Vol. 39, No. 2, April 2014.
[10] Nandi, A *et al.* 2016. "Increased Duration of Paid Maternity Leave Lowers Infant Mortality in Low- and Middle Income Countries: A Quasi-Experimental Study," PLoS Medicine. March 29, 2016. http://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1001985.
[11]Linda Hass and C. Philip Hwang. 2008. "The Impact of Taking Parental Leave on Fathers' Participation in Childcare and Relationships with Children: Lessons from Sweden." Community, Work and Family 11(1): 85-104.
[12]Lenna Nepomnyaschy and Jane Waldfogel. 2007. "Paternity Leave and Fathers' Involvement with Their Young Children: Evidence from the American Ecls–B." Community, Work & Family 10(4): 427-453.
[13]Maria Del Carmen Huerta, et al. 2013. "Fathers' Leave, Fathers' Involvement and Child Development: Are They Related? Evidence from Four OECD Countries." OECD Social, Employment and Migration Working Papers, No. 140, retrieved from http://www.oecd-ilibrary.org/social-issues-migration-health/fathers-leave-fathers-involvement-and-child-development_5k4dlw9w6czq-en (last visited June 17. 2015).
[14]Sakiko Tanaka and Jane Waldfogel. 2007. "Effects of Parental Leave and Work Hours on Fathers' Involvement With Their Babies: Evidence from the Millennium Cohort Study." Community, Work and Family 10(4): 409-426.
[15]Huerta, et al (2013); Nepomnyaschy and Waldfogel (2007); Anna Sarkadi, et al. 2008. "Fathers Involvement and Children's Developmental Outcomes: A Systematic Review of Longitudinal Studies." Acta Pediatrica 97: 153-158; Erini Flouri and Ann Buchanan. 2002. "The Role of Father Involvement in Children's Later Mental Health." Journal of Adolescence 26: 63-78.
[16]Dept. of Labor Policy Brief, "Why Parental Leave for Fathers Is So Important for Working Families," June 16, 2016. https://www.dol.gov/asp/policy-development/PaternityBrief.pdf
[17] Feinberg LF. Paid Family Leave: An Emerging Benefit for Employed Family Caregivers of Older Adults. *Journal of the American Geriatrics Society*. 2019; 67(7):1336-1341.
[18]Wolff JL, Drabo EF, Van Houtven CH. Beyond Parental Leave: Paid Family Leave for an Aging America. *Journal of the American Geriatrics Society*. 2019; 67(7): 1322-1324.

Background

This resolution requests ACEP to advocate for paid family leave, including but not limited to supporting the American Medical Association's effort to study the effects of Family Medical Leave Act expansion including paid parental leave (AMA Policy H-405.954); conduct an environmental survey and develop a paper on best practices regarding maternity, paternity, and family leave for emergency physicians; and develop a policy statement in support of paid family leave outside of the language in ACEP's "Family and Medical Leave" policy statement revised in 2019.

Currently, federal law does not require employers to provide paid family or parental leave. The Family and Medical Leave Act (FMLA) entitles eligible workers to take job-protected, unpaid leave of up to 12 weeks for the birth of a child or to care for a child within one year of birth. Those eligible for this protection are workers with at least 1,250 hours of service during the previous 12 months at an employer with at least 50 employees. Many states and some major cities have enacted laws that expand on the FMLA protections, most typically by increasing the length of leave allowed and/or expanding coverage to a larger number of employees. Several states have also implemented paid parental leave programs. Typically funded by employee payroll taxes, these state programs mandate paid coverage of various lengths and amounts. For example, a New York law provides maximum leave benefit of 50% of an employee's weekly wage for up to eight weeks. Several cities also have mandatory paid parental leave programs for private employers. In 2016, San Francisco became the first major U.S. city to mandate fully paid parental leave, requiring employers with 20 or more employees to offer six weeks paid time off for new mothers and fathers.

Increasingly, private employers have voluntarily initiated or expanded paid parental leave programs, including several hospitals. New York Presbyterian Hospital expanded its leave policy to provide six to eight weeks of paid disability leave for the birth mother and an additional six weeks paid parental leave. Children's National Health System provides six to eight weeks paid maternity leave and two weeks paid paternity leave.

Several studies have concluded that extended paid maternity leave results in improved physical and mental health for the mother as well as health and developmental improvements for the child. While proponents claim the programs also improve worker morale, loyalty, and productivity, opponents raise concerns about the increase in taxation required to fund such programs and potential unintended consequences, such as employers becoming less likely to hire women due to concerns of higher costs and loss of productivity if new mothers can take extended periods of paid leave. On April 28, 2021, President Biden announced his support for paid family medical leave though his American Families Plan. The plan calls for the creation a national comprehensive paid family and medical leave program that will bring America in line with competitor nations that offer paid leave programs.

ACEP first adopted a policy statement on "Parental Leave of Absence" in 1990. The current version of the policy statement, revised and approved by the Board of Directors in 2019 and now entitled "Family and Medical Leave," states:

- The health and integrity of working physicians' relationships with parents, children, and family are essential to the physicians' well-being. The ability to respond to family needs promotes work satisfaction and career longevity which, in turn, contributes to higher quality patient care.
- The leaders of physician groups and residency programs, as well as employers, should support these policies actively by informing physicians of their availability and making such leave available without undue delay or administrative burden.
- Emergency physician groups, employers, and emergency medicine residency programs should have written policies that support family leaves of absence. These policies should take into consideration what can be done to support the individual financially, if needed, during the leave of absence. These policies should also apply to a personal serious physical and mental illness, both parents for the birth or adoption of a child, the care of a seriously ill family member, and situations involving either the safety or cohesion of the family.
- Mothers, or primary caregivers of biological or adoptive children, should expect at least twelve weeks without work around the time of their child's birth or adoption; the other parent should expect four weeks at the minimum.
- Flexible work schedules for parents before and after welcoming a new child should be made available whenever possible without disrupting the availability the availability of patient care.

AMA policy entitled "Parental Leave" (H-405.954) states:

> "1. Our AMA encourages the study of the health implications among patients if the United States were to modify one or more of the following aspects of the Family and Medical Leave Act (FMLA): a reduction in the number of employees from 50 employees; an increase in the number of covered weeks from 12 weeks; and creating a new benefit of paid parental leave.
> 2. Our AMA will study the effects of FMLA expansion on physicians in varied practice environments."

AMA has an additional relevant policy, entitled "Paid Sick Leave" (H-440.823), which states:

> "Our AMA: (1) recognizes the public health benefits of paid sick leave and other discretionary paid time off; (2) supports employer policies that allow employees to accrue paid time off and to use such time to care for themselves or a family member; and (3) supports employer policies that provide employees with unpaid sick days to use to care for themselves or a family member where providing paid leave is overly burdensome."

At the 2017 Annual Meeting of the House of Delegates (HOD), Resolution 416-A-17 was referred. Introduced by the New England Delegation and the Minority Affairs Section, Resolution 416-A-17 asked that the American Medical Association (AMA) advocate for: (1) improved social and economic support for paid family leave to care for newborns, infants and young children; and (2) federal tax incentives to support early child care and unpaid child care by extended family members. Board of Trustees Report 27 was submitted to the HOD at the 2018 Annual Meeting and referred back to the Board for further study.

At the 2019 Annual Meeting of the HOD, the following recommendations were adopted in lieu of Resolution 416-A-17 and the remainder of the report filed.

1. That our AMA reaffirm Policy H-440.823, which recognizes the public health benefits of paid sick leave and other discretionary paid time off, and supports employer policies that allow employees to accrue paid time off and to use such time to care for themselves or a family member.
2. That our AMA encourage employers to offer and/or expand paid parental leave policies.
3. That our AMA encourage state medical associations to work with their state legislatures to establish and promote paid parental leave policies.
4. That our AMA advocate for improved social and economic support for paid family leave to care for newborns, infants and young children.
5. That our AMA advocate for federal tax incentives to support early child care and unpaid child care by extended family members.

The Council and the Board of Directors adopted Amended Resolution 36(17) Maternity & Paternity Leave. The resolution directed ACEP to advocate for paid parental leave for emergency physicians, develop an information paper on best practices regarding paid parental leave for emergency physicians, and provide a report to the 2018 Council. The resolution was assigned to the Well-Being Committee. The committee had already been assigned an objective to review the policy statement "Family Leave of Absence" as part of the policy sunset review process.

The committee submitted proposed revisions to the "Family Leave of Absence" policy statement to the Board in September 2018. The revisions included tenets of Amended Resolution 36(17). The Board postponed discussion to the January 30-31, 2019, meeting. At their January 2019 meeting, the Board expressed concerns about the impact on small groups, as well as the difficulty in addressing all practice settings, and suggested that the policy be aspirational and not punitive to groups that cannot meet all aspects of the policy. It was also noted that independent contractors should be addressed in the policy statement.

The Board discussed an updated draft of the "Family Leave of Absence" policy statement in April 2019. The Board recommended that the policy statement remain succinct and that additional information be included in a Policy Resource & Education Paper (PREP) instead of an information paper as requested in Amended Resolution 36(17). A PREP is an adjunct to a policy statement and is intended to provide additional background, clarification, education and/or implementation assistance. A PREP may include references, bibliographies, discussion papers,

practice applications, and "how to" information. Additionally, a PREP is subject to the Policy Sunset Review Process along with the policy statement so that the information remains relevant. (Information Papers are not subject to the Policy Sunset Review process.) This has been an ongoing objective for the committee.

In June 2021, a representative from SAEM's Academy of Women in Academic Emergency Medicine (AWAEM), who is also a member of ACEP's Well-Being Committee, approached ACEP about appointing representatives to assist in the development of a document on "Best Practices for Parental Leave for Emergency Physicians." ACEP's president and president-elect discussed the request and approved modifying the Well-Being Committee's objective to work with AWAEM on this document. The committee co-chairs were also informed of this decision. This document will present recommendations for both academic and community emergency medicine. The committee anticipates completion of the paper by the end of 2021.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective A – Promote/advocate for efficient, sustainable, and fulfilling clinical practice environments.
  - Tactic 6 – Identify the factors that promote a "well" workplace.

Goal 2 – Enhance Membership Value and Member Engagement

- Objective A – Improve the practice environment and member well-being.
  - Tactic 2 – Update and promote resources on wellness burnout, practice environment improvement, resilience, and work/life balance for members in all stages of their career.

Fiscal Impact

Budgeted committee and staff resources. Unbudgeted and unknown costs for conducting an environmental survey. The cost will be based on the resources needed.

Prior Council Action

Amended Resolution 36(17) Maternity & Paternity Leave adopted. Directed ACEP to advocate for paid parental leave for emergency physicians, develop an information paper on best practices regarding paid parental leave for emergency physicians, and provide a report to the 2018 Council.

Amended Resolution 44(88) Perinatal Leave for Emergency Physicians adopted. The resolution called for the College to develop educational guidelines for emergency physicians regarding maternal/paternal/adoption leave and associated issues for emergency physicians and emergency medicine residents.

Prior Board Action

June 2019, approved the revised policy statement "Family and Medical Leave" with the current title; reaffirmed 2012; revised and approved October 2006, September 1999, and April 1994 titled "Family Leave of Absence;" originally approved June 1990 titled "Parental Leave of Absence."

April 2019, provided comments for addition revisions to the revised policy, "Family Leaveof Absence."

January 2019, provided comments for additional revisions to the revised policy "FamilyLeave of Absence."

October 2018, postponed discussion of the revised "Family Leave of Absence" policy statement to the January 30-31, 2019, Board of Directors meeting.

September 2018, postponed discussion of the revised "Family Leave of Absence" policy statement to the October 4, 2018, Board of Directors meeting.

Amended Resolution 36(17) Maternity & Paternity Leave adopted.

September 1988, Resolution 44(88) adopted.

Background Information Prepared by: Sonja Montgomery, CAE
Governance Operations Director

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 48(21)

SUBMITTED BY: Stephen Epstein, MD, MPP, FACEP
Thomas J. Sugarman, MD, FACEP

SUBJECT: Financial Incentives to Reduce ED Crowding

PURPOSE: Study financial and other incentives that might be used to reduce emergency department crowding.

FISCAL IMPACT: Budgeted committee and staff resources. If a task force is needed, $20,000 for one in person meeting. If additional data is needed, costs could range $100-000-200,000 for a third party study.

WHEREAS, Emergency department crowding remains a vexing issue, despite known policy solutions; and

WHEREAS, Emergency department crowding is known to be detrimental to patients; and

WHEREAS, Financial incentives may be necessary to reduce emergency department crowding; therefore be it

RESOLVED, That ACEP study financial and other incentives that might be used to reduce emergency department crowding.

Background

This resolution requests that the College to study financial and other incentives that might be used to reduce emergency department crowding.

Crowding in emergency departments has been reported since at least the 1990's.[1] The literature cites many causes of crowding, commonly broken into inflow (too many patients largely blamed on non-urgent patients), throughput (workflow within the ED) and output (the ability to move a patient to an inpatient bed).[2] Studies have shown that output issues have the greatest impact on crowding. When an inpatient bed is not available, patients "board" in the ED, at times for hours and even days.

The effect of crowding has been studied. It has an impact on the quality of care provided, the number of people who leave without being seen as well as the people who leave without registering (look and go), delay in care, increase in medical errors, increase in mortality, increase morbidity, ambulance diversion, and an increase in hospital length of stay.[2,4-7] There are multiple studies that convincingly show an increase hospital cost and lost hospital and ED revenue.[8-11]

With considerable literature showing increase cost/decrease revenue, the fact that hospitals do not act to reduce boarding remains difficult to understand. In part this lack of action could be the result of not knowing the impact, not believing the impact as it is spread over multiple cost centers, or the concern that the solution could be more costly, more difficult than allowing the situation to remain. Or it may be that the cost to 'fix' crowding is more expensive, more onerous than the revenue loss of boarding itself. In fact, some hospitals may perceive a financial incentive to board because of the difference in reimbursement between patients. Hospitals receive greater reimbursement for a surgical patient than for a medical patient. They receive more for a patient with private insurance than an identical patient with government insurance. And they receive greater reimbursement for a patient out of network (transferred) than a patient in network. Patients admitted through the ED are more likely to be uninsured/underinsured with medical

disorders, and to be in-network. Some institutions even try to save inpatient beds for patients with diagnoses associated with better reimbursement.

Although the hospital may profit overall by boarding patients in the ED, it negatively impacts the profitability of the ED and certainly hurts the revenue generation of emergency physicians compensated on a fee for service or productivity basis.

Boarding has increased with COVID-19, especially during the Delta variant surge. An informal survey of ACEP members in July 2021 showed that 70% reported crowding conditions worse than pre pandemic. During this time period, crowding is more widespread and with greater numbers forcing some EDs to abandon their ED footprint that is now filled with boarders, and see patient hallways, the waiting room, tents and even converted conference rooms and parking lots.

While crowding is a global issue, the cause may vary among countries. The UK, Ireland, Canada, Australia all have some form of 'targets' for ED length of stay. While these have not been uniformly successful, because their healthcare is largely reimbursed from a single source, penalties can be easily assessed. While the US has some of control through CMS and through groups like The Joint Commission, there have been few attempts by these agencies to curtail, or even quantitate, boarding in the ED. There have been a few state-wide programs, most notably the Department of Health for the State of New York who gathered data on the number of boarders in the ED for many years but would not share that data outside the department. Other states such as Massachusetts has done some very credible work, but this issue remains in that state. Solutions such as Full Capacity Protocol, smoothing the OR schedule, discharges out by noon, and 7 day a week hospital programs exist [7] but few hospitals are willing to entertain these, or sustain them over time.

It could be challenging to overcome the perceived financial and personnel incentives already in place. One option would be through the ED Accreditation Program currently being considered by ACEP. A task force has been appointed by ACEP President Mark Rosenberg DO, FACEP. The program is charged with ensuring that a person's "zip code does not define the emergency care they receive." Accreditation programs can be powerful tools to align administration and staff to improve care, in this case, emergency care. While seeking accreditation can be important for market share and to improve the brand of a hospital, losing accreditation can be devastating to an institution and an issue for their Board of Trustees. Measurements of boarding/crowding can be added to the accreditation and progressively require greater attention to boarding.

It also may be possible for ACEP to work with Federal agencies to address the issue of boarding/crowding. Many of these have been involved in prior actions including CMS and The Joint Commission. However, none of the metrics they instituted actually changed conditions within an institution. With new attention on emergency care from the current pandemic, additional meetings with these groups may lead to efforts that actually improve boarding/crowding.

Background References

[1]Gibbs, N. Do You Want to Die? TIME. May 28, 1990:58-65.
[2]Asplin BR, Magid DJ, Rhodes KV, Solberg LI, Lurie N, Camargo CA Jr. A conceptual model of emergency department crowding. *Ann Emerg Med*. 2003;42(2):173-80.
[3]Handel DA, Sklar DP, Hollander JE, et al. Institute of Medicine/Association of American Medical Colleges Panelist Group Society for Academic Emergency Medicine. Association of Academic Chairs in Emergency Medicine Panel. Executive summary: the Institute of Medicine report and the future of academic emergency medicine: the Society for Academic Emergency Medicine and Association of Academic Chairs in Emergency Medicine Panel: Association of American Medical Colleges annual meeting. *Acad Emerg Med.* 2007;14(3):261-7.
[4]Sun BC, Hsia RY, Weiss RE, et al. Effect of emergency department crowding on outcomes of admitted patients. *Ann Emerg Med*. 2013;61(6):605-11.
[5]Rasouli HR, Esfahani AA, Nobakht M, et al. Outcomes of Crowding in Emergency Departments; a Systematic Review. *Arch Acad Emerg Med*. 2019;7(1):e52.
[6]Abir M, Goldstick JE, Malsberger R, et al. Evaluating the impact of emergency department crowding on disposition patterns and outcomes of discharged patients. *Int J Emerg Med.* 2019;12:4.
[7]ACEP EM Practice Committee. Emergency Department Crowding: High Impact Solutions. 2016. Accessed [8]/13/2021.
8Krochmal P, Riley TA. Increased health care costs associated with ED overcrowding. *Am J Emerg Med.* 1994;12(3):265-6.
[9]Bayley MD, Schwartz JS, Shofer FS, et al. The financial burden of emergency department congestion and hospital crowding for chest pain patients awaiting admission. *Ann Emerg Med.*. 2005;45(2):110-7.
[10]Falvo T, Grove L, Stachura R, et al. The opportunity loss of boarding admitted patients in the emergency department. *Acad Emerg Med.* 2007;14(4):332-7.

[11]Falvo T, Grove L, Stachura R, et al. The financial impact of ambulance diversions and patient elopements. *Acad Emerg Med.* 2007;14(1):58-62.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective A – Promote/advocate for efficient, sustainable, and fulfilling clinical practice environments.
  - Tactic 2 – Work with organizations including the American Hospital Association, The Joint Commission, CMS, and other medical societies, to identify and remove barriers to the efficient practice of emergency medicine.
  - Tactic 5 – Continue to advocate to measure and reduce boarding and improve patient throughput.

Fiscal Impact

Budgeted committee and staff resources. If a task force is needed, $20,000 for one in person meeting. If additional data is needed, costs could range $100-000-200,000 for a third party study

Prior Council Action

Amended Resolution 13(16) ED Crowding and Boarding is a Public Health Emergency adopted. Directed ACEP to work with the U.S. Department of Health and Human Services, the U.S. Public Health Service, The Joint Commission, and other appropriate stakeholders to determine action steps to reduce ED crowding and boarding.

Amended Resolution 42(15) Prolonged Emergency Department Boarding adopted. Directed ACEP to work with other organizations and stakeholders to develop multi-society policies that establish clear definitions for boarding and crowding and limit the number of hours and volume of boarders to allow for continued patient access and patient safety. Also directed that ACEP promote to other organizations and stakeholders known solutions to mitigate boarding and crowding, including but not limited to smoothing of elective admissions, increasing weekend discharges, discharge of patients before noon, full availability of ancillary services seven days a week, and implementation of a full-capacity protocol and promote legislation at the state and national level that limits and discourages the practice of emergency department boarding as a solution to hospital crowding.

Resolution 28(08) Nationwide ED Crowding Crisis not adopted. The resolution directed ACEP members to work with state medical associations and/or health departments to encourage hospitals and health care organizations to develop mechanisms to increase availability of inpatient beds. Salient provisions of this resolution were included in Substitute Resolution 25(08) State Department of Health Crowding Surveys.

Substitute Resolution 25(08) State Department of Health Crowding Surveys adopted. Directed ACEP to investigate options to collect data from individual hospitals throughout the states regarding boarding and crowding, encourage members to work with their state medical associations and/or state health departments to develop appropriate mechanisms to facilitate the availability of inpatient beds and use of inpatient hallways for admitted ED patients, identify and develop a speakers bureau of individuals who have successfully implemented high-impact, low-cost solutions to boarding and crowding.

Amended Resolution 27(07) Hospital Leadership Actions to Ameliorate Crowding adopted. Directed ACEP to develop a position paper on the systematic changes in hospital operations that are necessary to ameliorate crowding and treatment delays affecting ED and other hospital patients.

Amended Resolution 26(07) Hallway Beds adopted. The resolution directed ACEP to revise the policy statement "Boarding of Admitted and Intensive Care Patients in the ED," work with state and national organizations to promote the adoption of such policies, and to distribute information to the membership and other organizations related to patient safety outcomes caused by the boarding of admitted patients in the ED.

Resolution 39(05) Hospital Emergency Department Throughput Performance Measure referred to the Board of Directors. Called for ACEP to work with CMS and other stakeholders to develop measures of ED throughput that will

reduce crowding by placing the burden on hospitals to manage their resources more effectively.

Substitute Resolution 18(04) Caring for Emergency Department 'Boarders' adopted. Directed ACEP to endorse the concept that overcrowding is a hospital-wide problem and the most effective care of admitted patients is provided in an inpatient unit, and in the event of emergency department boarding conditions, ACEP recommends that hospitals allocate staff so that staffing ratios are balanced throughout the hospital to avoid overburdening emergency department staff while maintaining patient safety.

Amended Resolution 33(01) ED Overcrowding: Support in Seeking Local Solutions adopted. Directed ACEP to develop a specific strategy to coordinate all activities related to emergency department and hospital crowding to support state efforts, analyze information and experiences to develop a resource tool to assist chapters in efforts to seek solutions to emergency department and hospital crowding at the local level.

Amended Substitute Resolution 15(01) JCAHO Mandate for Inpatients adopted. The resolution called for ACEP to meet with appropriate regulatory agencies, including the AMA, JCAHO, and the American Hospital Association and other interested parties to establish monitoring criteria and standards that are consistent with ACEP's policy "Boarding of Admitted and Intensive Care Patients in the Emergency Department." The standard should address the prompt transfer of patients admitted to inpatient units as soon as the treating emergency physician makes such a decision.

Prior Board Action

April 2019, approved the revised policy statement "Crowding;" revised and approved February 2013; originally approved January 2006.

June 2017 approved the revised policy statement "Boarding of Admitted and Intensive Care Patients in the Emergency Department;" revised and approved April 2011, April 2008, January 2007; originally approved October 2000.

Amended Resolution 13(16) ED Crowding and Boarding is a Public Health Emergency adopted.

June 2016, reviewed the updated information paper, "Emergency Department Crowding High-Impact Solutions"

Amended Resolution 42(15) Prolonged Emergency Department Boarding adopted.

Substitute Resolution 25(08) State Department of Health Crowding Surveys adopted.

Amended Resolution 27(07) Hospital Leadership Actions to Ameliorate Crowding adopted.

Amended Resolution 26(07) Hallway Beds adopted.

April 2007, reviewed the information paper "Crowding and Surge Capacity Resources for EDs."

October 2006, reviewed the information paper "Approaching Full Capacity in the Emergency Department."

Substitute Resolution 18(04) Caring for Emergency Department 'Boarders' adopted

Amended Resolution 33(01) ED Overcrowding: Support in Seeking Local Solutions adopted.

Amended Substitute Resolution 15(01) JCAHO Mandate for Inpatients adopted.

Background Information Prepared by: Sandy Schneider, MD, FACEP
Senior Vice President, Clinical Affairs

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 49(21)

SUBMITTED BY: New York Chapter

SUBJECT: Forced EMS Diversion

PURPOSE: Work with other stakeholders to discourage the use of forced EMS diversion to substitute for system-wide hospital admission load balancing and collect data on the clinical impact of EMS diversion policies.

FISCAL IMPACT: Budgeted committee, section, and staff resources. Potential unbudgeted and unknown costs for a data analyst depending on the type of data to be collected.

WHEREAS, Individual States have imposed surge capacity restrictions on hospitals during the COVID-19 pandemic such that they may not have more than 85% admission capacity for example; and

WHEREAS, Individual hospitals have responded by using EMS diversion in order to comply with strict Department of Health policies regarding hospital capacity; and

WHEREAS, EMS diversion is hazardous to individual patients who may suffer from delays in access to care; and

WHEREAS, EMS diversion should only be activated in situations dictated by conditions in an individual Emergency Department (ED) based on regionally approved polices with input from ED and EMS system leadership; and

WHEREAS, EMS diversion across regions should be managed by the State EMS Medical Director with the knowledge and understanding of the systemwide impact of such diversion; therefore be it

RESOLVED, That ACEP work with other stakeholders to discourage states and hospitals from using forced EMS diversion to substitute for system-wide hospital admission load balancing; and be it further

RESOLVED, That ACEP collect data on the clinical impact of EMS diversion policies.

Background

This resolution calls for the College to work with other stakeholders to discourage the use of forced EMS diversion to substitute for system-wide hospital admission load balancing and collect data on the clinical impact of EMS diversion policies.

Hospital resources such as the emergency department capacity, surgical availability, available critical care beds, and even hospital bedding capacity may occasionally be overwhelming and they may not be able to provide the usual level of care for varying periods of time. There are several factors that may contribute to this problem including a shortage of available health care providers, a lack of hospital-based resources, and an unusually high demand for emergency services. The current COVID-19 pandemic has placed a huge strain on the nation's health care delivery system including the EMS system. EMS diversion is being used as one means to attempt to address this issue.

EMS diversion is not a new phenomenon and has been around since the early 1990s in various forms. The College has addressed EMS diversion issues in the past through various policy statements and a Policy Resource Education Paper

(PREP). These were consolidated with other policy statements in January 2018 into a new policy statement "Emergency Medical Services Interfaces with Health Care Systems" in an effort to reduce the number of single topic policy statements where feasible. The other policy statements that were consolidated addressed related topics such as Emergency Ambulance Destination, EMS Regionalization of Care, and Interfacility Transportation of the Critical Care Patient and Its Medical Direction. The current policy statement addresses EMS destination protocols.

Historically EMS Diversion is most effectively handled at the local or regional level. The medical directors and administration of the local hospitals and EMS services typically meet and agree on a plan to address the specific needs of the local system. Coordination between all involved parties and an agreement to follow a planned solution is essential to the success of the system.

ACEP can collaborate with other stakeholder organizations to discourage states and hospitals from using forced EMS diversion instead of system or regional hospital admission load balancing through means such as developing policy statements, sharing best practices, and encouraging local EMS and healthcare systems to work together to address solutions specific to their local needs. ACEP can monitor the environment through member feedback on the EMS Section engagED site to gauge the level of success or if additional actions are needed. Collecting data on the clinical impact of EMS diversion policies may require the assistance of a data analyst depending on the type of data to be collected.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective A – Promote for efficient, sustainable, and fulling clinical practice environments
  - Tactic 5 – Continue to advocate to measure and reduce boarding and improve patient throughput.

Fiscal Impact

Budgeted committee, section, and staff resources. Potential unbudgeted and unknown costs for a data analyst depending on the type of data to be collected.

Prior Council Action

Amended Resolution 40(00) Ambulance Diversion adopted. The resolution called for data collection and practice guidelines that address ambulance diversion and effective communications plan for the public.

Prior Board Action

February 2018, approved the policy statement "Emergency Medical Services Interfaces with Health Care Systems;" replaced four rescinded policy statements "Ambulance Diversion," "Emergency Ambulance Destination," "EMS Regionalization of Care," and "Interfacility Transportation of the Critical Care Patient and Its Medical Direction."

Amended Resolution 40(00) Ambulance Diversion adopted.

October 2006, reviewed the information paper "Approaching Full Capacity in the Emergency Department."

October 1999, reviewed by the ACEP Board of Directors the Policy Resource Education Paper (PREP) "Guidelines for Ambulance Diversion"

Background Information Prepared by: Rick Murray, EMT-P
EMS & Disaster Preparedness Director

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 50(21)

SUBMITTED BY: Michael Carius, MD FACEP
Roneet Lev, MD FACEP
Gregory Shangold, MD FACEP
Thomas J. Sugarman, MD, FACEP
Connecticut College of Emergency Physicians
Rhode Island Chapter

SUBJECT: Harms of Marijuana

PURPOSE: Develop a policy statement on the harms of marijuana as seen in EDs and provide education and guidance to emergency physicians for documentation and overall awareness of cannabis-related ED diagnoses.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Several studies have shown that emergency department (ED) visits with a cannabis related diagnosis have increased[1][2][3]; and

WHEREAS, The National Poison Data System reported 28,630 exposures from 2017 – 2019 due to cannabis exposure and 27% of the calls were for children under 10-year-old[4]; and

WHEREAS, Youth access to cannabis has significant long-term and short-term negative effects on cognitive ability and can induce devastating mental health issues; and

WHEREAS, Cannabis induced psychosis is common, especially with current availability of high potency smoked and ingested THC products and daily cannabis use has a 5 times increased odds ratio of developing a psychotic disorder when using high potency cannabis[5][6][7][8][9][10]; and

WHEREAS, ED boarding of psychiatric patients remains a major concern in emergency department across the country, and a percentage of patients with psychosis related ED boarding is due to cannabis related psychosis; and

[1] Monte AA, et al. Acute Illness Associated with Cannabis Use by Route of Exposure: An Observational Study. Annals of Internal Medicine, 2019. https://www.acpjournals.org/doi/10.7326/M18-2809
[2] San Diego Marijuana Prevention Initiative 2020 Report. https://www.ccrconsulting.org/media/attachments/2020/05/04/mpi-report-5.4.2020-corrections.pdf
[3] Shen JJ, et al. Trends and Related Factors of Cannabis Associated Emergency Department Visits in the United States 2006-2014. J Addict Med, 2019.
[4] Dilley JA, Graves JM, Brooks-Russell A, Whitehill JM, Liebelt EL. Trends and Characteristics of Manufactured Cannabis Product and Cannabis Plant Product Exposures Reported to US Poison Control Centers, 2017-2019. *JAMA Netw Open.* 2021;4(5):e2110925. doi:10.1001/jamanetworkopen.2021.10925
[5] Mustonen A, Niemelä S, Nordström T, Murray GK, Mäki P, Jääskeläinen E, Miettunen J. Adolescent cannabis use, baseline prodromal symptoms and the risk of psychosis. Br J Psychiatry. 2018 Apr;212(4):227-233. doi: 10.1192/bjp.2017.52. PMID: 29557758.
[6] Bourque J, Afzali MH, Conrod PJ. Association of Cannabis Use With Adolescent Psychotic Symptoms. *JAMA Psychiatry.* 2018;75(8):864–866. doi:10.1001/jamapsychiatry.2018.1330
[7] Carney, R et al. "Cannabis use and symptom severity in individuals at ultra high risk for psychosis: a meta-analysis." *Acta psychiatrica Scandinavica* vol. 136,1 (2017): 5-15. doi:10.1111/acps.12699
[8] Arianna Marconi, Marta Di Forti, Cathryn M. Lewis, Robin M. Murray, Evangelos Vassos, Meta-analysis of the Association Between the Level of Cannabis Use and Risk of Psychosis, *Schizophrenia Bulletin*, Volume 42, Issue 5, September 2016, Pages 1262–1269, https://doi.org/10.1093/schbul/sbw003
[9] Moore THM, et al. Cannabis use and risk of psychosis or affective mental health outcomes: a systemic review. The Lancet, 2007.
[10] Forti MD, et al. The contribution of cannabis use to variation in the incidence of psychotic disorder across Europe: a multicentre case-control study. The Lancet, 2019.

WHEREAS, Cannabis Hyperemesis syndrome can be a frequent ED diagnosis[11]; and

WHEREAS, Increased use of cannabis leads to increased trauma including motor vehicle fatalities and workplace injuries; and

WHEREAS, Smoking and vaping cannabis is associated with lung injury such as reactive airway disease, pneumothorax, and cancer risk[12][13][14]; and

WHEREAS, Patients may present to the ED with seizures that are exacerbated by cannabis use[15][16]; and

WHEREAS, Patients have presented to the ED with bleeding complications due to drug interactions of anti-coagulants and cannabis use[17]; and

WHEREAS, Many medical organizations have published position statements on cannabis harms related to their specific specialty such as the American Academy of Pediatrics, American College of Obstetrics and Gynecology, American Glaucoma Foundation, American Heart Association, American Lung Association, and International Association for the Study of Pain; and

WHEREAS, ACEP has a public health and education duty for disease prevention, including the harms of marijuana that present to the ED; and

WHEREAS, Some emergency physicians may not be aware of associated cannabis related harms and drugs interactions, thereby under reporting the incidence of cannabis related ED visits; therefore be it

RESOLVED, That ACEP develop a policy statement on the harms of marijuana as seen in emergency department presentations; and be it further

RESOLVED, That ACEP provide education and guidance to emergency physicians in relationship to documentation and overall awareness of cannabis related ED diagnoses.

Background

This resolution calls for ACEP to develop a policy statement on the harms of marijuana as seen in emergency departments and provide education and guidance to emergency physicians in relationship to documentation and overall awareness of cannabis related ED diagnoses.

The legalization of both recreational and medicinal use of cannabis continues to be highly controversial, enhanced by conflicting studies demonstrating various effects experienced in states where marijuana use has been legalized. The medical use of cannabis is legalized in thirty-six states, four out of five permanently inhabited U.S. territories, and the District of Columbia. Twelve other states have laws that limit THC content for the purpose of allowing access to products that are rich in cannabidiol (CBD). The recreational use of cannabis is legalized in eighteen states, the

[11] Monte AA, Shelton SK, Mills E, Saben J, Hopkinson A, Sonn B, Devivo M, Chang T, Fox J, Brevik C, Williamson K, Abbott D. Acute Illness Associated With Cannabis Use, by Route of Exposure: An Observational Study. Ann Intern Med. 2019 Apr 16;170(8):531-537. doi: 10.7326/M18-2809. Epub 2019 Mar 26. PMID: 30909297; PMCID: PMC6788289.
[12] Callaghan, R.C., Allebeck, P. & Sidorchuk, A. Marijuana use and risk of lung cancer: a 40-year cohort study. *Cancer Causes Control* **24,** 1811–1820 (2013). https://doi.org/10.1007/s10552-013-0259-0
[13]Boyd CJ, McCabe SE, Evans-Polce RJ, Veliz PT. Cannabis, Vaping, and Respiratory Symptoms in a Probability Sample of U.S. Youth. J Adolesc Health. 2021 Feb 22:S1054-139X(21)00047-1. doi: 10.1016/j.jadohealth.2021.01.019. Epub ahead of print. PMID: 33676824.
[14] Wayne R. Ott, Tongke Zhao, Kai-Chung Cheng, Lance A. Wallace, Lynn M. Hildemann,
Measuring indoor fine particle concentrations, emission rates, and decay rates from cannabis use in a residence,
Atmospheric Environment: X,Volume 10,2021,100106,ISSN 2590-1621, https://doi.org/10.1016/j.aeaoa.2021.100106.
[15] de Havenon, Adam et al. "The secret "spice": an undetectable toxic cause of seizure." *The Neurohospitalist* vol. 1,4 (2011): 182-6. doi:10.1177/1941874411417977
[16] Malyshevskaya, O., Aritake, K., Kaushik, M.K. *et al* Natural (Δ-THC) and synthetic (JWH-018) cannabinoids induce seizures by acting through the cannabinoid CB_1receptor. *Sci Rep* **7,** 10516 (2017). https://doi.org/10.1038/s41598-017-10447-2
[17] Drugs.com drug interaction checker with cannabis and cannabidiol

District of Columbia, the Northern Mariana Islands, and Guam. Another thirteen states and the U.S. Virgin Islands have decriminalized its use. Although the use of cannabis remains federally illegal, some of its derivative compounds have been approved by the Food and Drug Administration (FDA) for prescription use. For non-prescription use, cannabidiol derived from industrial hemp is legal at the federal level, but legality and enforcement varies by state.

Over time the American Medical Association has modified its position on recreational and medicinal use of marijuana through the adoption of new and revised policies that include:

- Cannabis Legalization for Adult Use (commonly referred to as recreational use) H-95.924 (Recently Modified)
- Public Health Impacts of Cannabis Legalization D-95.960 (Recently Modified)
- Regulation of Cannabidiol Products H-120.926 (Recently Modified)
- Cannabis Legalization for Medicinal Use D-95.969
- Cannabis and Cannabinoid Research H-95.952

Recently, ACEP members have published multiple articles and editorials:

- The perils of recreational marijuana use: relationships with mental health among emergency department patients (JACEP Open; March 8, 2020)
- Indications and preference considerations for using medical Cannabis in an emergency department: A National Survey (The American Journal of Emergency Medicine; July 10, 2020)
- Letter to Editor: A National Survey of US Medicine Physicians on their Knowledge Regarding State and Federal Cannabis Laws (Cannabis & Cannabinoid Research; December 2020)
- The emergency department care of the cannabis and synthetic cannabinoid patient: a narrative review (International Journal of Emergency Medicine; February 2021)

ACEP has developed education that is available on demand related to ED presentations related to marijuana, which include:

- Deadly Spice: A CME Now Case Study (352 enrollments)
- Legal and Legit? Vices of the Young:
    - ACEP20 course (30 enrollments)
    - ACEP19 on demand course (68 enrollments)
- Still Dope: New on the Scene 2020:
    - ACEP20 course (95 enrollments)
    - ACEP19 on demand course (64 enrollments)

Based on direction in Amended Resolution 36(18) ACEP Policy Related to Medical Cannabis and recommendation from the Federal Government Affairs Committee, ACEP Supported H.R. 3797, the "Medical Marijuana Research Act of 2019," introduced by Representatives Earl Blumenauer (D-OR) and Andy Harris, MD (R-MD). This legislation was consistent with ACEP policy, amending the Controlled Substances Act to establish a less burdensome registration process specifically for marijuana research, and providing approved researchers with the ability to acquire cannabis needed for their studies. The House of Representatives approved the ACEP-supported "Medical Marijuana Research Act" at the conclusion of the 116th Congress, but it was not enacted into law. This legislation was intended to ensure a supply of marijuana for research purposes through the National Institute on Drug Abuse Drug Supply Program, directed the FDA to issue guidelines on the production of marijuana, and encouraged authorized researchers and manufacturers to produce marijuana. ACEP continues to monitor legislative efforts in the 117th Congress to expand clinical trials of the effects of medical-grade cannabis on the health outcomes of covered veterans diagnosed with chronic pain and those diagnosed with PTSD.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum, including rural areas.
- Objective C – Promote the value of emergency medicine and emergency physicians as essential components of the health care system.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Amended Resolution 36(18) ACEP Policy Related to Medical Cannabis adopted. Directed ACEP to support rescheduling of cannabis to facilitate well-controlled studies of cannabis and related cannabinoids for medical use.

Resolution 37(18) ACEP Policy Related to "Recreational" Cannabis not adopted. Called for ACEP to align ACEP policy on recreational use of cannabis with current AMA policy on the issue.

Resolution 54(17) Use of Cannabis as an Exit Drug for Opioid Dependency not adopted. Called for ACEP to adopt a policy stating that a chronic pain patient in a pain management program should not be eliminated from the program solely because they use cannabis as recommended by their physician.

Resolution 53(17) Supporting Research in the Use of Cannabidiol in the Treatment of Intractable Pediatric Seizure Disorders not adopted. Directed ACEP to publicly and officially state support for scientific research to evaluate the risks and benefits of cannabidiol in children with intractable seizure disorders who are unresponsive to medications currently available.

Resolution 42(17) ACEP Policy Related to Cannabis not adopted. Directed that ACEP not take a position on the medical use of marijuana, cannabis, or synthetic cannabinoids and not support the non-medical use of marijuana, cannabis, synthetic cannabinoids and similar substances.

Resolution 30(16) Treatment of Marijuana Intoxication in the ED referred to the Board of Directors. Directed ACEP to determine if there are state or federal laws providing guidance to emergency physicians treating marijuana intoxication in the ED; investigate how other specialties address the treatment of marijuana intoxication in clinical settings; and provide resources to coordinate the treatment of marijuana intoxication.

Resolution 10(16) Criminal Justice Reform – National Decriminalization of Possession of Small Amounts of Marijuana for Personal Use referred to the Board. The resolution directed ACEP to adopt and support a national policy for decriminalization of small amounts of marijuana possession for personal and medical use and submit a resolution to the AMA for national action on decriminalization of possession of small amounts of marijuana for personal use.

Resolution 16(15) Decriminalization and Legalization of Marijuana not adopted. Directed ACEP to support decriminalization for possession of marijuana for recreational use by adults and to support state and federal governments to legalize, regulate, and tax marijuana for adult use.

Resolution 15(15) CARERS Act of 2015 not adopted. Directed ACEP to endorse S. 683 and require the AMA Section Council on Emergency Medicine to submit a resolution directing the AMA to endorse this legislation.

Resolution 27(14) National Decriminalization of Possession of Marijuana for Personal and Medical Use not adopted. Directed ACEP to adopt and support policy to decriminalize possession of marijuana for personal use, support medical marijuana programs, and encourage research into its efficacy, and have the AMA Section Council on EM submit a resolution for national action on decriminalization for possession of marijuana for personal and medical use.

Amended Resolution 19(14) Cannabis Recommendations by Emergency Physicians not adopted. The original resolution called for ACEP to support emergency physician rights to recommend medical marijuana where it is legal;

object to any punishment or denial of rights and privileges at the state or federal level for emergency physicians who recommend medical marijuana; and support research for medical uses, risks, and benefits of marijuana. The amended resolution directed ACEP to support research into the medical uses, risks, and benefits of marijuana.

Resolution 23(13) Legalization and Taxation of Marijuana for both Adult and Medicinal Use not adopted. This resolution requested ACEP to support, endorse, and advocate for the legalization and taxation of marijuana.

Resolution 25(11) Regulate Marijuana Like Tobacco not adopted. This resolution would have revised ACEP policy on tobacco products to apply to marijuana or cannabis.

Resolution 20(10) Legalization and Taxation of Marijuana not adopted. This resolution requested ACEP to support, endorse, and advocate for the legalization and taxation of marijuana.

Resolution 16(10) Classification Schedule of Marijuana as a Controlled Substance not adopted. The resolution requested ACEP to convene a Marijuana Technical Advisory Committee to advocate for change in the classification status of marijuana from a DEA Schedule I to a Schedule II drug.

Resolution 16(09) Legalization and Taxation of Marijuana not adopted. This resolution requested ACEP to support, endorse, and advocate for the legalization and taxation of marijuana and for a trust fund to be established using tax revenue from marijuana sales that would fund research and treatment of drugs and alcohol dependence.

Prior Board Action

June 2019, approved the policy statement: Medical Cannabis

Amended Resolution 36(18) ACEP Policy Related to Medical Cannabis adopted.

June 2017, approved the Emergency Medicine Practice Committee's recommendation to take no further action on Resolveds 1, 2, and 4 and approved their recommendations for Resolved 3 (assign to the Tox Section or other body for additional work) and Resolved 5 (educate ED providers to document diagnosis of marijuana intoxication and subsequent efforts be made to correlate said diagnosis with concerning emergent presentations, including those in high-risk populations such as children, pregnant patients, and those with mental illness. Once that data is obtained, ACEP can then appropriately focus on determining what resources are needed to coordinate treatment of marijuana intoxication).

June 2017, adopted the recommendation of the Emergency Medicine Practice Committee, Medical-Legal Committee, and the Public Health & Injury Prevention Committees to take no further action on Referred Resolution 10(16) Criminal Justice Reform – National Decriminalization of Possession of Small Amounts of Marijuana for Personal Use.

Background Information Prepared by: Sam Shahid, MBBS, MPH
Practice Management Manager

Kaeli Vandertulip, MBA, MSLS, AHIP
Clinical Practice Manager

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 51(21)

SUBMITTED BY: Georgia College of Emergency Physicians

SUBJECT: Medical Bill of Rights for Detained and Incarcerated Persons While Receiving Emergency Medical Care

PURPOSE: Adopt a Medical Bill of Rights for detained and incarcerated persons in reference to patients presenting under custody for medical evaluation and work with stakeholders to develop federal legislation requiring health care facilities to inform patients in custody about their rights as a patient.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Detained, arrested, and/or incarcerated patients have the right to medical neutrality from their treating physician regardless of their status as a detained or incarcerated person[1]; and

WHEREAS, Detained, arrested, and/or incarcerated persons have the right to speak with their provider confidentially[1]; and

WHEREAS, Detained, arrested, and/or incarcerated persons have the right to removal of physical restraints for the purpose of a physical exam at the discretion of the treating physician[4]; and

WHEREAS, Detained, arrested, and/or incarcerated persons have the right to medical care at a facility that has a protocol for and supports ongoing quality improvement of medical care for the incarcerated patient[1]; and

WHEREAS, Detained, arrested, and/or incarcerated persons have the right to privacy and protection from inquiry regarding charges, conviction, or duration of sentence unless immediately pertinent to patient care[1]; and

WHEREAS, Detained, arrested, and/or incarcerated persons have the right to informed consent; to be adequately informed of diagnoses, treatment options, risks and alternatives, and follow-up plans with respect to educational status and literacy as necessary[1]; and

WHEREAS, Detained, arrested, and/or incarcerated persons have the right to refuse care, diagnostic testing, nutrition, laboratory studies, medications, and procedures, for as long as the patient has medical decision making capacity as deemed by the treating physician or is not at immediate risk of harm to self or others[5]; and

WHEREAS, Detained, arrested, and/or incarcerated persons have the right to timely administration of all interventions and necessary consultations while in the emergency department as deemed by the attending physician[1]; and

WHEREAS, Detained, arrested, and/or incarcerated persons have the right to make their healthcare decisions independent of law enforcement officials when competent, and to appoint an appropriate surrogate medical decision-maker in the event they become incompetent. Wardens, sheriffs, guards, police officers, prison administrators, and other law enforcement officials are not eligible medical decision-makers[2]; and

WHEREAS, Detained, arrested, and/or incarcerated persons have the right to consultation by their medical decision-maker according to state laws regardless of the policies of law enforcement or carceral institutions[1]; and

WHEREAS, The term “capacity” is defined by physicians and represents a patient’s ability to make decisions

and is separate from the legal term "competency" in this document[3]; therefore be it

RESOLVED, That ACEP adopt the following Medical Bill of Rights for detained and incarcerated persons in reference to patients presenting under custody for medical evaluation:

Detained, arrested, and incarcerated persons have the right to:

1. Medical neutrality – equal evaluation and treatment for emergency medical conditions regardless of their status as a detained or incarcerated person.
2. Speak with their provider privately.
3. Removal of physical restraints for the purpose of a physical exam at the request of the treating physician.
4. Medical care at a facility that has a protocol for and supports quality analysis of medical care.
5. Privacy and protection from inquiry regarding charges, conviction, or duration of sentence unless expressly pertinent to delivery of care.
6. Informed consent – to be adequately informed of diagnoses, treatment options, risks and alternatives, and follow-up plans.
7. Refuse care and diagnostic testing, including nutrition, laboratory studies, medications, and procedures, with the exception of psychoactive medications if the patient is deemed a potential harm to self or others if psychoactive medications are withheld OR with the exception of previously set forth state policies or contracts determining otherwise.
8. Administration of interventions and requests for consultations in a timely manner consistent with local standards of care.
9. Make their healthcare decisions independently, if deemed competent, and to appoint an appropriate surrogate medical decision-maker in the event they become incompetent. Wardens, sheriffs, guards, police officers, prison administrators, and other law enforcement officials are not eligible medical decision-makers.
10. Visitation by their medical decision-maker according to state laws regardless of the policies of law enforcement or carceral institutions.; and be it further

RESOLVED, That ACEP work with interested parties and key stakeholders to develop federal legislation requiring health care facilities to inform patients in custody about their rights as a patient.

Background

The resolution calls for the College to adopt a Medical Bill of Rights (as outlined in the first resolved) for detained and incarcerated persons in reference to patients presenting under custody for medical evaluation and for ACEP to work with interested parties and key stakeholders to develop federal legislation requiring health care facilities to inform patients in custody about their rights as a patient.

According to the U.S. Department of Justice Bureau of Justice Statistics, as of 2018, more than 2.1 million people were incarcerated in U.S. prisons or jails. This is the largest incarcerated population in the world, as well as the highest per-capita incarceration in the world. Nearly two dozen U.S. states have incarceration rates higher than every other country on earth, with 70 percent of convictions for criminal offenses resulting in incarceration.

The incarcerated population presents specific underlying health challenges and burdens when compared to the general population, with higher rates of serious diseases such as Hepatitis C, HIV, tuberculosis; higher risks of serious injuries from beatings or rape; or high rates of serious mental health issues. The COVID-19 pandemic has also brought these existing public health challenges into sharp relief, with an already vulnerable population at greater risk, as well as the downstream effects and risks for individuals who work at or interact with correctional/detention facilities. The ACEP COVID-19 Field Guide section, Incarcerated Population, details some of the background, unique challenges, best practices, and guidelines for prevention and treatment of COVID-19 in these populations.

Rapid assessment and treatment of incarcerated populations pose unique challenges for emergency physicians. These individuals are subject to limitations on their access to care, including emergency care. When transport to an emergency department is deemed necessary by the correctional officer(s) or facility, incarcerated individuals must

undergo searches and careful scrutiny by both health care personnel and security personnel before gaining clearance for transport. Access to primary care, specialty care, or other alternative health care providers is exceptionally limited, often leaving the emergency department as the first and only option for medical care outside of a correctional facility.

Other significant barriers may also affect the ability or willingness to seek treatment for medical conditions, such as fear, lack of privacy, stigma, or even a perception that they do not have the right to seek medical care. Incarcerated persons may also be subject to unconscious or implicit bias by physicians and other health care personnel that may affect their treatment and outcomes as well. An ACEP resource document developed by the Public Health Committee in 2006, "Recognizing the Needs of Incarcerated Patients in the Emergency Department," further details the scope of the problem, barriers to care, historical perspectives, considerations for provision of care, as well as guidelines for and other information on emergency medical care for incarcerated individuals.

The 1976 Supreme Court decision in *Estelle v. Gamble* established what is essentially the foundation of legal standards of medical care for incarcerated individuals, establishing the principle that deliberate indifference to serious medical needs of prisoners was a violation of the Eighth Amendment. Additional Supreme Court and lower court cases have expanded upon the precedent established in *Estelle*, laying out a set of basic rights for incarcerated individuals, and Congress has also enacted legislation in the years since to outlaw particularly egregious and inhumane aspects of care for this population. While these rights to care have been outlined by the federal legislature and judiciary, incarcerated individuals are still at greater risk of receiving substandard treatment from the health care system due to the myriad challenges unique to this population.

ACEP has maintained a liaison relationship with the National Commission on Correctional Health Care (NCCHC) since at least 1987. NCCHC is a non-profit organization with a mission to "improve the quality of health care in jails, prisons and juvenile confinement facilities" and establishes standards for care in correctional facilities, offers accreditation for facilities, and provides other related resources.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum, including rural areas.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Amended Resolution 16(00) Support of the National Commission on Correctional Health Care (NCCHC) adopted. Directed the College to continue supporting the liaison relationship with the NCCHC.

Prior Board Action

Amended Resolution 16(00) Support of the National Commission on Correctional Health Care (NCCHC) adopted.

Background Information Prepared by: Ryan McBride, MPP
Senior Congressional Lobbyist

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 52(21)

SUBMITTED BY: Utah Chapter

SUBJECT: Standardization of Medical Screening Exams of Arrested Persons Brought to the ED

PURPOSE: Work with interested state chapters, law enforcement personnel, and other stakeholders to: 1) develop protocols and standards for the medical screening examination of individuals in law enforcement custody when the arresting agency requests a medical evaluation of that individual prior to processing into a detention center; and 2) develop best practice guidelines for the conveying of an arrested person's pertinent medical information to medical personnel at the receiving correctional facility, consistent with medical ethics and medical privacy laws.

FISCAL IMPACT: Budgeted committee or task force and staff resources if a meeting is held virtually. Unbudgeted expenses of $20,000 – $30,000 for an in- person meeting depending on the size of the group.

WHEREAS, Law enforcement personnel will frequently bring arrested persons to emergency departments for "medical clearance" exams prior to booking the arrested person into a correctional facility; and

WHEREAS, Currently no national protocols or standards exist that define the most appropriate medical screening exam or expectations of the emergency physician in this situation; and

WHEREAS, It is not clear under what circumstances the medical information obtained on an arrested individual should or can legally be conveyed to medical personnel at the receiving correctional facility, nor is there a standardized, confidential way in which to do so; and

WHEREAS, This creates confusion and may put the arrested individual at medical risk and the emergency physician at medicolegal risk if the arrested person later develops an emergency medical condition after being booked into a correctional facility; therefore be it

RESOLVED, That ACEP work with interested state chapters, law enforcement personnel, and other stakeholders to develop protocols and standards for the medical screening examination of individuals who are in law enforcement custody when the arresting agency requests a medical evaluation of that individual prior to processing into a detention center; and be it further

RESOLVED, That ACEP develop best practice guidelines for the conveying of an arrested person's pertinent medical information to medical personnel at the receiving correctional facility, consistent with medical ethics and medical privacy laws.

Background

This resolution requests ACEP to work with interested state chapters, law enforcement personnel, and other stakeholders to develop protocols and standards for the medical screening examination of individuals who are in law enforcement custody when the arresting agency requests a medical evaluation of that individual prior to processing into a detention center and to develop best practice guidelines for the conveying of an arrested person's pertinent medical information to medical personnel at the receiving correctional facility, consistent with medical ethics and medical privacy laws.

ACEP recognizes the importance of protection of patient information. ACEP's policy statement *"*Confidentiality of

Patient Information" includes:

"ACEP believes confidentiality of patient information is an important but not absolute principle. Confidential patient information may be disclosed when patients or their legal surrogates agree to disclosure, when mandated by law, or when there exist overriding and compelling grounds for disclosure, such as the prevention of substantial harm to identifiable other persons." This was further supported and more specifically addressed in the Policy Resource Education Paper (PREP) "Hippocrates to HIPPA: Privacy and Confidentiality in Emergency Medicine" Part I and Part II. The PREP discusses HIPAA and exceptions outlined in federal law. ACEP's policy statement "Law Enforcement Information Gathering in the Emergency Department" applies indirectly to treatment and patient health information regarding the patient's condition as mandated by law and ethical decisions by physicians.

ACEP's information paper: "Recognizing the Needs of Incarcerated Patients in the Emergency Department" addresses patients presenting from prisons, already incarcerated in local jails, and in police custody from the street and discusses each of these scenarios as applied to the patients right to refusal, implicit bias, thorough medical examination, safety, and information sharing.

ACEP's information paper: *"*Implicit Bias and Cultural Sensitive: Effects on Clinical and Practice Management*"* also addresses bias and implied bias and uses a patient in police custody as an example.

An article written by ACEP member Robert A. Bitterman, MD, JD, FACEP: *"*Federal law, EMTALA, and state law enforcement: Conflict in the ED?*"* discusses CMS regulations regarding Medical Clearance for the incarcerated also referred to as "Jail Clearance" and parameters for medical clearance.

Several other references include:

- "When your patient is in police custody" from the Nursing 2021 Journal. The article discusses follow up care and documentation.
- "Q and A: The Hospital, The Law, And the Patient" from Patient Safety & Quality Healthcare (PSQH). Discusses the necessity for hospital policies regarding patients in custody and references an incident in Utah where a nurse was arrested for refusing to comply with what was found to be an unlawful order.
- "Law Enforcement and Healthcare: When Consent, Privacy and Safety Collide" published in the Journal of Urgent Care Medicine. Discusses further compliance issues, EMTALA, requests for patient health information, and limitations of those requests.

ACEP has maintained a liaison relationship with the National Commission on Correctional Health Care (NCCHC) since at least 1987. NCCHC is a non-profit organization with a mission to "improve the quality of health care in jails, prisons and juvenile confinement facilities" and establishes standards for care in correctional facilities, offers accreditation for facilities, and provides other related resources.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective A – Promote/advocate for efficient, sustainable, and fulfilling clinical practice environments.
- Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum.
- Objective C – Establish and promote the value of emergency medicine as an essential component of the health care system.

Goal 2 – Enhance Membership Value and Member Engagement

Objective A – Improve the practice environment and member well-being.

Fiscal Impact:

Budgeted committee or task force and staff resources if a meeting is held virtually. Unbudgeted expenses of $20,000 –

$30,000 for an in- person meeting depending on the size of the group.

Prior Council Action

Amended Resolution 16(00) Support of the National Commission on Correctional Health Care (NCCHC) adopted. Directed the College to continue supporting the liaison relationship with the NCCHC.

Prior Board Action

June 2017, approved the revised policy statement "Law Enforcement Information Gathering in the Emergency Department;" revised and approved April 2010; originally approved September 2003.

April 2017, reviewed the information paper "Implicit Bias and Cultural Sensitive: Effects on Clinical and Practice Management."

January 2017, approved the revised policy statement "Confidentiality of Patient Information" with the current title; reaffirmed October 2008, October 2002, and October 1998; originally approved January 1994 titled "Patient Confidentiality."

April 2006, reviewed the information paper "Recognizing the Needs of Incarcerated Patients in the Emergency Department."

January 2005, reviewed the Policy Resource Education Paper (PREP)-"Hippocrates to HIPPA: Privacy and Confidentiality in Emergency Medicine" Part I and Part II.

Amended Resolution 16(00) Support of the National Commission on Correctional Health Care (NCCHC) adopted.

Background Information Prepared by: Patrick R. Elmes, EMT-P
EMS and Disaster Preparedness Manager

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 53(21)

SUBMITTED BY: Taylor Nichols, MD
Alexander Schmalz, MD, MPH
Kevin Durgun, MD
California Chapter
Young Physicians Section

SUBJECT: Reporting of Injuries Suspected or Reported to be Resulting from Law Enforcement Actions

PURPOSE: 1) Support a reporting process to an independent entity regarding injuries suspected or reported to be resulting from law enforcement actions; and 2) create an educational toolkit regarding identifying and reporting injuries suspected or reported to be resulting from law enforcement actions.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Use of force by law enforcement continues to be a dominant issue among public health officials, politicians, and the general public; and

WHEREAS, Physicians are often mandated reporters for injuries suspected or reported to be from assaultive or abusive conduct in vulnerable populations, with all 50 states mandating that child abuse be reported to state authorities and 47 states mandating that elder abuse be reported to state authorities or local law enforcement[1] ; and

WHEREAS, Physicians in most states are also mandated reporters of assault by firearm or other deadly weapon as well as for severe injuries, sexual assault, or other "injuries that result from a criminal act"[1]; and

WHEREAS, ACEP encourages research regarding the epidemiology of abuse and neglect in these vulnerable populations as well as an understanding of best practice approaches to screening, assessment and intervention for these victims[2-3]; and

WHEREAS, "Prisoners" are a specifically protected category of people in medical ethics, as indicated by the customary conventions of the Department of Health and Human Services, Institutional Review Boards at institutions conducting research involving human subjects, and that patients in police custody are functionally imprisoned and therefore consistent with other vulnerable populations[4]; and

WHEREAS, The currently established channels available for reporting of injuries suspected or reported to be resulting from assaultive or abusive conduct, including of injuries suspected or reported to be resulting from law enforcement actions, are most often to report directly to local law enforcement agencies; and

WHEREAS, There is a conflict of interest in reporting injuries suspected or reported to be resulting from law enforcement actions directly to the law enforcement agencies of the officer(s) involved in said assaultive or abusive conduct; and

WHEREAS, Patients may underreport injuries resulting from law enforcement actions due to this conflict of interest in currently available reporting mechanisms; and

WHEREAS, In our role as emergency physicians we both work with law enforcement agencies on a regular basis and care for victims of police violence, and therefore we have a conflict of interest in best serving caring for our patients while having to report directly to these law enforcement agencies; and

WHEREAS, Emergency physicians may under-recognize and therefore underreport injuries resulting from law enforcement actions due to a lack of adequate information and training tools on this topic[5]; and

WHEREAS, This underreporting further contributes to the lack of adequate data collected regarding injuries resulting from law enforcement actions, which contributes to further the underrepresentation of this public health problem and the mistrust between law enforcement and the communities they serve [6]; and

WHEREAS, There is a precedent for the establishment of an independent entity for the reporting of abuse and neglect in vulnerable populations[1]; and

WHEREAS, The establishment of an independent entity to whom physicians could report suspected or reported assault by law enforcement would help resolve these conflicts of interest as well as improve reporting, epidemiological monitoring, and data gathering from which we could perform research to improve our care as emergency physicians; therefore be it

RESOLVED, That ACEP issue a statement regarding support for a reporting process to an independent entity regarding injuries suspected or reported to be resulting from law enforcement actions, as doing so will allow emergency physicians to avoid conflicts of interest, improve reporting, data gathering and epidemiologic monitoring, which will better enable us to research how we can best provide the most safe and appropriate care to our patients; and be it further

RESOLVED, That ACEP create an educational toolkit regarding identifying and reporting injuries suspected or reported to be resulting from law enforcement actions similar to that which exists regarding child and elder or dependent abuse or neglect, thereby enhancing physician understanding of these injuries and improving reporting.

References

1. Sachs CJ. Mandatory Reporting of Injuries Inflicted by Intimate Partner Violence. *AMA Journal of Ethics: Virtual Mentor.* 2007;9(12):842-845. doi.org/10.1001/virtualmentor.2007.9.12.oped1-0712
2. ACEP // Domestic Family Violence. https://www.acep.org/patient-care/policy-statements/domestic-family-violence/. Accessed August 31, 2020.
3. ACEP // American College of Emergency Physicians. https://www.acep.org/imports/clinical-and-practice-management/resources/violence/domestic-family-violence/. Accessed August 31, 2020.
4. Title 45: Public Welfare, Part 46- Protection of Human Subjects, 46.303 Definitions. Electronic Code of Federal Regulation. Depart of Health and Human Services. https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=83cd09e1c0f5c6937cd9d7513160fc3f&pitd=20180719&n=pt45.1.46&r=PART&ty=HTML#se45.1.46_1303. Accessed November 5, 2020.
5. Reinenger A, Robinson E, McHugh M. Mandated training of professionals: A means for improving reporting of suspected child abuse. *Child Abuse and Neglect*. 1995; 19(1): 63-69. doi.org/10.1016/0145-2134(94)00105-4
6. Wanted: better data on police shootings to reduce mistrust between the police and the communities they serve. *Nature*. 2019;573(7772):5. doi.org/10.1038/d41586-019-02614-4

Background

This resolution directs the College to issue a statement supporting a process to report to an independent entity any injuries suspected or reported to be resulting from law enforcement actions and to create an educational toolkit that would further enhance the emergency physician's knowledge and understanding regarding the identification and reporting of such suspected injuries.

There currently exists a process for reporting child and elder abuse or dependent abuse or neglect. Having a standardized reporting process would allow emergency physicians to avoid possible conflicts of interest when dealing with and reporting these types of injuries. It would also facilitate improved reporting and data gathering during epidemiology monitoring to advance related research activities.

The College has a history of developing and disseminating policy statements that address violence prevention and reporting abuse and injuries to the appropriate authorities. This issue of suspected injuries resulting from law enforcement actions falls within the College's support for the goal of a violence free society. There are definite challenges to be addressed considering the close relationship between law enforcement and emergency physicians in

the emergency department. An appropriate set of checks and balances to validate any suspected injuries would be an important part of the reporting system.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective A- Promote/advocate for efficient, sustainable, and fulfilling clinical practice environments.
- Objective B-Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum.
- Objective C-Establish and promote the value of emergency medicine as an essential component of the health care system.

Goal 2 – Enhance Membership Value and Member Engagement

- Objective A-Improve the practice environment and member well-being.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

None that are specific to a reporting process to an independent entity regarding injuries suspected or reported to be resulting from law enforcement actions or educational resources about such reporting.

Substitute Resolution 49(20) Strangulation Policy Statement and Education Resources adopted. The resolution directed that ACEP acknowledges the hazard associated with air-choke holds, strangulation and carotid restraint and educate its members and relevant stakeholders on the hazards and the recognition and appropriate management of patients who present to the ED with injuries associated with air-choke holds, strangulation and carotid restraint maneuvers in various settings.

Resolution 39(20) Urging the Prohibition of Law Enforcement Use of Rubber Bullets and Tear Gas for Crowd Control not adopted. The resolution called for condemning the use of rubber bullets and tear gas to control or disperse crowds.

Resolution 22(10) Policy Pursuits not adopted. Called for the College to strongly encourage the use of safer alternatives to police pursuits, support the enactment of laws requiring law enforcement agencies to accept responsibility for their actions with respect to police pursuits, and support mandatory tracking of pursuit-related injury data by the National Highway Traffic Safety Administration (NHTSA).

Resolution 26(96) Mandatory Reporting of Domestic Violence referred to the Board of Directors. The resolution called for ACEP to oppose the mandatory reporting of domestic violence and support other ways to help identify victims.

Amended Resolution 25(96) Domestic Violence – Effects on Children adopted. Directed ACEP to investigate the development of guidelines to encourage and facilitate collaborative efforts between EDs and child protective agencies.

Amended Resolution 11(93) Violence Free Society adopted. Develop a policy statement supporting the concept of a violence free society and increase efforts to educate member about the preventable nature of violence and the important role physicians can play in violence prevention.

Substitute Resolution 45(92) Domestic Violence adopted. Directed ACEP to develop a plan for addressing domestic violence.

Prior Board Action

Substitute Resolution 49(20) Strangulation Policy Statement and Educational Resources adopted.

February 2020, approved the revised policy statement "Use of Patient Restraints," revised and approved April 2014; reaffirmed October 2007; revised April 2001, June 2000, January 1996; originally approved January 1991.

April 2019, approved the revised policy statement "Domestic Family Violence;" reaffirmed June 2013; originally approved October 2007, replacing rescinded policies: "Child Abuse," "Domestic Violence," "Emergency Medicine and Domestic Violence," "Management of Elder Abuse and Neglect," "Support for Victims of Family Violence," and "Mandatory Reporting of Domestic Violence to Law Enforcement and Criminal Justice Agencies."

April 2019, approved the revised policy statement "Violence-Free Society;" reaffirmed June 2013; revised and approved January 2007; reaffirmed October 2000; originally approved January 1996.

April 2016, approved the revised policy statement "Protection from Violence in the Emergency Department" with the current title; revised and approved June 2011; revised April 2008 titled "Protection from Physical Violence in the Emergency Department Environment;" reaffirmed October 2001 and October 1997; originally approved January 1993 titled "Protection from Physical Violence in the Emergency Department."

Amended Resolution 25(96) Domestic Violence – Effects on Children adopted.

Amended Resolution 11(93) Violence Free Society adopted.

Substitute Resolution 45(92) Domestic Violence adopted.

Background Information Prepared by: Rick Murray, EMT-P
EMS & Disaster Preparedness Director

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 54(21)

SUBMITTED BY: Diversity, Inclusion, & Health Equity Section
International Emergency Medicine Section
Social Emergency Medicine Section

SUBJECT: Understanding the Effects of Law Enforcement Presence in the Emergency Department

PURPOSE: Support research, development, and adoption of best practices for emergency physicians regarding law enforcement presence in the ED consistent with transparency and patient rights and advocate for chapter development of toolkits outlining state specific policies and laws related to law enforcement presence in EDs.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, The Emergency Department serves a safety net for many vulnerable patient populations, particularly racial minorities, undocumented immigrants, and incarcerated persons who have been historically marginalized[1]; and

WHEREAS, In medical ethics, "prisoners" are a specifically protected group of individuals as indicated by the Department of Health and Human Services, Institutional Review Board at institutions conducting research involving human subjects, and that patients in police custody are functionally imprisoned and therefore consistent with other vulnerable populations[2]; and

WHEREAS, The courts have interpreted the ED as an extension of public streets which enable law enforcement to conduct highly intrusive investigations within the ED which can violate patient privacy, confidentiality, and processes for informed consent[1]; and

WHEREAS, When hospital policies regarding law enforcement access to the ED are unclear, or when emergency medicine professionals fulfill law enforcement requests without adhering to hospital policies, the patient-physician relationship and patient health outcomes can be negatively impacted[3]; and

WHEREAS, The presence of law enforcement in the ED is a deterrent for vulnerable patients seeking care, has been shown to cause medical mistrust, and compounds biases and racial disparities that already exist in healthcare and law enforcement[3]; and

WHEREAS, The undocumented community will avoid interactions with official agencies or entities, including hospitals, because of fear that if their status were revealed they would be deported and this results in many patients putting off seeking health services for as long as possible[4]; and

WHEREAS, ACEP believes that emergency physicians have a fundamental professional responsibility to protect the confidentiality of their patients' personal health information[5]; and

WHEREAS, Law enforcement information gathering should not interfere with essential patient care[5]; and

WHEREAS, The World Medical Association International Code of Medical Ethics states that there are "particular challenges for health professionals throughout the world when the subordination of the patient's interests to state or other purposes risks violating the patient's human rights"[6]; and

WHEREAS, When emergency physicians do not have an understanding of state specific laws or hospital

policies, this increases the risk of violating the rights of vulnerable patient populations, especially incarcerated and undocumented patients when seeking care in the ED; and

WHEREAS, Establishing best practices through a patient rights-centered approach and encouraging awareness and state-specific educational material for emergency physicians would help resolve some of the conflicts of interest between emergency physicians and law enforcement officials; therefore be it

RESOLVED, That ACEP support the research, development, and adoption of best practices for emergency physicians regarding law enforcement presence in the ED to create transparency and protect the rights of its vulnerable patient populations; and be it further

RESOLVED, That ACEP advocate for state chapters to create easily accessible transparent toolkits that outline state-specific policies and laws regarding law enforcement presence in the ED, thereby enhancing physician understanding of patient and physician rights in their interactions with law enforcement within the ED as well as their own rights as physicians.

References

1. Seon Song J. Policing the Emergency Room. *Harvard Law Review*. June 2021; 134(8): 2647-2719. https://harvardlawreview.org/2021/06/policing-the-emergency-room/
2. Title 45: Public Welfare, Part 46- Protection of Human Subjects, 46.303 Definitions. Electronic Code of Federal Regulation. Depart of Health and Human Services. https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=83cd09e1c0f5c6937cd9d7513160fc3f&pitd=20180719&n=pt45.1.46&r=PART&ty=HTML#se45.1.46_1303 . Accessed July 16, 2021.
3. Working Group on Policing and Patient Rights. Police in the Emergency Department. A Medical Provider Toolkit for Protecting Patient Privacy. https://www.law.georgetown.edu/health-justice-alliance/wp-content/uploads/sites/16/2021/05/Police-in-the-ED-Medical-Provider-Toolkit.pdf
4. Caballero A. ICE in the ER: How U.S. Policies are Causing an Immigrant Health Crisis. *Physicians for Human Rights Resources Blog*. Decemeber 2018. https://phr.org/our-work/resources/ice-in-the-er-how-u-s-policies-are-causing-an-immigrant-health-crisis/ Accessed July 25th, 2021.
5. ACEP // Law Enforcement Information Gathering in the Emergency Department https://www.acep.org/patient-care/policy-statements/law-enforcement-information-gathering-in-the-emergency-department/ Accessed July 16, 2021.
6. World Medical Association. International Code of Medical Ethics. https://www.wma.net/policies-post/wma-international-code-of-medical-ethics/ Accessed July 16, 2021.

Background

The resolution calls for ACEP to support research, development, and adoption of best practices for emergency physicians regarding law enforcement presence in the emergency department consistent with transparency and patient rights and advocate for chapter development of toolkits outlining state specific policies and laws related law enforcement presence in emergency departments.

For a variety of reasons law enforcement officers may be present in the emergency department in conjunction with a presenting patient. Increasingly, such officers while observing and overhearing patient interactions may be wearing body cameras or engaging in other forms of investigative activity.

While recognizing the interest of law enforcement officers in gathering information for investigation, emergency physicians express concerns that the presence of such officers will cause persons in need of emergency care to forego treatment. In addition to patient access concerns, it is noted that the presence of persons in the emergency department without the consent of the patient or a specified interest in patient treatment or payment may run afoul of the patient privacy provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), similar state based privacy laws, and various laws related to consent, implied or otherwise, in both a legal and healthcare environment. The role of hospital policy creates an additional complexity. All of these considerations come into play in the context of the interest of physicians in advocating for best practices for protecting patients while providing patient care consistent with ACEP's Code of Ethics for Emergency Physicians.

National ACEP could recommend that chapters create the state-specific toolkits requested in the resolution and/or work with them to do so. However, as independently incorporated entities, ACEP chapters have autonomy to determine their own actions, within the parameters of ACEP and chapter bylaws and may not choose to work with ACEP as directed the resolution.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective D – Promote quality and patient safety, including continued development and refinement of quality measures and resources.

Fiscal Impact

Budgeted committee and staff resources

Prior Council Action

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 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 requiring collection of evidence from a patient in the absence of consent and develop a policy statement addressing the issue.

Resolution 30(15) Use of Body Cameras Worn by Law Enforcement in the Emergency Department referred to the Board of Directors.

Amended Resolution 20(97) Permissive Reporting of Blood Alcohol Content (BAC) to Law Enforcement Authorities adopted. Directed the BAC Reporting Task Force to develop a position paper, policy, and/or PREP.

Prior Board Action

Amended Resolution 46(18) Law Enforcement Information Gathering in the ED Policy Statement adopted.

June 2019, approved the revised policy statement "Audiovisual Recording in the Emergency Department" with the current title; revised and approved January 2017 titled "Recording Devices in the Emergency Department;" originally approved April 2011.

June 2017, approved the revised policy statement "Law Enforcement Information Gathering in the Emergency Department;" originally approved September 2003.

January 2017, approved the revised policy statement "Code of Ethics for Emergency Physicians;" revised and approved June 2016 and June 2008; reaffirmed October 2001; revised and approved with the current title June 1997; originally approved titled "Ethics Manual" January 1991.

Resolution 22(16) Court Ordered Forensic Evidence Collection in the ED adopted.

November 2015, assigned Referred Resolution 30(15) Use of Body Cameras Worn by Law Enforcement in the Emergency Department to the Ethics Committee.

Amended Resolution 20(97) Permissive Reporting of Blood Alcohol Content (BAC) to Law Enforcement Authorities adopted.

Background Information Prepared by: Harry Monroe
State Legislation Director

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 55(21)

SUBMITTED BY: New York Chapter

SUBJECT: Patient Experience Scores

PURPOSE: 1) Acknowledge and affirm that some patient satisfaction instruments are in clear violation of existing ACEP policy. 2) Define standardized inclusion and exclusion criteria for patient experience survey populations. 3) Define improved methodologies for patient experience surveys, including wording to reduce or eliminate bias and appropriate power calculations so that sufficient surveys are collected to yield more statistically valid results. 4) Advocate for patient experience survey validity and work with CMS and other stakeholders to implement change to current ED practices.

FISCAL IMPACT: Budgeted staff resources. Investment in new ED Accreditation Program.

WHEREAS, ACEP's existing policy statement stipulates Emergency Department (ED) patient experience survey tools should be standardized[1], yet neither institutions nor survey vendors have established widespread standardization of survey tools, populations, or methodologies; and

WHEREAS, ACEP's policy statement stipulates the survey should be "based on statistically valid sample size" yet many hospitals and survey vendors sample only a fraction of a percentage of the patients seen in the ED, resulting in statistically invalid surveys; and

WHEREAS, ACEP's policy statement stipulates the survey should be "free from selection bias"[2] yet survey methodologies, including inclusion and exclusion criteria have not been consistently applied and patients who are admitted are typically excluded, resulting in biased surveys[3,4]; and

WHEREAS, Emergency physicians appropriately give a disproportionate amount of time and attention to their sickest patients, while not having an opportunity to have this care evaluated by those very patients if they happen to be admitted; and

WHEREAS, Despite a prolonged trial of Emergency Department Patient Experience of Care (EDPEC), a subsequent trial of Emergency Department Consumer Assessment of Healthcare Providers and Systems (ED CAHPS), and nearly a decade of testing survey instruments, CMS has still not validated nor issued standard ED surveys; and

WHEREAS, Factors leading to poor patient experience scores, including wait times, are often related to factors extrinsic to ED operations and outside the control of the staff working in the ED[5]; therefore be it

RESOLVED, That ACEP acknowledge and affirm that current iterations of patient satisfaction instruments are in clear violation of existing ACEP policy; and be it further

RESOLVED, That ACEP define standardized inclusion and exclusion criteria for patient experience survey populations; and be it further

RESOLVED, That ACEP define improved methodologies for patient experience surveys, including wording to reduce or eliminate bias, and appropriate power calculations such that sufficient surveys are collected to yield more statistically valid results; and be it further

RESOLVED, That ACEP aggressively advocate for patient experience survey validity and work with CMS and other stakeholders to implement prompt, actionable change to current ED survey practices.

References

[1] https://www.acep.org/globalassets/new-pdfs/policy-statements/patient.experience.of.care.surveys.pdf
[2] https://www.acep.org/globalassets/new-pdfs/policy-statements/patient.experience.of.care.surveys.pdf
[3] https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/CAHPS/ED
[4] https://www.cms.gov/files/document/edpec-dtc-survey-recommended-guidelines-february-2020.pdf
[5] Sonis et al. J Patient Exp. 2018 Jun;5(2):101-106.

Background

This resolution asks ACEP to acknowledge and affirm that some patient satisfaction instruments are in clear violation of existing ACEP policy. It also directs ACEP to define standardized inclusion and exclusion criteria for patient experience survey populations, and to 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. Finally, it directs ACEP to advocate for patient experience survey validity and work with CMS and other stakeholders.

ACEP's policy statement "Patient Experience of Care Surveys" states:

> *"The American College of Emergency Physicians (ACEP) recognizes that patient experience of care surveys that are methodologically and statistically sound can be a valid measure of the patient's perception of health care value and that patient outcome can be related to perceived patient experience of care.*
> *Patient experience of care survey tools should be:*
> - *Standardized and validated for the average education level of those being surveyed.*
> - *Administered and tabulated as close to the date of service as possible.*
> - *A measure of the specific components of service received in the emergency department (ED) with discrete data points.*
> - *Based on a statistically valid sample size free from selection bias.*
> - *Transparent in the administration and analysis methodologies.*
> - *Explicit in the intended purpose and use.*
> - *Addressing meaningful aspects of the patient's perception of care in the ED.*
>
> *Due to the difficulty in segregating whether patient experience of care scores are a result of physician performance or due to demands and restrictions of the current health care system or other factors out of the control of the physician, patient experience of care methods that have not been validated should not be used for purposes such as credentialing, contract renewal, and incentive bonus programs.*
>
> *Using patient experience of care scores for credentialing, contract renewal, and incentive bonus programs could have potential negative impacts on quality patient care, including safe prescribing of controlled substances, use of antibiotics and imaging. Emergency department patient experience of care measurement should incorporate the experience of admitted patients, to whom emergency physicians provide timely and intensive critical services.*
>
> *ACEP recommends that the topic of patient experience of care measurement be incorporated into the training of residents in emergency medicine."*

In the recent past, and with input from ACEP members, CMS worked with the RAND Corporation on the Emergency Department Patient Experience of Care (EDPEC) survey, now renamed the Emergency Department Consumer Assessment of Healthcare Providers & Systems (ED CAHPS) survey. ACEP members Thom Mayer, MD, FACEP, and Jay Kaplan, MD, FACEP, were members of the Technical Expert Panel that modified the original ED PEC survey, making it more physician friendly. Even in its revised format, it was 24 questions long with an additional 11 demographic questions. CMS has decided to not make the ED CAHPS survey mandatory.

ACEP can define standardized inclusion and exclusion criteria for the patient populations and define improved methodologies. Unfortunately, ACEP's influence over patient survey companies is limited. At the moment, there is no incentive to change.

ACEP could create its own survey tool for hospitals to use, but it is unlikely that hospitals will pay for two surveys of the same patient. ACEP could work with CMS to utilize the longer ED CAHPS described above.

ACEP could define a minimum number of survey responses as a statistically valid sample for an individual physician. Currently, CMS states the minimum number is 30, and recommend 50, however that standard is not uniformly applied by physician groups and hospitals when they act on these scores. CMS estimates a cost of $10-20 per survey depending on the vendor.[1] The most recent reported response rate to Press Ganey surveys was 16.5% .[2] Therefore, to get an additional 10 responses, the hospital would bear the additional cost of $500-$1,200 per physician per survey period.

It should be noted that the use of patient experience scores during the pandemic has had greater detrimental effect. It is widely known that boarding and crowding affect patient experience scores, particularly when they include the question "did you receive timely care."[6]

In 2021, ACEP President Mark Rosenberg, DO, FACEP, established an ED Accreditation Program Task Force to investigate the feasibility of ACEP creating a program for emergency departments. If the Board of Directors approves moving forward with this program, ACEP could start accrediting programs as early as the fall of 2022. As ACEP would establish the standards, it would be reasonable to include the proper use/interpretation of patient experience scores as one of the criteria.

Background References

[1]Pines JM, Iyer S, Disbot M, Hollander JE, Shofer FS, Datner EM. The effect of emergency department crowding on patient satisfaction for admitted patients. *Acad Emerg Med*. 2008 Sep;15(9):825-31.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective A – Promote/advocate for efficient, sustainable, and fulfilling clinical environments.

Goal 2 – Enhance Membership Value and Member Engagement

- Objective D – Increase ACEP brand awareness, growth, and impact internationally in a cost-effective manner.

Fiscal Impact

Budgeted staff resources. Investment in new ED Accreditation Program.

Prior Council Action

Resolution 39(15) Patient Satisfaction Surveys in Emergency Medicine referred to the Board. Called for the College to acknowledge that higher patient satisfaction scores are associated with many indicators of poor quality of medical care, many factors unrelated to medical care, many components of medical care not under physician control, and to oppose the use of patient satisfaction surveys for physician credentialing or for emergency medicine financial incentives or disincentives.

Amended Resolution 38(15) Patient Satisfaction Scores and Safe Prescribing adopted. Directed ACEP to oppose any non -evidence based financial incentives for patient satisfaction scores; work with stakeholders to create a quality measure related to safe prescribing of controlled substances; and that the AMA Section Council on Emergency Medicine support and advocate our position to the AMA regarding patient satisfaction scores and safe prescribing.

Resolution 43(13) Patient Satisfaction Scores not adopted. Called for the College to take a clear public stance to reject

the continued use of non-valid patient satisfaction scoring tools in emergency medicine and that current patient satisfaction surveys should not be used to determine ED physician compensation and reimbursement. Referred to the Board of Directors.

Resolution 26(12) Patient Satisfaction Scores and Pain Management not adopted. Called for the College to work with appropriate agencies and organizations to exclude complaints from ED patients with chronic non -cancer pain from patient satisfaction surveys; to oppose new core measures that relate to chronic pain management in the ED; to continue to promote timely, effective treatment of acute pain while supporting treating physicians' rights to determine individualized care plans for patients with pain; and to bring the subject of patient satisfaction scores and pain management to the American Medical Association for national action.

Substitute Resolution 22(09) Patient Satisfaction Surveys adopted. Directed ACEP to disseminate information to educate members about patient satisfaction surveys, including how emergency physicians armed with more knowledge can assist hospital leaders with appropriate interpretation of the scores and encourage hospital and emergency physician partnership to create an environment conducive to patient satisfaction.

Substitute Resolution 12(98) Benchmarking adopted. Directed ACEP to study and develop appropriate criteria for methodology and implementation of statistically valid patient satisfaction surveys in the ED.

Resolution 51(95) Criteria for Assessment of EPs adopted. States that ACEP believes that multiple criteria can be used to assess the professional competency and quality of care provided by an individual emergency physician.

Prior Board Action

June 2016, approved the revised policy statement "Patient Experience of Care Surveys;" originally approved September 2010 titled "Patient Satisfaction Surveys."

Amended Resolution 38(15) Patient Satisfaction Scores and Safe Prescribing adopted.

June 2013, reviewed the information paper "Patient Satisfaction Surveys."

February 2013, approved "Crowding" policy statement. Originally approved January 2006.

June 2011, reviewed the information paper "Emergency Department Patient Satisfaction Surveys."

Substitute Resolution 22(09) Patient Satisfaction Surveys adopted.

Substitute Resolution 12(98) Benchmarking adopted.

Resolution 51(95) Criteria for Assessment of EPs adopted.

Background Information Prepared by: Sandy Schneider, MD, FACEP
Senior Vice President, Clinical Affairs

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 56(21)

SUBMITTED BY: Diversity, Inclusion, & Health Equity Section
Social Emergency Medicine Section
District of Columbia Chapter

SUBJECT: Race-Based Science and Detrimental Impact on Black, Indigenous, and People of Color Communities

PURPOSE: 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 and commit to the education of ACEP members by denouncing the use of race-based calculators in clinical policies.

FISCAL IMPACT: Budgeted committee, section, and staff resources.

WHEREAS, ACEP was founded in 1968, the year the Fair Housing Act was passed and four years after the Civil Rights Act of 1964. In the 53 years since its founding, institutional racism has persisted within the field of emergency medicine and has perpetuated disparities in the quality of and access to care among Black, Indigenous, and People of Color (BIPOC) communities; and

WHEREAS, This disparity has devastated the health of generations of people in our country; and

WHEREAS, Emergency medicine, in its capacity as a safety net, must prioritize an antiracist approach to healthcare; and

WHEREAS, From the mid-1800s, the dogma of racial inferiority meant that racial-genetic explanations were invoked as biological justification for discriminatory and genocidal policies.[1,2] In the last half of the 20th century and extending into the present, the utility of race has been viewed from two distinct perspectives: as a descriptive category—necessary to document health inequalities—and as a causal explanation of ill health—through unspecified genetic influences[3]; and

WHEREAS, We believe the biological effects of racism should be recognized and a biological basis for differences among races be denounced; and

WHEREAS, Race science, the notion of race being a biologically rooted form of difference, has provided a form of scientific legitimacy, and thereby supported institutional racism; and

WHEREAS, From a distinct formula for eGFR[4] to the myth of different pain tolerances among races, science has allowed for a different standard of care among patients of different races; and

WHEREAS, Biologic racism (pseudoscience), craniology, psychometry, and polygenism failed to be supported by factual evidence, their effects and consequences on society remain extremely large[5]; and

WHEREAS, For decades, race-adjusted calculations have affected disease management, led to delays in critical interventions such as dialysis and renal transplantation, and contributed to disparities in the morbidity and mortality in the BIPOC patient population[6]; therefore be it

RESOLVED, That ACEP issue a statement to the membership regarding the lack of validity in race-based science and its detrimental impact on the health of Black, Indigenous, and People of Color patients and communities;

and be it further

RESOLVED, That ACEP commit to the education of its membership by denouncing the use of race-based calculators in its clinical policies.

References

1. Montagu A. Man's most dangerous myth: The fallacy of race. AltaMira, New York, 1997
2. Cooper R. Use of race in public health surveillance: Perspective of a health scientist. *MMWR* 42: 11–12. 1993
3. Copper RS. Health and the social status of blacks in the United States. *Ann Epidemiol. 1993* Mar; 3(2):137-44.
4. Junyan Shi et al. Calculating estimated glomerular filtration rate without the race correction factor: Observations at a large academic medical system.*Clinica Chimica Acta* **520**, 16-22. 2021
5. "Ostensibly scientific": cf. Theodore M. Porter, Dorothy Ross (eds.) The Cambridge History of Science: Volume 7, The Modern Social Sciences Cambridge University Press, p. 293. 2003
6. Vyas DA, Eisenstein LG, Jones DS. Hidden in plain sight—reconsidering the use of race correction in clinical algorithms. *N Engl J Med*. 2020;383(9):874–82.

Background

This resolution asks ACEP to issue a statement to the membership denouncing the validity of the use of race-based science and its detrimental impact on the health of Black, Indigenous, and People of Color (BIPOC) patients and communities and commit to the education of ACEP members by denouncing the use of race-based calculators in clinical policies.

A recent article highlights the NFL's reversal of "race norming" and highlights the prominence of it that still remains in medicine. The NFL was using stereotypes about African Americans cognitive function as part of its concussion settlement fund. This practice was discriminatory and denied Black players equal compensation for damages sustained from playing football.

ACEP's policy statement "Cultural Awareness and Emergency Care" supports that cultural awareness is essential to the training of healthcare professionals in providing quality patient care. It also confirms ACEP's position that resources be made available to emergency departments and emergency physicians to assure they properly respond to the needs of all patients regardless of background. This is important to the subject of implicit bias, as cultural awareness helps combat negative assumptions and associations. The implementation of a policy will help bring awareness to outdated practices such as the use of race-based calculators.

In July 2021, ACEP held a congressional panel discussion during the 2021 Leadership and Advocacy Conference (LAC), entitled "Breaking Down Barriers: Improving Health Equity Through the Emergency Department." The panel featured congressional staff that ACEP has worked with on health equity issues to provide insight on how emergency physicians can engage with legislators on these topics.

In March 2021, ACEP submitted a response to the Senate Health, Education, Labor, and Pensions (HELP) Committee hearing on COVID-19-related health disparities, detailing issues identified in the emergency department and strategies for prevention, screening, and mitigation.

In October 2020, ACEP responded to a request for information (RFI) from the House of Representatives Committee on Ways and Means Chairman Richard Neal regarding racial health inequities and specific questions about the misuse of race and ethnicity in clinical decision support (CDS) tools and algorithms. ACEP's response included specific efforts and initiatives the College has undertaken to reduce disparities and improve outcomes for communities of color, including efforts to reduce unconscious or implicit bias in the delivery of emergency care. It also detailed disparities resulting from or exacerbated by COVID-19 that were identified in the ACEP COVID-19 Field Guide. Additionally, the letter addressed questions about the use of race and ethnicity in CDS tools and clinical algorithms and how this was an ongoing topic of discussion and study not just within emergency medicine, but also the broader field of medicine.

In November 2020, the Ways and Means Committee followed up with additional questions, specifically about the use of the STONE Score for Uncomplicated Ureteral Stone in the emergency department. As part of this effort, a virtual

meeting was held with Chairman Neal's staff to discuss the STONE Score and the concerns of race and ethnicity in clinical tools. ACEP Public Affairs staff also reached out to one of the authors of the STONE Score and discussed the reasoning behind the inclusion of ethnicity in the score and potential benefits or disadvantages associated with removing the variable. In December 2020, ACEP submitted a formal response to the committee about ACEP's efforts to review and reevaluate the use of race and ethnicity in tools like the STONE Score, what guidance the College could provide to members to redirect clinicians' use of these algorithms, and insights on various options for remedies to address these challenges, as well as the role of the federal government and ACEP in implementing these remedies. ACEP continues to engage with the Committee as federal attention to this particular issue moves forward, and has also proactively reached out to the three leaders of the Committee's Racial Equity Initiative to share the College's ongoing advocacy priorities and efforts and open up additional lines of communication with federal legislators.

In March of 2018, ACEP, as a recommendation of the Diversity & Inclusion Task Force, launched the one-hour accredited CME course Unconscious Bias in Clinical Practice. This course focuses on the following objectives:

- Defining unconscious/implicit bias and its manifestations, based on metacognition and brain function.
- Discuss the link between social determinants of health, cultural competence, bias, and patient care.
- Review evidence on effects of implicit bias on clinical practice and disparities in patient care and outcomes
- Identify strategies to protect against and minimize the impact of implicit bias on patient care

ACEP's policy statement "Non-Discrimination and Harassment" reinforces that "ACEP acknowledges that implicit and explicit biases, attitudes, or stereotypes affect our understanding, actions, and decisions."

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Member Engagement

- Objective G – Promote/facilitate diversity and inclusion and cultural sensitivity within emergency medicine.

Fiscal Impact

Budgeted committee, section, and staff resources.

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 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) 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

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."

April 2017, reviewed the information paper "Implicit Bias and Cultural Sensitivity: Effects on Clinical and Practice Management."

Substitute Resolution 41(05) Non-Discrimination adopted.

Background Information Prepared by: Riane Gay, MPA, CAE
Director, Corporate Development

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 57(21)

SUBMITTED BY: Nikkole J. Turgeon
Anna G. Wright, MD
Laura Janneck, MD, FACEP
Dominique Gelmann
Betty Chang, MD, FACEP
Daniel B. Gingold, MD, MPH
International Emergency Medicine Section
Social Emergency Medicine Section

SUBJECT: Social Determinants of Health Screening in the Emergency Department

PURPOSE: Support research of evidence-based social determinants of health (SDH) screening and interventions in the ED to develop feasible interventions for implementation in the ED, advocate for resources (both private and public) to identify and address SDH in the ED, and work towards systemic solutions through advocacy efforts.

FISCAL IMPACT: Budgeted committee, section, and staff resources.

WHEREAS, Social determinants of health (SDH), such as economic stability, social and community context, neighborhood and built environment, health care and quality, and education access and quality, influence overall health outcomes to a much greater degree than medical care alone[1,2]; and

WHEREAS, The efficacy of medical treatment decreases in the absence of understanding and addressing relevant SDH[3]; and

WHEREAS, The emergency department reaches patients who are not cared for in other healthcare settings; and

WHEREAS, SDH (such as racism, joblessness, mental health conditions, and homelessness) correlate with repeated emergency department visits among patients (both adult and pediatric) with chronic disease[4]; and

WHEREAS, The emergency department can play a crucial role in screening, evaluating, and mitigating SDH which adversely affect patients[5]; and

WHEREAS, The field of emergency medicine is still developing evidence-based, comprehensive, and standardized ED screenings to SDH; and

WHEREAS, Effectively addressing SDH includes not only screening, but also interventions, including advocacy, community collaboration, and program development; and

WHEREAS, The body of existing research into emergency department SDH interventions involves addressing seven broad categories of SDH – access to care, discrimination, violence, food insecurity, housing insecurity/instability, literacy (health and language), and poverty[6]; and

WHEREAS, Current research into emergency department modification of SDH, while encouraging, focuses predominantly on access to care and the impact of exposure to violence and crime, but contains a paucity of research into affecting change in the other categories of SDH[6]; therefore be it

RESOLVED, That ACEP seek to improve the recognition of, and attention to, social determinants of health (SDH) by supporting research of evidence-based SDH screening and interventions in the ED with a focus on the unique strengths and challenges the ED setting poses for identifying and influencing SDH in order to develop interventions feasible for implementation in the ED; and be it further

RESOLVED, That ACEP advocate for the allocation of private and public sector resources for identifying and addressing social determinants of health in the emergency department; and be it further

RESOLVED, That ACEP push for legislative and political action to achieve broad, systemic solutions to those social determinants of health that create inequity in health status and outcomes so that to the greatest extent possible, addressing social determinants of health is considered integral to improving the health of the country.

References

1. Centers for Disease Control and Prevention // Social Determinants of Health https://www.cdc.gov/socialdeterminants/index.htm Accessed on July 21st, 2021
2. Hsieh D. Achieving the Quadruple Aim: Treating Patients as People by Screening for and Addressing the Social Determinants of Health. *Annals of Emergency Medicine*. 74(5):S19-24.
3. Anderson ES, Lippert S, Newberry J, Bernstein E, Alter HJ, Wang NE. Addressing Social Determinants of Health from the Emergency Department through Social Emergency Medicine. *West J Emerg Med*. 2016;17(4):487-489. doi:10.5811/westjem.2016.5.30240
4. Duquette E, Khan A. Social Determinants of Health Associated with Emergency Department Recidivism in Patients with Diabetes. *Annals of Emergency Medicine*. 2019;74(4):S117.
5. Samuels-Kalow ME, Ciccolo GE, Lin MP, Schoenfeld EM, Camargo Jr. CA. The Terminology of Social Emergency Medicine: Measuring Social Determinants of Health, Social Risk, and Social Need. *JACEP Open*. 2020;1(5):852-856.
6. Walter LA, Schoenfeld EM, Smith CH, et al. Emergency Department-based interventions affecting social determinants of health in the United States: A Scoping Review. *Academic Emergency Medicine*. 2021;28(6):666-674.

Background

Support research of evidence-based social determinants of health (SDH) screening and interventions in the ED to develop feasible interventions for implementation in the ED, advocate for resources (both private and public) to identify and address SDH in the ED, and work towards systemic solutions through advocacy efforts.

The World Health Organization (WHO) defines SDH as "the non-medical factors that influence health outcomes. They are the conditions in which people are born, grown, work, live and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems." The WHO further notes the influence of these factors and notes that numerous studies suggest that SDH account for between 30-55% of health outcomes.

There are a growing number of tools for assessing SDH within a community. These include measure indices – mapping tools to determine SDH in a specific population or location. Examples of tools include the Health Resources and Services Administration (HRSA) Area Deprivation Index, subsequent Neighborhood Atlas, County Health Rankings and Roadmaps, and more. Additionally, tools to measure individual social risk factors are also available. Tools include the CMMI The Accountable Health Communities Health-Related Social Needs Screening Tool, toolkits, guides, and even electronic tools. Some EDs have adopted SDH models, such as coordinating care services that combine social services with medical care. Other examples include substance use disorder screening, intervention, and referral.

Some believe that emergency medicine is uniquely positioned to address SDH as emergency physicians treat more than 25% of all acute care in the U.S. with more than 50% of that for the uninsured. Additionally, EDs are often referred to as society's "safety net," leading some to define the ED as a de facto environment for incorporating social context into patient care. EDs also see a growing demand for serving lower socioeconomic patients with unmet social needs. The ICD-10-CM codes (Z55-Z65) now include categories of potential health hazards related to a patient's socioeconomic or psychosocial environment, and other factors that can influence their health status. Others believe that taking on a SDH perspective could overburden already overwhelmed EDs and that it would interfere with the ED's primary mission of caring for acute medical issues, while others rebuttal that without treating patients adequately (to include SDH) patients will likely continue to return. Others opposed recognize the added costs, lack of

available follow up services, and the potential impact on ED throughput. One study that looked at the feasibility of incorporating a SDH screening process within an ED. It found that while they were able to demonstrate the ability to systematically screen and refer for needs, ensuring buy-in from staff conducting the screening was critical as well as ensuring that there were available resources within the community.

In 2017, ACEP hosted thought leaders in social emergency medicine to hold a consensus conference to establish the framework for how to incorporate social context within the structure and practice of emergency medicine. Around the same time, the Social Emergency Medicine Section was formed. Other efforts within the College include calling on the House Committee on Ways and Means to address SDH and racial health inequalities, responding to RFIs addressing health equity, and working through other regulatory processes to address structural SDH issues.

ACEP's policy statement "Safe Discharge from the Emergency Department" states:

> "ACEP recognizes the social, societal, and physical determinants of health that often affect patients discharged after an emergency encounter, but also recognizes that there are unique procedural and resource limitations that differentiate inpatient and emergency department (ED) discharges. As such, ACEP believes the decision to discharge a patient from the ED should be a clinical decision by the emergency department physician or provider who cares for that patient and deems the patient stable and safe for discharge. ACEP opposes local, state, federal, and other externally mandated "safe" discharge requirements that supersede the clinical judgment of a treating emergency physician or provider."

ACEP's policy statement Social Work and Case Management in the ED" and the Policy Resource & Education Paper (PREP) "Social Work and Case Management in the Emergency Department" address the importance of access to community resources for medical and social reasons after discharge from the emergency department. The policy statement affirms that ACEP "supports the development and maintenance of case management services that are available to ED patients, that such services include appropriate clinical personnel as well as partnerships with community-based organizations, governmental agencies, and other appropriate entities to ensure prompt access to community services for its patients."

ACEP's policy statement "Human Trafficking" supports EDs including approaches to interfacing with outside entities such as social service organizations to care for patients.

ACEP's legislative and regulatory priorities include "promote legislative options and solutions to identify and eliminate health disparities, address structural racism, and improve health equity in the health care system."

The Emergency Medicine Foundation (EMF) has awarded a $50,000 COVID-19 research grant "Social Determinants of Health and COVID-19 Infection in North Carolina: A Geospatial and Qualitative Analysis." Additionally, EMF has approved funding of $50,000 each for two health disparities grants during the FY 21-22 grant cycle: EMF Health Disparities Grant and the EMF/ENAF Health Disparities Grant.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective A – Promote/advocate for efficient, sustainable, and fulfilling clinical practice environments.

Fiscal Impact

Budgeted committee, section, and staff resources.

Prior Council Action

Amended Resolution 26(20) Addressing Systemic Racism as a Public Health Crisis adopted. 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 to support members to seek to reform discriminatory systems and advocate for policies promoting the social determinates of health with historically disenfranchised communities at the 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 through the lens of health equity and provide members a biennial assessment of the work as it pertains to health equity.

Amended Resolution 50(19) Social Work in the Emergency Department adopted. Directed CEP to promote the inclusion of social workers and/or care coordinators within the ED team, educate hospitals on including social workers in team-based care, compile best practices on ED care models that included social workers or care coordinators, and advocate for payment for care coordination services in emergency medicine.

Resolution 23(15) Integrating Emergency Care into the Greater Health Care System adopted. Directed ACEP to pursue reimbursement strategies to promote coordination of care, effective ED information sharing, and performance incentives for case management of high utilizers.

Resolution 36(13) Development of a Rapid Integration of Care Toolkit adopted. Directed that ACEP develop a rapid integration of care toolkit to focus on transitions of care and care coordination, provide best practices based upon hospital type and location, tools/resources for the design and implementation of rapid integration of care programs, and measures to report success of efforts.

Amended Resolution 22(11) Emergency Medicine and Transitions of Care adopted. Directed ACEP to define the role of emergency medicine in transitions of care for emergency medicine patients; to participate in all significant forums of discussion with regulatory entities, Department of Health and Human Services, Centers for Medicare & Medicaid Services, The Joint Commission, National Quality Forum, related to performance parameters and proposed standards for emergency medicine transitions of care; to monitor and have input into any reimbursement issues tied to transitions of care, including performance incentives and accountable care organization collaboration; and to identify resources and educational materials to improve transitions of care for emergency patients.

Substitute Resolution 34(07) Patient Support Services Addressing the Gaps adopted. Stated that ACEP "supports that hospitals develop resources to improve emergency department patients' access to outpatient community health and support services."

Prior Board Action

October 2020, approved the revised policy statement "Social Work and Case Management in the ED" with the current title; revised and approved April 2019; reaffirmed June 2013; originally approved October 2007 titled "Patient Support Services."

October 2020, reviewed the Policy Resource & Education Paper (PREP) "Social Work and Case Management in the Emergency Department."

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.

April 2021, approved the revised policy statement "Cultural Awareness and Emergency Care;" revised and approved April 2020; reaffirmed April 2014; originally approved April 2008 with the current title replacing "Cultural Competence and Emergency Care" approved October 2001.

Amended Resolution 50(19) Social Work in the Emergency Department adopted.

June 2019, approved the policy statement "Safe Discharge from the Emergency Department."

April 2021, approved the revised policy statement "Non-Discrimination and Harassment;" revised and approved June 2018; revised and approved April 2012 with the current title; originally approved October 2005 titled "Non-Discrimination."

October 2017, reviewed the information paper "Disparities in Emergency Care."

April 2017, reviewed the information paper "Unconscious Bias and Cultural Sensitivity and their Effects on Clinical Practice Management."

January 2017 revised and approved "Code of Ethics for Emergency Physicians." Revised and approved June 2016 and June 2008. It was reaffirmed October 2001. It was revised and retitled in June 1997. Originally approved January 1991 titled "Ethics Manual." Part II D defines the role of the emergency physicians with society.

April 2016, approved the policy statement "Human Trafficking."

Resolution 23(15) Integrating Emergency Care into the Greater Health Care System adopted.

October 2014, reviewed the Rapid Integration of Care Toolkit.

Resolution 36(13) Development of a Rapid Integration of Care Toolkit adopted.

October 2012, reviewed the information paper, Transitions of Care Task Force Report. The information paper recommended strategies for emergency medicine. The 2012 Council Town Hall meeting focused on Transitions of Care and highlighted aspects of the task force report.

Amended Resolution 22(11) Emergency Medicine and Transitions of Care adopted.

Substitute Resolution 34(07) Patient Support Services Addressing the Gaps adopted.

Background Information Prepared by: Loren Rives, MNA
Senior Manager, Academic Affairs

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 58(21)

SUBMITTED BY: Missouri Chapter
Pennsylvania College of Emergency Physicians

SUBJECT: Updating and Enhancing ED Buprenorphine Treatment Training and Support

PURPOSE: 1)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 2) 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.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Buprenorphine therapy is associated with reductions in illicit opioid use, mortality, HIV, Hepatitis C, criminal activity, and healthcare costs[1-6]; and

WHEREAS, Buprenorphine treatment initiated in the ED is associated with reduction in illicit opioid use and significant increase in post-ED addiction treatment[7,8]; and

WHEREAS, Regulations governing buprenorphine treatment and, specifically, ED buprenorphine treatment continue to evolve; and

WHEREAS, An X-waiver is required to prescribe buprenorphine; and

WHEREAS, Historically, X-waiver applicants have been required to complete 8 hours of dedicated training before being eligible to apply; and

WHEREAS, The Department of Health and Human Services released practice guideline exemptions on 4/27/2021 indicating that physicians are no longer required to complete dedicated buprenorphine or opioid use disorder (OUD) treatment training in order to apply for an X-waiver[9]; and

WHEREAS, ACEP and emergency physician experts in OUD management had previously developed emergency medicine-specific training to fulfill the 8-hour training requirement; and

WHEREAS, Eight-hour duration is a barrier to many emergency physicians being able to complete such training; and

WHEREAS, Many emergency physicians are not comfortable with initiating or prescribing buprenorphine therapy due in part to a lack of experience or training[10]; and

WHEREAS, Among the College are experts in addiction and opioid use disorder management who have shared expertise and experience with colleagues both formally and informally; and

WHEREAS, Training sessions for practicing emergency physicians focused on incorporation of buprenorphine management including current regulations, medication induction, and prescribing best practices remains practically necessary even if no longer required for X-waiver certification; and

WHEREAS, Increasing the comfort level and implementation of evidence-based buprenorphine and other

opioid use disorder interventions in the ED will improve the care provided to patients and reduce individual and societal harms associated with opioid use and overdose; and

WHEREAS, Both real-time and asynchronous mentoring will benefit emergency physicians throughout the College to support and encourage ongoing expansion of service delivery and maintain comfort with an evolving regulatory landscape; and

WHEREAS, The ACEP Council has consistently reaffirmed the importance of ED buprenorphine treatment in recognition of the large and growing body of evidence supporting such interventions; therefore be it

RESOLVED, That ACEP support the development of training sessions focused solely on the implementation of buprenorphine induction and prescribing in the emergency department setting to replace the 8-hour training that had previously been required for X-waiver applications; and be it further

RESOLVED, That ACEP develop an online peer mentoring platform, similar to Providers Clinical Support System, but limited to emergency physicians, that utilizes the expertise of members of the College to support the development and implementation of ED substance use disorder practices while responding to specific practice-based challenges that arise in an asynchronous messaging forum available to all ACEP members.

References

1. Bart G. Maintenance Medication for Opiate Addiction: The Foundation of Recovery. *J Addict Dis.* 2012 July; 31(3): 207-225.
2. Weiss, R.D.; Potter, J.S.; Griffin, M.L. et al. Long-term outcomes from the National Drug Abuse Treatment Clinical Trials Network Prescription Opioid Addiction Treatment Study. *Drug and Alcohol Dependence* 150:112-119, 2015
3. Tsui JI et al. Opioid agonist therapy is associated with lower incidence of hepatitis C virus infection in young adult persons who inject drugs. *JAMA Intern Med.* 2014 December; 174(12): 1974-1981.
4. Schuckit MA. Treatment of Opioid-Use Disorders. *N Engl J Med.* 2016 July 28; 375: 357-368
5. Tkacz J, Volpicelli J, Un H, Ruetsch C. Relationship between buprenorphine adherence and health service utilization and codsts among opioid dependent patients. J Subst Abuse Treat. 2014 Apr; 46(4): 456-62
6. National Academies of Sciences, Engineering, and Medicine 2019. Medications for Opioid Use Disorder Save Lives. Washington, DC: The National Academies Press. https://doi.org/10.17226/25310

Background

This resolution asks the College 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. Additionally, it asks ACEP to 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.

The immense scope of opioid use disorder (OUD) and its associated public health impacts have become increasingly evident across all fields of medicine. The size of the crisis prompted the Department of Health and Human Services to declare the opioid crisis a public health emergency in October of 2017. Given the impact of OUD on ED patients, emergency physicians are taking the lead on addressing this crisis. Since 2012, ACEP has promoted the use of non-opioid analgesics to treat pain and has engaged in addressing prescribing patterns in the ED. However, emergency physicians are responsible for less than 5% of total opioid prescribing nationwide, and changing prescribing patterns does little for our patients already suffering from OUD.

Medication for OUD refers to any addiction treatment that includes pharmacologic therapy. In the context of OUD this includes medications that act as opioid agonists, partial agonists, or antagonists. Popular examples are methadone, buprenorphine, and naltrexone. There is a growing body of literature showing that Medication Assisted Treatment (MAT) for OUD improves patient outcomes. Data suggests that patients receiving medication for OUD have decreased fatal overdose compared to those who receive counseling alone. Additionally, patients maintained on buprenorphine for at least one year are noted to have less ED visits and inpatient hospital stays.

ACEP's policy statement "Optimizing the Treatment of Acute Pain in the Emergency Department" supports all patients being treated appropriately for acute pain with prompt, safe, and effective pain management. The policy statement acknowledges that acute pain management is patient-specific and provides guidance on pharmacological and non-pharmacological pain interventions. This is a joint statement by ACEP, the American Academy of Emergency Nurse Practitioners, and the Emergency Nurses Association. Emergency physicians will continue to be on the front lines of this public health emergency as the nation struggles with OUD. Given the scale of this problem, it is critical to use the best treatment available for patients. While there are many potential solutions to this issue, medication for OUD is a promising tool and is the only evidence-based treatment available for the treatment of OUD. It has proven to be both an effective and safe treatment for ED patients suffering from opioid addiction.

ACEP had led and participated in numerous advocacy efforts over the past decades in championing the critical role of ED physicians in the fight against the opioid epidemic and removal of barriers to access to treatment. Examples of key advocacy efforts have included:

- ACEP met with the head of Substance Abuse and Mental Health Services Administration (SAMHSA), Assistant Secretary for Mental Health and Substance Use Dr. Elinore McCance-Katz, on May 15, 2019. During our meeting with Dr. McCance-Katz, we discussed issues that are extremely important to emergency physicians and our patients, including the ability to administer buprenorphine in the ED for patients with OUD and how to improve care for patients with mental health illnesses. ACEP mentioned the resources and tools that we have created to help our physicians and patients, highlighting the EM-specific DATA 2000/Medications for Addiction Treatment waiver training course that is now being offered to our members, as well as new web-based and mobile device applications around opioids and the management and treatment of suicidal patients. We expressed our commitment to helping SAMHSA achieve the goal and identified opportunities to work together going forward.
- On July 16, 2019, ACEP member Dr. Eric Ketcham participated in a panel discussion sponsored by Pew Charitable Trusts focused on how to reduce barriers that impede the ability for providers to treat patients with Substance Use Disorder (SUD). Dr. Ketcham emphasized the need to remove the X-waiver training requirement. Dr. Ketcham also discussed the importance of initiating buprenorphine in the ED, and how the X-waiver requirement creates an unnecessary barrier that impedes access to this potentially life-saving medication. Finally, he and other panelists talked about other treatment barriers to SUD, including stigma and misperception, outpatient access issues, and insurance prior-authorization, and how policy makers can best address these impediments. Representative Paul Tonko (D-NY) also was present and kicked off the panel discussion. Representative Tonko is the sponsor of the ACEP-supported H.R. 2482, the "Mainstreaming Addiction Treatment Act," which would remove the X-waiver requirement as well as address other barriers to SUD treatment. ACEP also supports the Senate companion bill, S. 2074, sponsored by Senators Maggie Hassan (D-NH) and Lisa Murkowski (R-AK).
- After the panel discussion, Dr. Ketcham and the other panelists met with Admiral Brett Giroir, the Assistant Secretary for Health at the U.S. Department of Health and Human Services (HHS). Adm. Giroir's office is looking into possibly reforming the restrictive "three-day" rule for administering buprenorphine. This rule allows non-waivered providers to administer (but not prescribe) buprenorphine to patients for a three-day period. However, the rule forces providers to administer buprenorphine one-day at a time, requiring patients to come back to the ED or other settings each day to receive treatment. ACEP has long advocated for eliminating this unnecessary hurdle and allowing providers to provide the patient with three-days' worth of treatment during one session. We have previously met with Admiral Giroir and others at HHS to discuss this issue and are encouraged that the Department is considering a policy change.
- On August 29, 2019, ACEP responded to an HHS request for information on ensuring appropriate access to opioid treatments. In the response, HHS is urged to do what is in their authority to reduce barriers to the treatment of patients with OUD. ACEP also issued a press release highlighting the major points contained in the letter.

On January 23, 2020, ACEP convened a Summit, Addressing the Opioid Stigma in the Emergency Department, gathering 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. Objectives for the summit included identification of strategies and behaviors to reduce practices that perpetuate

stigma in the ED and discover innovative solutions to combat stigma in the ED. Summit participation included representation from: federal partnering organizations, representative from the health care team, key stakeholders and individuals who have experienced stigma related to a personal history of substance use. As part of the outcomes of the summit ACEP developed a short video featuring interviews with former ED patients with OUD sharing their experiences and strategies to improve care will be highlighted alongside ED physician interviews to convey the impact of Stigma around Opioid Use Disorder in the ED, and the opportunities to improve care.

ACEP has long supported legislation sponsored by emergency physician and U.S Representative Raul Ruiz (D-CA/36th) called the Easy MAT Act. The Easy MAT Act was incorporated into a short-term funding bill that was signed into law on December 11, 2020. The new law requires the Attorney General (who will delegate this to the DEA) to revise the Three-day Rule within six months so that "practitioners, in accordance with applicable State, Federal, or local laws relating to controlled substances, are allowed to dispense not more than a three-day supply of narcotic drugs to one person or for one person's use at one time for the purpose of initiating maintenance treatment or detoxification treatment (or both)." The key update is that under this new law, practitioners (not just physicians) will be allowed to dispense three-days' worth of medication at one time. Therefore, patients can presumably receive one day's-worth of medication while at the ED and then take the two remaining days-worth home, saving them from having to make subsequent trips to the ED.

In June 2020, the ACEP Board approved Clinical Policy: Critical Issues Related to Opioids in Adult Patients Presenting to the Emergency Department.

In late April 2021, the U.S. Department of Health and Human Services released new buprenorphine practice guidelines that remove the need for an 8-hour training course previously required to get a waiver to administer the addiction medication. Emergency physicians have cited this training as a barrier to treating more people with OUDs. The new guidelines exempt emergency physicians and other eligible practitioners from federal certification requirements related to training, counseling and other services that are part of the process for obtaining a waiver (known as the X-waiver). If providers utilize the exception of the practice guidelines, they may only prescribe up to 30 patients at a time. These 30 patients are counted against the provider limit until they are transitioned to a community provider or 30 days from the last prescription if not transitioned.

In February 2021, the ACEP Board of Directors approved the "Consensus Recommendations on the Treatment of Opioid Use Disorder in the Emergency Department." These recommends that emergency physicians offer to initiate OUD treatment with buprenorphine in appropriate patients and provide direct linkage to ongoing treatment for patients with untreated OUD and provide strategies for OUD treatment initiation and ED program implementation, including harm reduction strategies (including overdose education and naloxone distribution) or prescriptions is also an essential component of the ED visit.

The United States is in the grips of a substance use and overdose epidemic that has escalated in the wake of the COVID-19 pandemic. More than 92,000 individuals died from a drug overdose from December 2019 through December 2020 – an almost 30 percent increase from the previous 12-month period. Over the past two decades, this unprecedented morbidity and mortality has demanded that all healthcare practitioners, institutions, and financing systems improve access to substance use disorder treatment. ACEP continues to advocate for access to and initiation of OUD treatment with buprenorphine in appropriate patients and increased provision of direct linkage to ongoing treatment for patients. ACEP continues to provide education and provide training sessions focused solely on the implementation of buprenorphine induction and prescribing in the emergency department setting, including 8 hour DATA 2000 EM MAT Waiver trainings, 4-hr EM MAT Waiver trainings (as part of the 4x4 wavier trainings), and 2-hour "core/condensed" EM MAT waiver trainings. Additionally, ACEP has also developed the following tools and resources:

- **Opioid Regulations: State by State Guide (PDF)**
- A series **of free webinars on various topics related to Opioid Use Disorder and Treatment and Management of OUD in the ED**
- **Buprenorphine in the ED Point of Care tool** that is an algorithm-like tool that walks clinicians through the process of patient evaluation and assessment through to prescription.

- Buprenorphine Initiation in Emergency Departments: Interactive Case Vignettes
- Hosted and developed an **Initiation of Buprenorphine and Pain Management in the ED-Implementation Workshop**. Topics covered in the workshop covered everything from setting up a ED-Buprenorphine program, Naloxone program, stigma, and pain management in the ED.
- E-QUAL Network Opioid Initiative

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

Goal 1 – Improve the Delivery System for Acute Care
- Objective A – Promote/advocate for efficient, sustainable, and fulfilling clinical environments.
  - Tactic 4 – Develop and promote to members best practices and clinical tools, including apps, for caring for patients with important clinical conditions.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Substitute Resolution 23(19) Expanding Emergency Physician Utilization and Ability to Prescribe Buprenorphine adopted. Directed ACEP work directly with the DEA and SAMHSA to minimize barriers for emergency physicians to enact meaningful therapy for patients in a time of opioid crisis in the unique environment in which we work; advocate to the DEA and SAMHSA for ED specific requirements and curriculum to reach the greatest number of patients safely and without onerous barriers; continue to advocate for the removal of the DEA X-waiver requirement for emergency physicians who prescribe a bridging course of buprenorphine for opioid use disorder from the ED.

Amended Resolution 47(18) Supporting Medication for Opioid Use Disorder adopted. Directed ACEP to work with Pain Management & Addiction Medicine Section to develop a guideline on the initiation of medication for OUD for appropriate ED patients, advocate for policy changes that lower regulatory barriers to initiating MAT in the ED, and support expansion of outpatient and inpatient opioid treatment programs.

Amended Resolution 23(16) Medical Medication Assisted Therapy for Patients with Substance Use Disorders in the ED adopted. The resolution directed ACEP to provide education to emergency physicians on ED-initiated treatment of patients with substance use disorders and support through advocacy the availability and access to novel induction programs such as buprenorphine from the ED.

Resolution 21(16) Best Practices for Harm Reduction Strategies adopted. Directed ACEP to set a standard for linking patients with a Substance Use Disorder to an appropriate potential treatment resource after receiving medical care from the ED.

Amended Resolution 42(14) Reverse an Overdose, Save a Life adopted. The resolution directed ACEP to advocate and support Naloxone use by first responders, availability of Naloxone Over the Counter (OTC), and support research of the effectiveness of ED-initiated overdose education.

Amended Resolution 44(13) Prescription Drug Overdose Deaths adopted. Directed ACEP to appoint a task force to review solutions to decrease death rates from prescription drug overdoses, provide best practice solutions to impact the epidemic of prescription drug overdoses with the goal of reducing the number of prescription overdose deaths.

Amended Resolution 17(12) Ensuring ED Patient Access to Adequate and Appropriate Pain Treatment adopted. The resolution supports chapter autonomy to establish guidelines or protocols for ED pain management, development of

evidence-based, coordinated pain treatment guidelines, opposes non-evidence-based limits on prescribing opiates, and work with government and regulatory bodies on the creation of evidence supported guidelines for responsible emergency prescribing.

Resolution 16(12) Development of Guidelines for the Treatment of Chronic Pain not adopted. Directed ACEP to support state autonomy to establish guidelines for treatment of patients with chronic pain who present to the ED requesting significant doses of narcotic pain medications or other controlled substances, including the establishment of referral networks to existing pain treatment centers

Prior Board Action

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 Clinical Policy: Critical Issues Related to Opioids in Adult Patients Presenting to the Emergency Department

February 2020, approved changing the name of the ED Pain & Addiction Management Accreditation Program to Pain & Addiction Care in the ED (PACED).

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.

February 2018, revised and approved the policy statement "Ensuring Emergency Department Patient Access to Appropriate Pain Treatment;" originally approved October 2012.

April 2017, approved the revised policy statement "Optimizing the Treatment of Acute Pain in the Emergency Department;" originally approved June 2009 with the title "Optimizing the Treatment of Pain in Patients with Acute Presentations." This is a joint policy statement with the American Academy of Emergency Nurse Practitioners, the Emergency Nurses Association, and the Society for Academic Emergency Medicine.

Amended Resolution 23(16) Medical Medication Assisted Therapy for Patients with Substance Use Disorders in the ED adopted.

Resolution 21(16) Best Practices for Harm Reduction Strategies adopted.

June 2016, approved the revised policy statement "Naloxone Access and Utilization for Suspected Opioid Overdoses;" originally approved October 2015.

October 2015, approved the policy statement "Naloxone Prescriptions by Emergency Physicians."

Amended Resolution 42(14) Reverse an Overdose, Save a Life adopted.

Amended Resolution 44(13) Prescription Drug Overdose Deaths adopted.

Amended Resolution 17(12) Ensuring ED Patient Access to Adequate and Appropriate Pain Treatment adopted.

June 2012, approved the Clinical Policy: Critical Issues in the Prescribing of Opioids for Adult Patients in the Emergency Department.

Background Information Prepared by: Sam Shahid, MBBS, MPH
Practice Management Manager

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 59(21)

SUBMITTED BY: Laura Janneck, MD, FACEP
Nikkole Turgeon, BS
International Emergency Medicine Section
Social Emergency Medicine Section

SUBJECT: Use of Medical Interpreters in the Emergency Department

PURPOSE: Promote the use of qualified medical interpreters for all ED patient interactions in patients with limited English proficiency and provide resources for EDs on available interpreter services and challenges ACEP to envision a method for documenting that providers are qualified to interpret in a medical setting.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Use of medical interpreters has been shown to increase quality of health care provided in several settings; and

WHEREAS, Language barriers increase risks to patient safety[1]; and

WHEREAS, There is a risk of medically consequential miscommunications between emergency department staff and patients when interpreters are not used in appropriate scenarios; and

WHEREAS, The emergency department serves as the entry point into the U.S. health care system for many patients with limited English proficiency (LEP); and

WHEREAS, Under the Affordable Care Act, any healthcare provider or health insurance company receiving federal assistance must provide LEP patients with a qualified interpreter[2]; and

WHEREAS, Qualified interpretation has been associated with improvements in patient satisfaction, communication, and health care access, however, these services are largely under-utilized in emergency department settings[3]; therefore be it

RESOLVED, That ACEP promote the use of qualified medical interpreters for all emergency department patient interactions with patients with limited English proficiency unless the communicating provider has proven qualifications to self-interpret in a medical setting; and be it further

RESOLVED, That ACEP provide resources for emergency departments on available interpreter services and how providers can prove qualification for interpreting in a medical setting.

References

[1]Divi C, Koss RG, Schmaltz SP, Loeb JM. Language proficiency and adverse events in US hospitals: a pilot study. *Int J Qual Health Care*. 2007 Apr;19(2):60-7. doi: 10.1093/intqhc/mzl069. Epub 2007 Feb 2. PMID: 17277013.
[2]Department of Health and Human Services // Section 1557 of the Patient Protection and Affordable Care Act https://www.hhs.gov/civil-rights/for-individuals/section-1557/index.html Accessed on July 19th 2021.
[3]Ramirez D, Engel KG, Tang TS. Language interpreter utilization in the emergency department setting: a clinical review. *J Health Care Poor Underserved*. 2008 May;19(2):352-62. doi: 10.1353/hpu.0.0019. PMID: 18469408.

Background

This resolution calls for the College to promote the use of qualified medical interpreters for all ED patient interactions in patients with limited English proficiency unless the provider has proven qualifications to self-interpret in medical settings. Additionally asks the College to provide resources listing available interpreter services for EDs and challenges ACEP to envision a method for documenting that providers are qualified to interpret in a medical setting.

As of 2019, every state has laws on language access in healthcare settings. Thirteen states and the District of Columbia reimburse providers directly for language services used by patients on Medicaid and the Children's Health Insurance Program.[1] As of 2012, 9% of the U.S. population is at risk for an adverse event because of language barriers.[2]

In the Comprehensive Accreditation Manual for Hospitals (CAMH), The Joint Commission requires hospitals to "effectively communicate with patients when providing care, treatment and services."[3]

The AMA has a policy supporting "…efforts that encourage hospitals to provide and pay for interpreter services for the follow-up care of patients that physicians are required to accept as a result of that patient's emergency room visit and Emergency Medical Treatment and Active Labor Act (EMTALA)-related services."[4]

The crux of the issue seems to be that the burden of providing interpreter services should fall upon the hospital, not just the ED, as all areas of the hospital must provide for interpreter services. It seems reasonable that each hospital should have a plan for interpreter coverage that would include ED patients.

According to Brenner et al, patients with limited English proficiency who require interpreter services use ED services significantly more often than those of similar ages not needing an interpreter."[5]

In June 2016, the ACEP Board of Directors approved a Clinical Emergency Data Registry (CEDR) quality measure "Interpreter Health Service Measure." After an environmental scan, the Technical Expert Panel had feasibility concerns with this measure and it was not pursued.

ACEP's policy statement "Emergency Department Planning and Resource Guidelines" states: "In accordance with regulations, translation and communication capabilities should exist for foreign languages and for the vision and/or hearing impaired."[6]

There are many online resources that can be utilized to develop a resource list of interpreters, including the National Council on Interpreting in Health Care, who has developed a Code of Ethics and National Standards for Interpreters in Healthcare. The Joint Commission allows for practitioners to communicate directly with a patient in their preferred language but "it is recommended that the organization has a process to make sure that communication with the patient in the non-English language is effective and meets the patient's needs."[7] There are more than 380 languages and dialects. Building a program to track dialects and cross referencing it with geographic availability would be a resource intensive undertaking. Most institutions have a pathway to identify qualified interpreters among their medical staff.

Background References

[1]National Health Law Program. Summary of State Law Requirements Addressing Language Needs in Health Care. 2019.
[2]Agency for Healthcare Research and Quality. Improving Patient Safety Systems for Patients with Limited English Proficiency – A Guide for Hospitals. 2012.
[3]The Joint Commission. Patient-centered communication standards for hospitals. PC.02.01.21.
[4]AMA. Interpreter Services and Payment Responsibilities H 385.917. Reaffirmed June 2021.
[5]Brenner JM, Baker EF, Iserson KV, et al. Use of interpreter services in the emergency department. *Ann Emerg Med*. 2018;72(4):432-7.
[6]ACEP. Emergency Department Planning and Resource Guidelines [policy statement]. Approved April 2021.
[7]The Joint Commission. Standards FAQs. Language Access and Interpreter Services – Understanding the Requirements. March 2021.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective E – Pursue strategies for fair payment and practice sustainability to ensure patient access to care.
  - Strategy 6 – Advocate at the federal level and address legislation that ensures fair and appropriate reimbursement for emergency services. Support efforts with PR campaigns, as needed.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

None.

Prior Board Action

April 2021, approved the revised policy statement "Emergency Department Planning and Resource Guidelines;" revised and approved April 2014, October 2007, June 2004, June 2001 with the current title; reaffirmed September 1996; revised and approved June 1991; originally approved December 1985 titled "Emergency Care Guidelines."

June 2016, Approved CEDR Quality Measure "Interpreter Health Service Measure"

Background Information Prepared by: Julie Rispoli
CUAP Accreditation Manager

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2021 Council Meeting

Reference Committee Members

Reference Committee D – Scope of Practice & Workforce Resolutions 60-77

Abhi Mehrotra, MD, FACEP (NC) Chair
William Falco, MD, FACEP (WI)
Daniel Freess, MD, FACEP (CT)
Todd Slesinger, MD, FACEP (FL)
Odetolu Odufuye, MD, FACEP (D&I Section)
Scott Pasichow, MD, MPH (YPS)

Adam Krushinskie, MPA
Harry Monroe

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 60(21)

SUBMITTED BY: Emergency Medicine Residents' Association (EMRA)

SUBJECT: Accountable Organizations to Resident and Fellow Trainees

PURPOSE: Create a task force to: 1) determine which organizations or governmental entities are capable of being permanently responsible for resident and fellow interests without conflicts of interests; 2) determine how these organizations can be held accountable for fulfilling their duties to protect the rights and well-being of resident and fellow trainees; 3) determine methods of advocating for residents and fellows that are timely and effective, without jeopardizing trainees' current and future employability; and 4) In the event that no organizations or entities are identified that meet the above criteria, determine how such an organization may be created.

FISCAL IMPACT: Budgeted task force and staff resources if a meeting is held virtually. Unbudgeted expenses of $20,000 – $30,000 for an in-person task force meeting depending on the size of the task force.

WHEREAS, The stated mission of the Accreditation Council for Graduate Medical Education (ACGME) is to, "improve healthcare and population health by assessing and advancing the quality of resident physicians' education through accreditation[1];"and

WHEREAS, To achieve its mission the ACGME has determined that it has two main purposes, "(1) to establish and maintain accreditation standards that promote the educational quality of residency and subspecialty training programs; and (2) to promote conduct of the residency educational mission with sensitivity to the safety of care rendered to patients and in a humane environment that fosters the welfare, learning, and professionalism of residents[1];" and

WHEREAS, While the ACGME has taken steps to advocate for residents, its ability to effectively and timely work on their behalf is limited by "blunt tools" related to removal of accreditation and delay in providing feedback to programs[3]; and

WHEREAS, Resident and fellow trainees still endure suboptimal training conditions with recourse to address these issues limited by multiple factors, including a high debt burden and fear of their program losing accreditation thus affecting future career prospects, ultimately making reporting even gross ACGME guideline infractions difficult to encourage[4,5];and

WHEREAS, As exemplified by the Hahnemann University Hospital closure, residents and fellow trainees are vulnerable to the negative effects of hospital closures that threaten the quality and completion of their graduate medical education, financial wellbeing, and legal status within the United States[6,7]; and

WHEREAS, The Centers for Medicare & Medicaid Services (CMS) is tasked with distributing the majority of GME funding, but is not responsible for overseeing the quality of training programs nor the wellness or treatment of trainees[9]; and

WHEREAS, None of the organizations that responded to the Hahnemann residency closures were required to by law, nor was the response coordinated, regulated, or monitored by any type of oversight organization, and an ACGME investigation of the closure of the Hahnemann University Hospital found that no existing organizations represented resident and fellow interests to the exclusion of other stakeholder interests;[2,8] therefore be it

RESOLVED, That ACEP establish a task force with the following goals:

1. Determine which organizations or governmental entities are capable of being permanently responsible for resident and fellow interests without conflicts of interests.
2. Determine how these organizations can be held accountable for fulfilling their duties to protect the rights and well-being of resident and fellow trainees.
3. Determine methods of advocating for residents and fellows that are timely and effective, without jeopardizing trainees' current and future employability.
4. In the event that no organizations or entities are identified that meet the above criteria, determine how such an organization may be created.

References

1. *ACGME Manual Of Policies And Procedures*. Originally published 06/1992, Updated 06/2020. Online. <https://www.acgme.org/Portals/0/PDFs/ab_ACGMEPoliciesProcedures.pdf> Accessed August 30 2020.
2. Nasca T, Johnson PF, Weiss KB, Brigham TP. Elevating Resident Voices in Health Systems Change: Lessons From the Closure of Hahnemann University Hospital. *Acad Med*. 2020;95(4):506-508. Doi:10.1097.
3. Lypson M, Hamstra S, Colletti L. Is the Accreditation Council for Graduate Medical Education a Suitable Proxy for Resident Unions? Acad Med. 2009;84(3)296-300. doi: 10.1097/ACM.0b013e3181971f77
4. Bernstein J. Washington's Struggling Medical Residents Need a Raise. The Nation. https://www.thenation.com/article/archive/medical-strike-seattle/ Published October 9, 2019. Accessed September 10, 2020.
5. Alker A. As coronavirus rages, medical residents are stressed to breaking point. USA Today. https://www.usatoday.com/story/opinion/hiddencommonground/2020/05/22/coronavirus-places-already-stressed-medical-residents-high-risk-column/5235163002/ Published May 22, 2020. Accessed September 10, 2020
6. Orlowski J. Displaced Hahnemann residents and attending physicians may soon lose liability insurance. AAMC. https://www.aamc.org/news-insights/displaced-hahnemann-residents-and-attending-physicians-may-soon-lose-liability-insurance Published January 7, 2020. Accessed September 10, 2020.
7. Craven J. The wide-ranging impact of hospital closures. The Hospitalist. https://www.the-hospitalist.org/hospitalist/article/220570/mixed-topics/wide-ranging-impact-hospital-closures Published April 10, 2020. Accessed September 10, 2020.
8. O'Reilly, Kevin. Grants will help residents displaced by record hospital closure. AMA news. https://www.ama-assn.org/residents-students/residency/grants-will-help-residents-displaced-record-hospital-closure. Published August 27, 2019. Accessed September 11, 2020.
9. Direct Graduate Medical Education (DGME). https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/DGME. CMS.gov. Last modified on 05/12/2020. Accessed September 11, 2020.

Background

The resolution requests ACEP to set create a task force that would: 1) determine which organizations or governmental entities are capable of being permanently responsible for resident and fellow interests without conflicts of interests; 2) determine how these organizations can be held accountable for fulfilling their duties to protect the rights and well-being of resident and fellow trainees; 3) determine methods of advocating for residents and fellows that are timely and effective, without jeopardizing trainees' current and future employability; and 4) in the event that no organizations or entities are identified that meet the above criteria, determine how such an organization may be created.

The resolution discusses the current roles of the Accreditation Council for Graduate Medical Education (ACGME) and the Centers for Medicare & Medicaid Services (CMS) in training residents and funding resident slots respectively, but states that both organizations do not truly advocate for the rights of residents when they "endure suboptimal training conditions."

The stated purpose of ACGME is to accredit institutions, residency, and fellowship programs. Beyond accreditation, ACGME does dedicate resources to specific initiatives, some of which relate to physician well-being. The ACGME also offers two ways of reporting an issue about a residency program through the Office of the Ombudsperson and by filing a formal complaint. The Office of the Ombudsperson "offers an opportunity to anonymously report issues about residency programs and institutions without impacting their accreditation or Recognition status," while formal complaints "may affect the accreditation or Recognition status(es) of a Sponsoring Institution or program and, therefore, must include the complainant's name and contact information." The ACGME states that it does not act as a "mediator or adjudicator for formal complaints. The ACGME only addresses matters regarding non-compliance with the published Institutional, Program, and/or Recognition Requirements and does not adjudicate individual disputes between persons in residency or fellowship programs or those programs' Sponsoring Institutions."

The resolution also refers to the closure of Hahnemann University Hospital (HUH). As background, on June 26, 2019, the American Academic Health System announced that HUH in Philadelphia would be permanently closed in early September. This statement created an uncertain future for the 570+ residents and fellows across 36 GME programs just as the new academic year was about to start. Based on previous program closures, residents and fellows on their own began seeking to transfer to other existing programs. On July 10, HUH announced the sale and transfer of the CMS-funded GME slots to Tower Health, where the residents would continue their training. Tower Health only had 118 trainees at the time, and not all residencies and fellowships were available. Trainees were in limbo as they were still under contract with HUH and unable to take their funding with them to continue training at a new institution. The matter was litigated in the courts. Eventually, a settlement was reached, and the residents were released with partial funding. In 2020, The AMA Council on Medical Education released two reports the "Protection of Resident and Fellow Training in the Case of Hospital or Training Program Closure" and the "Graduate Medical Education and the Corporate Practice of Medicine" examining the related issues. In response to the HUH closure, CMS revised its policy in the Fiscal Year (FY) 2021 Inpatient Prospective Payment System (IPPS) final rule regarding resident transfers when hospitals close and/or announce that their residency programs are ending. Specifically, instead of linking temporary funding for the affected residents to the day prior to or on the day the hospital and/or residency program closes, the determining day is instead now the day that the closure was publicly announced. Further, CMS is allowing funding to be transferred temporarily for certain residents who are not physically at the closing hospital/closing program. ACEP, along with EMRA, strongly supported these changes, and wrote to CMS stating that they will help protect our residents and provide sufficient funding to teaching hospitals that take in displaced residents.

ACEP Strategic Plan Reference

This resolution aligns with the following objective.

Goal 1 – Improve the Delivery System for Acute Care

- Objective F – Develop and implement solutions for workforce issues that promote and sustain quality and patient safety.

Fiscal Impact

Budgeted task force and staff resources if a meeting is held virtually. Unbudgeted expenses of $20,000 – $30,000 for an in-person task force meeting depending on the size of the task force.

Prior Council Action

Amended Resolution 59(19) Opposition to the Sale and Commoditization of Graduate Medical Education Slots adopted. Directed ACEP to immediately support CMS in opposing the sale of GME slots and oppose any sale or other commoditization of GME slots.

Substitute Resolution 23(99) Resident Physician Safeguards in the Event of a Residency Program Closure adopted. Directed ACEP to work with appropriate organizations and agencies to develop strategies to implement protections for resident physicians to complete their training in the event of residency program closures.

Prior Board Action

June 2020, Amended Resolution 59(19) Opposition to the Sale and Commoditization of Graduate Medical Education Slots adopted.

June 2018, approved the revised policy statement "Resident Training for Practice in Non-Urban/Underserved Areas;" reaffirmed April 2012 and October 2006; originally approved in June 2000.

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.

June 2018, approved the revised policy statement "Financing of Graduate Medical Education in Emergency Medicine;" revised and approved October 2012, reaffirmed September 2005; originally approved September 1999.

Substitute Resolution 23(99) Resident Physician Safeguards in the Event of a Residency Program Closure adopted.

Background Information Prepared by: Jeffrey Davis
Regulatory and External Affairs Director

Jonathan Fisher, MD, MPH, FACEP
Senior Director, Workforce and Emergency Medicine Practice

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 61(21)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: Advocating for a Required Emergency Medicine Rotation at All U.S. Medical Schools

PURPOSE: Advocate for a required emergency medicine rotation in all allopathic and osteopathic, US-based medical schools.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, 61% of allopathic medical schools accredited by the Association of American Medical Colleges (AAMC) require a separate emergency medicine clerkship[1]; and

WHEREAS, All osteopathic medical schools accredited by the American Osteopathic Association (AOA) require a separate emergency medicine clerkship[2]; and

WHEREAS, The specialty and work environment of emergency medicine fulfills a large majority of the expectations determined by the AAMC's Physician Competency Reference Set (PCRS)[3]; and

WHEREAS, Many medical school graduates will go on to pursue fields of medicine different from several traditional core rotations; and

WHEREAS, Many hospital environments will not have one or more services or specialties represented by the medical fields of required rotations; and

WHEREAS, Most hospital settings have an emergency department where physicians take care of patients across the spectrum of age and medical/surgical pathology; and

WHEREAS, Most medical specialties will need to interact personally or clinically with the emergency department and emergency physicians pertaining to the care of mutual patients; therefore be it

RESOLVED, That ACEP advocate that all U.S. medical schools, allopathic and osteopathic, require at least one emergency medicine rotation.

References

1. AAMC. Percentage of Medical Schools with Separate Required Clerkships by Discipline: Emergency Medicine. https://www.aamc.org/data-reports/curriculum-reports/interactive-data/clinical-course-required-weeks-discipline
2. American Osteopathic Association. Student Doctors: Rotations: Planning for Rotations. https://osteopathic.org/students/rotations/planning-for-rotations/
3. AAMC. Competency Mapping (Medical School Program Expectations Mapped to Physician Competency Reference Set [PCRS]). https://www.aamc.org/data-reports/curriculum-reports/interactive-data/competency-mapping-medical-school-program-expectations-mapped-physician-competency-reference-set

Background

This resolution calls on ACEP to advocate for a required emergency medicine rotation in all allopathic and osteopathic, US-based medical schools. The American Osteopathic Association's Commission on Osteopathic College Accreditation (COCA) currently accredits 37 osteopathic medical schools. Osteopathic programs have the

following rotations: core, elective, and audition. Emergency medicine (EM) is considered a core, four-week rotation for osteopathic medical school. The Liaison Committee on Medical Education (LCME) currently accredits more than 150 medical programs leading to an MD degree. According to AAMC data, currently 61% of medical school have a separate EM-required clerkship (up from 50% in 2011).

The majority of medical schools organize their training into pre-clinical and clinical components with rotations traditionally occurring towards the latter portion of training. Over the past decade, many medical schools have redesigned their curriculum for the first two years but have largely left the latter years untouched. Later years tend to focus on student-chosen electives aimed to encourage career decisions and increase clinical exposer to other specialties. However, some medical schools have begun to take a more integrated approach and incorporate patient interaction, hands-on experience, and clinical training much earlier in the process. Each school has its own mission, curriculum, academic schedule, and course format. While type, length, and number of rotations can vary from school to school the following specialties are usually included: surgery, psychiatry, pediatrics, obstetrics and gynecology, family medicine, and internal medicine. For most schools, other rotations are generally provided as electives. Options to explore other specialties are specialty interest groups and student sections of medical specialty societies. The COVID pandemic has complicated fourth-year clerkships with long-term impacts yet to be determined. The LCME guidance issued in March 2020 noted that, "Some required fourth year clerkships (typically, emergency medicine, critical care, neurology) may be delayed or cancelled..."

Rotations are general perceived as a way to provide patient encounters and assess an individual's fit with the perceived attributes of a potential specialty (i.e., lifestyle, intellectual challenge, geographic options, potential for research or academic track, etc.). There is some evidence that suggests that the accuracy of understanding the day-to-day experience within a specialty can most impact the type or number of students choosing that specialty. One study found that prior life experiences and early exposure to emergency medicine, as well as specialty-specific mentorship, played a role in medical students selecting EM as a specialty during their medical school experience. Additionally, another study found that EM's perception as a having a "controllable lifestyle" was a factor. Research in surgery found that mentorship, experience in surgery, stereotypes, timing of exposure and personal factors influenced a student's decision to go into surgery. Another study found that work content, type of patients and lifestyle provided influenced students in three different clerkships. A more recent study focused on pathology as a specialty, found that clinical or research opportunities, autopsy observation and involvement in specialty groups were associated with medical student selecting pathology. Most research has focused on how exposure to a specialty influences a student's decision to enter that specialty, rather than on subsequent patient outcomes or transitions of care.

A 2007 study of residency program directors (PDs) tried to determine common struggles with interns to formulate goals for curricular reform. Through semi-structured interviews with 30 PDs in the ten most common specialties they found that while 93% highly recommended students complete a sub-internship in the field in which they were applying, 27% recommended emergency medicine and ambulatory care electives. Additionally, critical care and EM rotations were encouraged because PDs believed they provided cognitive, procedural, and communications skills training that students would need across a broad range of clinical presentations. Additionally, there has been encouragement in the past calling on academic emergency physicians to advocate for EM as a specialty with the medical school curricula. Others have noted the role that education plays in the continuum of health care with a continued focus on how it will impact coordinated patient care.

ACEP's policy statement, "Guidelines for Undergraduate Education in Emergency Medicine," states that, ACEP "believes that all medical students should be taught the basic principles of emergency medicine in order to recognize a patient requiring urgent or emergency care, initiate evaluation and management, and provide basic emergency care." It also states that, "every medical student should receive clinical exposure to emergency department patients and care" and that this can be accomplished through either a, "specific curriculum designed by emergency medicine faculty," or by "incorporating essential topics of emergency medicine into the existing curriculum." The policy also states that, "the exact format of teaching emergency medicine to medical students can take a variety of designs and should be tailored to local abilities, resources or curriculum needs, but should be driven by experts board certified in the field of emergency medicine."

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective F – Develop and implement solutions for workforce issues that promote and sustain quality and patient safety.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Substitute Resolution 39(88) Development of Emergency Medicine in Medical Schools adopted. Directed ACEP to continue to promote the development of academic divisions/departments of emergency medicine in all medical schools, work with UA/EM to encourage the implementation of the published "Guidelines for Undergraduate Education in Emergency Medicine" by all medical schools and adopt a position statement encouraging the requirement of a clinical rotation in emergency medicine as a graduation criterion for all medical schools.

Substitute Resolution 38(88) Emergency Medicine Training and Education: Medical Students adopted. Directed ACEP to assess and make available information on the status of emergency medicine in U.S. medical school and continue to support the establishment of independent academic departments of emergency medicine in all U.S. medical schools.

Resolution 38(79) Emergency Medicine Qualification for Primary Care Practice adopted. Directed ACEP to develop a rationale for emergency medicine's qualification for federal designation as primary care practice and that ACEP use its influence and means to secure that designation.

Prior Board Action

Substitute Resolution 39(88) Development of Emergency Medicine in Medical Schools adopted.

Substitute Resolution 38(88) Emergency Medicine Training and Education: Medical Students adopted.

Resolution 38(79) Emergency Medicine Qualification for Primary Care Practice adopted.

June 2021 approved the revised policy statement "Guidelines for Undergraduate Education in Emergency Medicine;" revised June 2015 and April 2008; reaffirmed October 2001; revised January 1997; originally approved September 1986.

June 2017, approved the revised policy statement "Academic Departments of Emergency Medicine in Medical Schools.; reaffirmed April 2011 and September 2005; approved March 1999; originally approved November 1974..

Background Information Prepared by: Loren Rives, MNA
Senior Manager, Academic Affairs

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 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(21)

SUBMITTED BY: Emergency Medicine Residents' Association
Pennsylvania College of Emergency Physicians

SUBJECT: Support of Telehealth Education in Emergency Medicine Residency

PURPOSE: Endorse telehealth training opportunities for residents, advocate for telehealth inclusion in The Model of the Clinical Practice of Emergency Medicine and support the development of telehealth fellowship programs in EM.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Telehealth applications in emergency medicine are ever-expanding and include physician-to-physician consults (e.g., tele-stroke, tele-radiology, tele-trauma), decision support in emergency medical services prehospital care, mobile health and medical apps, and direct physician-to-patient services (e.g., tele-screening and tele-intake)[1-4]; and

WHEREAS, The use of telehealth in emergency medicine is increasing rapidly due to improvements in technology, expanded Centers for Medicare and Medicaid Services payment policies, and a need for innovative approaches to care during the COVID-19 pandemic[5]; and

WHEREAS, There is an emerging need for trained emergency medicine physicians who can effectively deliver telehealth services, requiring a new subset of skills for the EM residency graduate; and

WHEREAS, Telehealth is an emerging field within emergency medicine, now with multiple fellowships and certification programs[6]; and

WHEREAS, Select residency programs have demonstrated successful adoption of training in telehealth with positive feedback from resident participants, such as Thomas Jefferson University Department of Emergency Medicine's implementation of a resident-led, post-ED visit telehealth follow-up program[7]; and

WHEREAS, The Emergency Medicine Residents' Association (EMRA) explicitly supports telehealth for training opportunities for residents in Section IX.III of the EMRA policy compendium[8]; and

WHEREAS, Despite these examples of innovations in telehealth practice, telehealth has not become a core competency in medical education as demonstrated by its absence in the Accreditation Council for Graduate Medical Education (ACGME) residency education milestones and The Model of the Clinical Practice of Emergency Medicine, and many emergency medicine residency programs lack training opportunities in telehealth[9]; therefore be it

RESOLVED, That ACEP promote and endorse telehealth training opportunities for emergency medicine residents; and be it further

RESOLVED, That ACEP advocate for inclusion of telehealth in *The Model of the Clinical Practice of Emergency Medicine*; and be it further

RESOLVED, That ACEP support the development of additional telehealth fellowship programs in emergency medicine.

References

1. Sikka N, Paradise S, Shu M. Telehealth in Emergency Medicine: A Primer. *ACEP Emergency Telemedicine Section*; 2014. Accessed at: https://www.acep.org/globalassets/uploads/uploaded-files/acep/membership/sections-of-membership/telemd/acep-telemedicine-primer.pdf

2. Rademacher NJ, Cole G, Psoter KJ, et al. 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
3. Joshi AU, Randolph FT, Chang AM, et al. Impact of Emergency Department Tele-intake on Left Without Being Seen and Throughput Metrics. *Acad Emerg Med*. 2020;27(2):139-147. doi:10.1111/acem.13890
4. Guyette FX et al. ACEP Whitepaper: Literature Based Progress in Telehealth. *ACEP Emergency Telemedicine Section* 2019. Accessed at: https://www.acep.org/globalassets/sites/acep/blocks/section-blocks/telemd/final-whitepaper---sans-definition-8-7-19.pdf
5. Hollander JE, Carr BC. Virtually Perfect? Telemedicine for Covid-19. *NEJM*. 2020;382(18):1679-1681. doi:10.1056/NEJMp2003539
6. Neumann A, Sikka N. Telemedicine. *EMRA Fellowship Guide*. 2020. Accessed at: https://www.emra.org/books/fellowship-guide-book/26-telemedicine/
7. Papanagnou D, Stone D, Chandra S, Watts P, Chang AM, Hollander JE. Integrating Telehealth Emergency Department Follow-up Visits into Residency Training. *Cureus*. 2018;10(4):e2433. doi:10.7759/cureus.2433
8. "Section IX.III: Support for Telemedicine in EM." *EMRA Policy Compendium*; 2018. Accessed at: https://www.emra.org/globalassets/emra/about-emra/governing-docs/policycompendium.pdf
9. Pourmand A, Ghassemi M, Sumon K, Amini SB, Hood C, Sikka N. Lack of Telemedicine Training in Academic Medicine: Are We Preparing the Next Generation? *Telemedicine and e-Health*; 2020, ahead of print. doi:10.1089/tmj.2019.0287

Background

This resolution calls on ACEP to endorse telehealth training opportunities for residents, advocate for telehealth inclusion in The Model of the Clinical Practice of Emergency Medicine and support the development of telehealth fellowship programs in EM.

Connecting remote sites and providing remote consultation service were some of the initial efforts of incorporating telemedicine within EDs. Since then, telehealth has increased rapidly over the years demonstrating that not only can it increase access to healthcare but has the potential to also increase efficiency (e.g., during overcrowding to facilitate the number of patients seen by healthcare workers, etc.). and help reduce costs. Telemedicine is used not only as a physician-to-physician consult service, but also as direct-to-consumer (patient) technology. The COVID-19 pandemic further changed the landscape of telemedicine in EDs. With regulatory and administrative barriers relaxed, more convenient and improved technology available, and institutions increasingly feeling pressure to reduce healthcare workers to potential exposure due to the lack of available PPE many sites saw even more widespread adoption of telehealth. While, some barriers remain such as concerns about privacy, limitations of physician examination and concerns about the patient experience, overall telehealth seems poised to continue to grow.

ACEP's policy statement "Emergency Medicine Training, Competency, and Professional Practice Principles" states that "it is the role and responsibility of the American Board of Emergency Medicine (ABEM) and the American Osteopathic Board of Emergency Medicine (AOBEM) to set and approve the training standards, assess competency through board certification processes and establish processional practice principles for emergency physicians."

In 1975, ACEP and the University Association for Emergency Medicine (now known as the Society for Academic Emergency Medicine), using expert opinion, conducted a practice analysis of emergency medicine to develop a listing of common conditions, symptoms, and diseases seen and evaluated in emergency departments, known then as the Core Content of Emergency Medicine. These were revised several times over the years ultimately leading to a large, complex, and unwieldy document. Several task forces were developed to address the need for a concise core resource based on an empirical foundation that would represent the needs of the specialty. Ultimately, the Core Content Task Force II developed *The Model of the Clinical Practice of Emergency Medicine*, relying on both empirical data and the input of several expert panels. A collaborative of six emergency medicine organizations (ABEM, ACEP, CORD, EMRA, RRC-EM, and SAEM) was asked to review the 2001 EM Model and propose changes and give feedback. The work of the task force was first published in June 2005 in both *Annals of Emergency Medicine* and *Academic Emergency Medicine.* These organizations continue to collaborate to review and revise subsequent EM Models.

Currently, *The Model of the Clinical Practice of Emergency Medicine* (EM Model) serves as "the basis for the content specifications for all ABEM examinations." It is reviewed every three years by the EM Model Review Task Force. There are three components to the EM Model (assessment of patient acuity, description of the tasks that must be performed to provide appropriate emergency medical care, and a listing of medical knowledge, patient care and procedural skills) that describe the practice of EM and differentiate it from the clinical practice of other specialties. The ABEM website states that it will use the 2019 version to develop examinations beginning in the fall 2022

examinations. The EM Model is meant to represent the most essential information and skills necessary for board-certified emergency physicians to practice. Section 20.0 of the EM Model provides a list of "Other Core Competencies of the Practice of Emergency Medicine," covering topics such as communication, ethics, clinical informatics, ED operations and more. Telehealth is not explicitly listed in this section. The ACGME Milestones are, "designed only for use in evaluation of residents in the context of their participation in ACGME-accredited residency programs," and "provide a framework for the assessment and development of the resident in key dimensions of.. competence." One review of the ACGME specialty and subspeciality milestones, only one specialty (Child and Adolescent Psychiatry) mentioned telehealth.

During the pandemic, on March 18, 2020, the ACGME released a statement saying that, instead of releasing its Common Program Requirements for supervisions of telemedicine visits carried out by residents and fellows, originally planned to go into effect on July 1, 2020, they would make them "effective immediately" and that "the ACGME will permit residents/fellows to participate in the use of telemedicine to care for patients affected by the pandemic." The ACGME further stated that, "Ultimately each specialty Review Committee will choose whether to continue to allow for this type of direct supervision with telemedicine in other situations." The EM Program Requirements currently in effect (VI.A.2.c).(1).(b) allow the resident to provide care through telecommunication as long as the supervising physician is, "concurrently monitoring the patient care through appropriate telecommunication technology."

An ACEP Emergency Telehealth Section survey from 2018, found that less than 5% of U.S. and Canadian medical students were satisfied with their telemedicine training. It also found that 90.8% reported at least some interest in telemedicine and 97% who believed that telemedicine would play some role in physician practice in ten years. Additionally, some residency programs are instituting their own telehealth electives.

ACEP's "Telehealth Inclusion" policy statement states that, "All existing ACEP policy statement, where applicable, are also pertinent to the practice of emergency medicine delivered via telehealth."

The American College of Telemedicine currently lists two fellowship programs on its website. The American Telehealth Association (ATA), founded in 1993, states that it now includes more than 400 organizations. The American Board of Telehealth offers a certificate program and states on their website that they "promote a gold standard for professionals and paraprofessionals to learn best practices for implementing and using telemedicine across the care continuum."

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Substitute Resolution 36(20) Telehealth Free Choice referred to the Board of Directors. Requests ACEP to: 1) 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; 2) 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; 3) 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, 4) 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 5) oppose restrictions to telehealth 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.

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 that 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 2021, approved the policy statement "Telehealth Inclusion."

February 2020, approved the revised policy statement "Emergency Medicine Telehealth;" originally approved January 2016.

October 2020, approved the "Practice Guidance for Emergency Telehealth and Acute Unscheduled Care Telehealth."

Amended Resolution 52(19) Telehealth Emergency Physician Inclusion adopted.

June 2016, approved the policy statement "Ethical Use of Telemedicine in Emergency Care."

Resolution 45(15) Telemedicine Appropriate Support and Controls adopted.

Resolution 36(14) Development of a Telemedicine Policy for Emergency Medicine adopted.

Amended Resolution 28(14) Fair Payment for Telemedicine Services adopted.

Background Information Prepared by: Loren Rives, MNA
Senior Manager, Academic Affairs

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 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(21)

SUBMITTED BY: Government Services Chapter

SUBJECT: Physician-Led Team Leader Training

PURPOSE: 1) Engage with the ACGME, CORD, SEMPA, AAENP, and AAPL to develop a standardized leadership curriculum for residency; 2) CME courses for those who have already completed their training; and 3) advocate for inclusion of leadership competencies in the next revision of The Model of the Practice of Clinical Emergency Medicine.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, ACEP has long held that the best emergency medical care is provided and led by ABEM- or AOBEM- certified emergency physicians, as affirmed in the 2018 Report from the Multi-Organization Emergency PA/NP Utilization Task Force; and

WHEREAS, According to that same report, emergency care must be physician-led and emergency physicians must supervise all care provided by physician assistants (PAs) and nurse practitioners (NPs); and

WHEREAS, The Society for Emergency Medicine Physician Assistants have multiple times affirmed their commitment to physician-led team based care and advocate for opportunities "to learn emergency medicine while reinforcing the physician-PA team concept"; and

WHEREAS, Emergency physicians should take an active role in the mentorship and continuing education of practicing PAs and NPs. This does not require training to the expertise of an emergency physician, but rather providing them with the knowledge, resources, and support necessary to maximize their contributions to the team within their defined role; and

WHEREAS, Physician-led teams assume physicians are skilled in how to effectively supervise NP/PAs and how foster highly effective teams to promote safety and quality of care, but few physicians are given formal leadership training; and

WHEREAS, It is also the responsibility of the supervising emergency physician to assist PAs and NPs in the care of any patient when requested, regardless of whether supervision is required by local ED policy; and

WHEREAS, Physician supervision of PA/NPs creates liability and physician can be at increased risk if they cannot establish and execute proper supervision of PA/NPs on their team; and

WHEREAS, It is important that all physicians at a site have a standardized and unified understanding of their supervisory requirements such that the entire emergency physician-led team has the same expectations; and

WHEREAS, The ACGME's Clinical Practice of Emergency Medicine details team management as an essential skill for emergency physicians, defined as the ability to "Coordinate, educate, or supervise members of the patient management team and utilize appropriate hospital resources."; and

WHEREAS, Specific curriculum for team leader training is not defined by the ACGME or any other governing bodies and no accepted curricula are available for developing educational and training products; and

WHEREAS, The disciplines of leadership development, organizational behavior, and experience from other industries such as the military and aviation can provide a framework for developing a leadership training curriculum; therefore be it

RESOLVED, That ACEP engage with the Accreditation Council for Graduate Medical Education, the Council of Residency Directors in Emergency Medicine, the Society of Emergency Medicine Physician Assistants, the American Academy of Emergency Nurse Practitioners, and the American Association of Physician Leaders, and other interested parties to develop a standardized curriculum for teaching physicians to function as team leaders in support of physician-led teams; and be it further

RESOLVED, That ACEP develop continuing medical education to instruct physician-led teams based on the curriculum identified by the stakeholders for physicians who are post residency; and be it further

RESOLVED, That ACEP advocate to the Accreditation Council for Graduate Medical Education that specific competencies in team leadership be incorporated in the next revision of *The Model of the Practice of Clinical Emergency Medicine*.

Resources

1. Position Statement, Society for Emergency Medicine Physician Assistants, Emergency Medicine Postgraduate Education for Physician Assistants Statement, Mar 23, 2020.
2. 2019 Model of the Clinical Practice of Emergency Medicine, https://www.cordem.org/globalassets/files/misc.-files/2019-em-model_website.pdf. Accessed 22 Jul 2021.

Background

This resolution calls on ACEP to engage with the ACGME, CORD, SEMPA, AAENP, and AAPL to develop a standardized leadership curriculum for residency and CME courses for those who have already completed their training. It also calls on ACEP to advocate for the inclusion of leadership competencies in the next revision of The Model of the Practice of Clinical Emergency Medicine.

A recent study of emergency medicine residents and attendings found that while 89.5% of respondents believed that learning about business topics during residency is "important" or "very important" and the majority of residents (61%) said that their program does not adequately prepare them for business and practice management issues, such as contracts and practice modes, credentialing, value-based payments, etc. Management skills and leadership have been proposed as core content within medical education. Data from 2009 found that fewer than 4% of U.S. hospitals were headed by physicians. A 2011 study that looked at the top-100 best hospitals (according to the *US News and World Report*) to see if hospitals were ranked more highly when led by medically trained physicians versus no-MD professional managers. Their analysis found that hospital quality scores were approximately 25% higher for physician-led hospitals compared to professional managers. The AMA states that, "physician assistants should be authorized to provide patient care services only so long as the physician assistant is functioning under the direction and supervision of a physician or group of physicians." ACEP considers board-certified/board-eligible emergency physician supervision as the gold standard.

Most leadership and management training takes place through external training opportunities (e.g., EMRA and ACEP Leadership program, Global Emergency Medicine Student Leadership Program, ACEP Young Physician Section Leadership Society, Chapter Leadership Development Programs, etc.), "on the job," online, insolated workshops, or through other venues, but rarely within a formal curriculum. There has been an increase in the percentage of medical school graduates completing dual MD/MBA degrees (up 50% between 2015-19). However, this represents less than 1% of graduates. Some programs, however, have made strides in integrating leadership and management training into their curriculum. These programs, for example, include rotations with leaders in finance, patient-safety, operations, etc. Other programs create a two-tier approach to introduce the fundamental principles of business, while others require a team-based innovation project as a capstone.

Currently, *The Model of the Clinical Practice of Emergency Medicine* (EM Model) serves as, "the basis for the

content specifications for all ABEM examinations." It is reviewed every three years by the EM Model Review Task Force. There are three components to the EM Model (assessment of patient acuity, description of the tasks that must be performed to provide appropriate emergency medical care and a listing of medical knowledge, patient care and procedural skills) that describe the practice of emergency medicine and differentiate it from the clinical practice of other specialties. The American Board of Emergency Medicine (ABEM) website states that it will use the 2019 version to develop examinations beginning in the fall 2022 examinations. The EM Model is meant to represent the most essential information and skills necessary for board-certified emergency physicians to practice. Section 20.0 of the EM Model provides a list of "Other Core Competencies of the Practice of Emergency Medicine," covering topics such as communication, ethics, clinical informatics, ED operations and more. Section 20.3.3 includes Leadership and management principles.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective A – Promote/advocate for efficient, sustainable, and fulfilling clinical practice.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Amended Resolution 40(88) Training Leaders in Academic Emergency Medicine adopted. The resolution called on ACEP to develop polices to ensure leaders in academic emergency medicine have access to leadership development materials.

Prior Board Action

January 2021, approved the revised policy statement "Definition of Emergency Medicine;" revised June 2015, April 2008, April 2001; reaffirmed October 1998; revised April 1994 with current title replacing "Definition of Emergency Medicine and the Emergency Physician."

June 2020, approved the revised policy statement "Guidelines Regarding the Role of Physician Assistance and Nurse Practitioners in the Emergency Department" with the current title; 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 "Guidelines on the Role of Physician Assistants in Emergency Departments" (2002) and "Guidelines on the Role of Nurse Practitioners" in the Emergency Department" (2000).

September 2019, "2019 Model of the Clinical Practice of Emergency Medicine" approved by ACEP, ABEM, CORD, EMRA, RRC-EM, and SAEM.

June 2018, reaffirmed the policy statement "Emergency Medicine Training, Competency, and Professional Practice Principles;" reaffirmed April 2012; revised January 2006; originally approved November 2001.

Background Information Prepared by: Loren Rives, MNA
Senior Manager, Academic Affairs

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 64(21)

SUBMITTED BY: Rural Emergency Medicine Section

SUBJECT: Rural Emergency Medicine Education and Recruitment

PURPOSE: ACEP support: 1) staffing rural EDs with board-certified emergency physicians; 2) the linkage between rural hospitals and academic institutions to help create more rural medicine internships and electives; 3) the use of government funding for rural elective rotations for emergency medicine residents; 4) student loan forgiveness for physicians choosing to practice emergency medicine in rural areas

FISCAL IMPACT: Budgeted staff resources.

WHEREAS, 42% of emergency departments in the United States are in a rural county and provide essential care to millions of Americans. Yet rural hospitals are consistently under significant financial constraint and more likely to close than their urban counterparts[1,2]; and

WHEREAS, Rural emergency departments are more likely to face staffing shortages and be staffed by non-emergency medicine board-certified physicians or advanced practice clinicians[3-7]; and

WHEREAS, Exposure to rural medicine in medical school and residency training significantly increases the likelihood that physicians will choose to practice in a rural area[5,8]; and

WHEREAS, Medical trainees with a rural background are more likely to practice in rural areas[9-11]; and

WHEREAS, The cost of medical training continues to rise, student loan forgivenesss is a major incentive for medical trainees to choose a rural medical practice[9,11]; therefore be it

RESOLVED, That ACEP support staffing rural hospitals with ED volumes greater than 5,000 patients per year with board-certified emergency physicians including cost-based reimbursement that covers the cost of 24/7 ABEM-certified physician coverage and support expanded ACEP-led rural provider education, board-certified emergency physician medical direction, and telemedicine access for all rural emergency departments including those who do not yet have full ABEM-certified physician coverage or those with extremely low volumes; and be it further

RESOLVED, That ACEP support the creation of links between rural hospitals and larger health networks and academic institutions, including medical schools and colleges, to facilitate the creation of rural medicine internships and electives for interested learners at the undergraduate and medical school level; and be it further

RESOLVED, That ACEP support the use of government funding for rural elective rotations for emergency medicine residents at rural critical access hospitals to better train residents for this work and recruit residents to rural practice, where they are most needed; and be it further

RESOLVED, That ACEP support student loan forgiveness for physicians choosing to practice emergency medicine in rural areas.

References

1. Muelleman RL, Sullivan AF, Espinola JA, Ginde AA, Wadman MC, Camargo CA Jr. Distribution of emergency departments according to annual visit volume and urban-rural status: implications for access and staffing. Acad Emerg Med. 2010 Dec;17(12):1390-7.
2. Rural Hospital Closures Database. Cecil Sheps Center for Health Services Research The University of North Carolina Chapel Hill.https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/

3. Bennett, Christopher L., et al. "National Study of the Emergency Physician Workforce, 2020." Annals of Emergency Medicine. 2020 Dec; 76(6): 695–708.
4. Mk, Hall, et al. "State of the National Emergency Department Workforce: Who Provides Care Where?" Annals of Emergency Medicine. 2018 Sept; 72(3).
5. Patterson, Davis G., et al. "Preparing Physicians for Rural Practice: Availability of Rural Training in Rural-Centric Residency Programs." Journal of Graduate Medical Education. 2019 Oct; 11(5): 550–57.
6. Peterson, Lars E., et al. "Family Physicians' Contributions to Rural Emergency Care and Urban Urgent Care." The Journal of the American Board of Family Medicine. 2019 May; 32(3).
7. Pines JM, Zocchi MS, Ritsema T, Polansky M, Bedolla J, Venkat A; US Acute Care Solutions Research Group. The Impact of Advanced Practice Provider Staffing on Emergency Department Care: Productivity, Flow, Safety, and Experience. Acad Emerg Med. 2020 Nov;27(11):1089-1099.
8. Brown SR, Birnbaum B. Student and resident education and rural practice in the Southwest Indian Health Service: a physician survey. Fam Med. 2005 Nov-Dec;37(10):701-5.
9. Mohammadiaghdam N, Doshmangir L, Babaie J, Khabiri R, Ponnet K. Determining factors in the retention of physicians in rural and underdeveloped areas: a systematic review. BMC Fam Pract. 2020 Oct 23;21(1):216. doi: 10.1186/s12875-020-01279-7. PMID: 33097002; PMCID: PMC7585284.
10. Patrick FM. Rural physician supply and retention: factors in the Canadian context. Can J Rural Med. 2018;23(1):15 –20.
11. Royston PJ, Mathieson K, Leafman J, Ojan-Sheehan O. Medical student characteristics predictive of intent for rural practice. Rural Remote Health. 2012;12:2107.

Background

This resolution asks ACEP to support: 1) staffing rural emergency departments (ED) with board-certified emergency physicians; 2) the linkage between rural hospitals and academic institutions to help create more rural medicine internships and electives; 3) the use of government funding for rural elective rotations for emergency medicine residents; and 4) student loan forgiveness for physicians choosing to practice emergency medicine in rural areas.

Overall, the resolution builds off of the specific findings and recommendations included in the Rural Emergency Medicine Care Task Force Report that was submitted to the ACEP Board of Directors in October 2020. With respect to the first resolve, the report recommends that ACEP develop a policy that "advocates that hospitals without EM board certified physician coverage…have telemedicine availability for consultation." ACEP in the past has advocated for board-certified emergency physicians to oversee all care delivered in EDs in rural areas – even remotely via telehealth. Most recently, ACEP made this specific request in the context of the new designation of rural emergency hospitals (REHs). ACEP held a meeting in June 2021 with Centers for Medicare & Medicaid Services (CMS) staff who are in charge of implementing REHs and emphasized the critical importance of requiring that emergency care in REHs be provided by or overseen by board-certified emergency physicians at all times. This position will be reiterated in a response to a request for information that CMS will issue regarding REHs.

In terms of creating links between rural hospitals and larger health networks and academic institutions to facilitate the creation of rural medicine internships and electives, the Rural Emergency Care Task Force Report also highlights the benefit of conducting rural rotations to "bridge the gap between academic training and community practice" and that residents show "strong resident support for these types of training opportunities." As the resolution states, "exposure to rural medicine in medical school and residency training significantly increases the likelihood that physicians will choose to practice in a rural area."

Regarding government funding, it is important to note that CMS finalized a policy in the Fiscal Year (FY) 2020 Inpatient Prospective Payment System Final Rule that allows a hospital (such as an academic medical center) to include residents training in a critical access hospital in its FTE count if the hospital incurs the residents' salaries and fringe benefits while the residents are training at that site. In other words, hospitals can continue receiving graduate medical education (GME) payments for their residents while they are on rotation at a critical access hospital (if the hospitals continue to pay their residents' salaries). Thus, Medicare already supports rural elective rotations.

There are several physician loan repayment/forgiveness programs to encourage practicing in a variety of designated settings such as underserved areas, the Indian Health Services, or performing NIH research. However, one of the largest programs is the National Health Service Corps and unfortunately, emergency physicians are NOT eligible to participate. ACEP has previously met with Congressional staff about the possibility of including emergency medicine participation in the National Health Service Corps.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum, including rural areas.
- Objective F – Develop and implement solutions for workforce issues that promote and sustain quality and patient safety.

Fiscal Impact

Budgeted staff resources.

Prior Council Action

Resolutions 48(20) Residency Program Expansion Referred to Board of Directors. Directed 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.

Substitute Resolution 19(08) Second Rural Workforce Task Force referred to the Board of Directors. The resolution called for the appointment of a second rural task force empowered to convene a second Rural Emergency Medicine Summit and develop recommendations for the ACEP Board.

Amended Resolution 37(05) Rural Emergency Medicine Workforce adopted. Directed ACEP to advocate for the inclusion of EM in the National Health Services Corps scholarship program, explore and advocate for various incentives for emergency medicine residency trained physicians to practice in in rural or underserved areas, explore funding sources for a new workforce study, and work with other emergency medicine organization to encourage the development and promotion of rural emergency medicine clerkships/rotations at medical schools and residency programs.

Substitute Resolution 20(01) Medical Education Debt adopted. The resolution directed ACEP to lobby appropriate state and federal agencies for inclusion of emergency physicians in medical education debt repayment programs, including but not limited to state programs, the National Public Health Service, rural and underserved regional grant programs, and other grants/ scholarship programs.

Amended Substitute Resolution 21(01) Rural Emergency Medicine Departments adopted. Directed ACEP to investigate the root causes related to the difficulty of securing board-certified emergency physician staffing for medically underserved and rural areas; the causes studies should include, but not be limited to, educational, financial, and resident candidate selection factors, and be it further resolved that ACEP investigate methods to improve educational opportunities in rural and underserved environments.

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.

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.

Substitute Resolution 37(88) Funding for Emergency Medicine Graduate Medical Education adopted. Directed ACEP to encourage development of new models for funding graduate medical education.

Prior Board Action

January 2021, approved the legislative and regulatory priorities for the First Session of the 117th Congress that include several initiatives related to rural emergency care.

October 2020, filed the report of the Rural Emergency Care Task Force. ACEP's Strategic Plan was updated to include tactics to address recommendations in the report.

June 2018, approved the revised policy statement "Resident Training for Practice in Non-Urban Underserved Areas;" reaffirmed April 2012 and October 2006; Originally approved in June 2000

August 2017, reviewed the information paper "Delivery of Emergency Care in Rural Settings."

June 2017, approved policy statement "Definition of Rural Emergency Medicine."

June 2015, accepted for information the report of the Rural Emergency Medicine Task Force.

June 2014, discussed the proposal from the Rural Emergency Medicine Section to support the Rural Emergency Medicine Education (REME) Program and appointed a Rural Emergency Medicine Task Force.

June 2009, took no further action on Referred Substitute Resolution 19(08) Second Rural Workforce Task Force because the intent of the resolution would be met by the Future of Emergency Medicine Summit.

Amended Resolution 37(05) Rural Emergency Medicine Workforce adopted.

September 2004, approved continuing the work of the Rural Task Force to complete their assigned tasks.

September 2003, approved the recommendations from the Rural Emergency Medicine Summit

February 2003, approved the development of a Rural Emergency Medicine Summit.

November 2002, approved convening a Rural Workforce Summit to identify specific needs of physicians practicing in rural emergency departments, explore solutions to staffing rural EDs, and make recommendations as to ACEP's role in this effort.

Amended Substitute Resolution 21(01) Rural Emergency Medicine Departments adopted.

Substitute Resolution 20(01) Medical Education Debt adopted.

Amended Resolution 65(95) Residency Positions in Emergency Medicine adopted.

Amended Resolution 17(90) Emergency Medicine Residency Training Programs adopted.

Substitute Resolution 37(88) Funding for Emergency Medicine Graduate Medical Education adopted.

Background Information Prepared by: Jeffrey Davis
Regulatory and External Affairs Director

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 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(21)

SUBMITTED BY: Rural Emergency Medicine Section

SUBJECT: Rural Provider Support and a Call for Data

PURPOSE: 1) Recognize that patients presenting to rural EDs are a vulnerable ED patient population; 2) Support/ develop a comprehensive survey of rural EDs to investigate volumes, clinician staffing patterns, and common barriers of care and staffing and for the survey to be based on volume-based stratification; 3) Recognize that ABEM/AOBEM-certified physicians are underrepresented in rural EDs and low volume EDs generally cannot support full-time ABEM/AOBEM-certified physicians; 4) Support rural EDS to retain ABEM/AOBEM-certified physicians to serve as ED medical directors; 5) Support staffing rural hospitals with ED volumes greater than 0.5 patients/hour with dedicated physician coverage; ABEM/AOBEM certified physicians are preferred if available; at volumes greater than 1.0 patients per hour, ABEM/AOBEM certified physician coverage is strongly encouraged; and will support cost-based reimbursement that covers the cost of 24/7 ABEM/AOBEM certified physician coverage; 6) Work with many other specialty societies, medical liability insurance carriers, health systems, physician groups, and other stakeholder organizations to develop and support a universal minimum standard for all non-emergency medicine trained physicians, NPs, and physician assistants practicing in rural EDs; 7) Evaluate and approve specific training pathways and onboarding protocols and clinical support systems (e.g., teleEM) for non-emergency medicine trained physicians, PAs and NPs working solo in extreme low volume facilities; and 8) Support and endorse rural-specific tools including telemedicine initiatives, development of regional expedited transfer agreements, regional hub and spoke model integration, and rural specific educational tools.

FISCAL IMPACT: Budgeted staff resources. Unbudgeted expenses of $150,000-200,000 for a comprehensive study and additional expenses of $20,000 – $30,000 for an in-person task force/stakeholder meeting depending on the size of the group.

WHEREAS, Patients in rural areas are especially vulnerable, suffering from higher age adjusted mortality, greater rates of chronic disease, increased high risk behaviors, and decreased life expectancy when compared to urban patients[1-3]; and

WHEREAS, Rural emergency department (ED) visit rates increased by more than 50%, while urban increased 7% from 2005-2016[15] and patient acuity in rural emergency departments is poorly understood, although data suggests rural emergency departments may see slightly less acute patients but experience worse outcomes when compared to urban emergency departments[4-8]; and

WHEREAS, Rural EDs, compared to their urban counterparts, are resource limited, financially stressed, experience higher interfacility transfer rates, and are more likely to experience prolonged ED holds due to an under-resourced EMS system.[9-15]; and

WHEREAS, Data needed to match rural ED volumes with the appropriate resources are limited and the arbitrary acute care bed cap of 25 for critical access hospitals makes correlation between beds and patient volumes unreliable, and the fact that there is no easily accessible data on who is medically staffing rural EDs[16]; and

WHEREAS, There is no ideal universal staffing model for rural emergency departments and no well-established minimal threshold ED volume (annual volume or patients per hour) to support an ABEM/AOBEM physician, even though most rural emergency departments can justify a full-time emergency physician specialist[17-21]; therefore be it

RESOLVED, That ACEP recognize that patients presenting to rural emergency departments are arguably our most vulnerable ED patient population in the U.S. and deserve increased support; and be it further

RESOLVED, That ACEP support/develop a comprehensive survey of rural emergency departments to investigate volumes, clinician staffing patterns, and common barriers of care and staffing and this survey should be volume based and stratified as follows:

Extreme Frontier	< 0.25 pts/hr (annual volume < 2,190)
Frontier	0.25 pts/hr - 0.5 pts/hr (annual volume 2,191 to 4,380)
Small Rural	0.5 pts/hr – 2 pts/hr (annual volume 4,381 to 17,520)
Medium Rural	2 pts/hr – 4 pts/hr (annual volume 17,521 to 35,040)
Large rural	> 4 pts/hr (annual volume > 35,041); and be it further

RESOLVED, That ACEP recognize that ABEM/AOBEM-certified physicians are underrepresented in rural emergency departments and that very low volume EDs generally cannot support full-time ABEM/AOBEM-certified physicians; and be it further

RESOLVED, That ACEP support rural emergency departments to retain ABEM/AOBEM-certified physicians to serve as emergency department medical directors so there will be physician-led teams in all U.S. EDs; and be it further

RESOLVED, That ACEP support staffing rural hospitals with ED volumes greater than 0.5 patients per hour with dedicated physician coverage; ABEM/AOBEM certified physicians are preferred if available; at volumes greater than 1.0 patients per hour, ABEM/AOBEM certified physician coverage is strongly encouraged; and ACEP will support cost-based reimbursement that covers the cost of 24/7 ABEM/AOBEM certified physician coverage; and be it further

RESOLVED, That ACEP work with the American Academy of Family Physicians, the American Board of Physician Specialties, the American Academy of Emergency Nurse Practitioners, the Society of Emergency Physician Assistants, medical liability insurance carriers, health systems, physician groups, and other stakeholder organizations to develop and support a universal minimum standard for all non-emergency medicine trained physicians, nurse practitioners, and physician assistants practicing in rural emergency departments; and be it further

RESOLVED, That ACEP closely evaluate and approve specific training pathways and onboarding protocols and clinical support systems (e.g., teleEM) for non-emergency medicine trained physicians, physician assistants, and nurse practitioners working solo in extreme low volume facilities; and be it further

RESOLVED, That ACEP support and endorse rural-specific tools including telemedicine initiatives, the development of regional expedited transfer agreements, regional hub and spoke model integration, and rural specific educational tools.

References

1. Moy E, Garcia MC, Bastian B, Rossen LM, Ingram DD, Faul M, Massetti GM, Thomas CC, Hong Y, Yoon PW, Iademarco MF. Leading Causes of Death in Nonmetropolitan and Metropolitan Areas- United States, 1999-2014. MMWR Surveill Summ. 2017 Jan 13;66(1):1-8. doi: 10.15585/mmwr.ss6601a1. Erratum in: MMWR Morb Mortal Wkly Rep. 2017 Jan 27;66(3):93. PMID: 28081058; PMCID: PMC5829895.
2. Singh GK, Siahpush M. Widening rural-urban disparities in all-cause mortality and mortality from major causes of death in the USA, 1969-2009. J Urban Health. 2014 Apr;91(2):272-92. doi: 10.1007/s11524-013-9847-2. PMID: 24366854; PMCID: PMC3978153.
3. (National Healthcare Quality and Disparities Report chartbook on rural health care. Rockville, MD: Agency for Healthcare Research and Quality; October 2017. AHRQ Pub. No. 17(18)-0001-2-EF.)
4. Yiadom MYAB, Baugh CW, Barrett TW, Liu X, Storrow AB, Vogus TJ, Tiwari V, Slovis CM, Russ S, Liu D; ED Operations Study Group 2015. Measuring Emergency Department Acuity. Acad Emerg Med. 2018 Jan;25(1):65-75. doi: 10.1111/acem.13319. PMID: 28940546; PMCID: PMC5764775.
5. Greenwood-Ericksen MB, Kocher K. Trends in Emergency Department Use by Rural and Urban Populations in the United States. JAMA Netw Open. 2019 Apr 5;2(4):e191919. doi: 10.1001/jamanetworkopen.2019.1919. PMID: 30977849; PMCID: PMC6481434.
6. Greenwood-Ericksen MB, Rothenberg C, Mohr N, Andrea SD, Slesinger T, Osborn T, Whittle J, Goyal P, Tarrant N, Schuur JD, Yealy

DM, Venkatesh A. Urban and Rural Emergency Department Performance on National Quality Metrics for Sepsis Care in the United States. J Rural Health. 2019 Sep;35(4):490-497. doi: 10.1111/jrh.12339. Epub 2018 Nov 28. PMID: 30488590.
7. Joynt KE, Harris Y, Orav EJ, Jha AK. Quality of care and patient outcomes in critical access rural hospitals. JAMA. 2011 Jul 6;306(1):45-52. doi: 10.1001/jama.2011.902. PMID: 21730240; PMCID: PMC3337777.
8. (Ivantage Health Analytics 2013 NATIONAL RURAL EMERGENCY DEPARTMENT STUDY)
9. Kaufman BG, Thomas SR, Randolph RK, Perry JR, Thompson KW, Holmes GM, Pink GH. The Rising Rate of Rural Hospital Closures. J Rural Health. 2016 Winter;32(1):35-43. doi: 10.1111/jrh.12128. Epub 2015 Jul 14. PMID: 26171848.
10. Freeman VA, Slifkin RT, Patterson PD. Recruitment and retention in rural and urban EMS: results from a national survey of local EMS directors. J Public Health Manag Pract. 2009 May-Jun;15(3):246-52. doi: 10.1097/PHH.0b013e3181a117fc. PMID: 19363405.
11. Gomez D, Berube M, Xiong W, Ahmed N, Haas B, Schuurman N, Nathens AB. Identifying targets for potential interventions to reduce rural trauma deaths: a population-based analysis. J Trauma. 2010 Sep;69(3):633-9. doi: 10.1097/TA.0b013e3181b8ef81. PMID: 20016384.
12. Heaton J, Kohn MD. EMS Inter-Facility Transport. 2020 Sep 27. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2021 Jan–. PMID: 32310376.
13. (EMS Workforce for the 21st Century: A National Assessment EMSWorkforceReport_June2008.pdf)
14. (EMS Services in Rural America: Challenges and Opportunities Nikki King, MHSA, Marcus Pigman, MHA, Sarah Huling, BS- ARRT, ARDMS, and Brian Hanson, PhD. Retrieved at 05-11-18-NRHA-Policy-EMS.pdf (ruralhealthweb.org))
15. Zagales I, Bourne M, Sutherland M, Pasarin A, Zagales R, Awan M, McKenney M, Elkbuli A. Regional Population-Based Workforce Shortages in General Surgery by Practicing Surgeon and Resident Trainee. Am Surg. 2021 Jun 26:31348211029870. doi: 10.1177/00031348211029870. Epub ahead of print. PMID: 34176319.
16. (Data taken from the AHA Dataquerry. Pulled 7/14/21)
17. Bennett CL, Sullivan AF, Ginde AA, Rogers J, Espinola JA, Clay CE, Camargo CA Jr. National Study of the Emergency Physician Workforce, 2020. Ann Emerg Med. 2020 Dec;76(6):695-708. doi: 10.1016/j.annemergmed.2020.06.039. Epub 2020 Aug 1. PMID: 32747085.
18. Hansroth J, Findley SW, Quedado KD, Marshall T, Vucelik A, Goode CS. Evaluating West Virginia's Emergency Medicine Workforce: A Longitudinal Observational Study. Cureus. 2021 Mar 1;13(3):e13639. doi: 10.7759/cureus.13639. PMID: 33824792; PMCID: PMC8012015.
19. Reames J, Handel DA, Al-Assaf A, Hedges JR. Rural Emergency Medicine: patient volume and training opportunities. J Emerg Med. 2009 Aug;37(2):172-6. doi: 10.1016/j.jemermed.2007.12.040. Epub 2008 Nov 12. PMID: 19004592.
20. (2018 New Mexico Emergency Department Data Annual Report. https://www.nmhealth.org/data/view/systems/2361/)
21. (Emergency Department Volume and Capacity by Facility - OSHPD)

Background

This resolution addresses many needs of rural hospitals. The multiple resolveds ask that ACEP: 1) Recognize that patients presenting to rural EDs are a vulnerable ED patient population; 2) Support/develop a comprehensive survey of rural EDs to investigate volumes, clinician staffing patterns, and common barriers of care and staffing and for the survey to be based on volume-based stratification; 3) Recognize that ABEM/AOBEM-certified physicians are underrepresented in rural EDs and low volume EDs generally cannot support full-time ABEM/AOBEM-certified physicians; 4) Support rural EDS to retain ABEM/AOBEM-certified physicians to serve as ED medical directors; 5) Support staffing rural hospitals with ED volumes greater than 0.5 patients/hour with dedicated physician coverage; ABEM/AOBEM certified physicians are preferred if available; at volumes greater than 1.0 patients per hour, ABEM/AOBEM certified physician coverage is strongly encouraged; and will support cost-based reimbursement that covers the cost of 24/7 ABEM/AOBEM certified physician coverage; 6) Work with many other specialty societies, medical liability insurance carriers, health systems, physician groups, and other stakeholder organizations to develop and support a universal minimum standard for all non-emergency medicine trained physicians, NPs, and physician assistants practicing in rural EDs; 7) Evaluate and approve specific training pathways and onboarding protocols and clinical support systems (e.g., teleEM) for non-emergency medicine trained physicians, PAs and NPs working solo in extreme low volume facilities; and 8) Support and endorse rural-specific tools including telemedicine initiatives, development of regional expedited transfer agreements, regional hub and spoke model integration, and rural specific educational tools

Some of the requests in this comprehensive resolution have been addressed in part. ACEP has had several rural health task forces, the most recent of which provided their findings to the ACEP Board of Directors in 2020. All of the rural emergency medicine task forces have, to at least some degree, discussed the vulnerable population that exists in rural America, and the lack of resources including emergency physicians in these areas. However, ACEP does not have a policy statement that states specifically that the rural population is one of the most vulnerable in our country. ACEP's policy statement "Definition of Rural Emergency Medicine" could be revised to include this acknowledgement.

It is well known that ABEM/ABOEM certified physicians are underrepresented in rural EDs. The recent paper by Bennet et al[1] clearly shows this to be a current problem. Specifically ACEP has several papers, but no policy statement that states this fact.

ACEP does not have comprehensive data about rural EDs and has not conducted a rigorous survey as requested in the resolution. In a brief review of the internet and medical literature, no such survey, as specifically outlined, exists. ACEP itself lacks immediate and easy access to this data. It should be noted that ACEP's current database does not contain the names and contact numbers for all ED directors, especially in rural areas and EDs where there are no ACEP members. Many of these smaller, rural hospitals do not have a physician director, and if present few are members of ACEP. Therefore a third party would be required to collect this information in the form required by the resolution.

The resolution also calls for ACEP to support staffing of rural hospitals with low volume. This is in line with the current ED Accreditation Task Force appointed by ACEP President Mark Rosenberg, DO, FACEP. The task force has been charged to create an accreditation program for EDs to ensure that "a person's zip code does not dictate the emergency care they receive." In today's interconnected world, telehealth offers the opportunity for smaller hospitals to have access to emergency physicians (as defined by ACEPs existing policy).[2] ACEP's most recent Rural Emergency Care Task Force Report highlights several successful models for promoting emergency physician-led care in rural areas. Although the criteria for ED accreditation has not yet been determined, we anticipate it will support leadership by an emergency physician and that it will require supervision of non-physicians, with small hospitals with a very low volume (number to be determined) able to utilize dedicated telehealth measures to ensure that all patients are "seen" by an emergency physician. This requirement would incorporate that there be appropriate reimbursement for physician telehealth coverage. This task force is just beginning its work but we anticipate a program launch by October 2022, if not before. The ACEP Board of Directors and the Council Officers will receive frequent updates from the important task force during the next year.

ACEP has supported the efforts of the Emergency Nurses Association (ENA), American Academy of Emergency Nurse Practitioners (AAENP), and the Society of Emergency Medicine Physician Assistants (SEMPA) to improve the skills of their membership. It should be noted that ACEP believes strongly that no additional skill set can substitute for physician training and support of additional training does not support, in any way, independent practice. It should be noted that current training models for nurse practitioners (NPs) and advanced practice nurses (APNs) can be quite variable and general, with the education of APNs primarily focused on patient education/administration/research rather than clinical care. Even the training of physician assistants (PAs) is general in nature. None of these training programs should be assumed to prepare the NP, APN, or PA to practice in an emergency setting. Therefore, ACEP will continue to encourage additional education for NPs, PAs, and especially APNs to practice in a supervised ED setting.

ACEP has for decades supported additional training of RNs as demonstrated by CEN (certified emergency nurse). ACEP has to date supported each organization (AAENP, SEMPA, and ENA specifically for CEN) in creating their own standards. Emergency physicians have been heavily involved in these efforts. Through the ED Accreditation Program outlined above, ACEP could require institutions to require staff to be certified via these pathways, after an initial period of experience in the ED.

This resolution also requests that ACEP work with other organizations to develop minimal standards for NPs and PAs. Today's training programs, particularly for NPs and APNs are, in some cases, largely online. There is concern that the training received in some programs is substandard, even for the generalist education. ACEP could meet with these organizations to help to create a minimum generalist curriculum, however, ACEP lacks the ability to ensure that this action would be followed by specific training programs. We would need to engage with those institutions that oversee such education, such as the American Association of College of Nursing. While accreditation through the Commission on Collegiate Nursing Education has existed for the past 20 years,[3] it does not appear that accreditation is required for an institution to enroll students.

It is important to note that this resolution promotes the use of non-physicians and physicians who do not meet the definition of an emergency physician per ACEP policy. This is contradictory to other resolutions being considered this year by the Council. In addition, it runs counter to our initial advocacy work regarding the implementation of

rural emergency hospitals (REHs). As background, in order to increase access to emergency services in rural areas, Congress included a provision in the Consolidated Appropriations Act (enacted last December) that would allow critical access hospitals and small rural hospitals (those with less to than 50 beds) to convert to REHs starting on January 1, 2023. REHs, once established, will not provide any inpatient services, but must be able to provide emergency services 24 hours a day/7 days a week and have a physician, nurse practitioner, clinical nurse specialist, or physician assistant available at all times. To get REHs up and running by 2023, the Centers for Medicare & Medicaid Services (CMS) must create all the requirements associated with the new facility-type through regulations. ACEP leadership held a meeting in June 2021 with CMS staff who are in charge of creating the new REH Medicare designation to provide our initial feedback. Specifically, we requested that, although REHs can legally be staffed by non-physician practitioners, we strongly believe that all care provided in REHs should be supervised by a board-certified emergency physician, even remotely via telehealth.

Background References

[1]Bennett C:, Sullivan AS, Ginde A, et al. National study of the emergency physician workforce, 2020. *Ann Emerg Med.* 2020;76:695-708.
[2]Definition of an Emergency Physician [policy statement]. Approved April 2017.
[3]Commission on Collegiate Nursing Education CCNE Accreditation (aacnnursing.org)

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum, including rural areas.
  - Tactic 14. Develop a document defining the scope of practice and supervision requirements for nurse practitioners and physician assistants in the ED.

Fiscal Impact

Unbudgeted expenses of $150,000-200,000 for a comprehensive study and additional expenses of $20,000 – $30,000 for an in-person task force/stakeholder meeting depending on the size of the group.

Prior Council Action

Substitute Resolution 41(19) Establish a Rural Emergency Care Advisory Board adopted. Directed ACEP to work with stakeholders within the College including the Rural Emergency Medicine Section and chapters to provide a regular mechanism to seek input from rural physicians in legislation that impacts rural communities; and seek rural physician representation on the State Legislative/Regulatory Committee and the Federal Government Affairs Committee to reflect the fact that nearly half of all US EDs are located in rural areas.

Resolution 40(19) Advancing Quality Care in Rural Emergency Medicine referred to Board. Directed ACEP to: 1) work with stakeholder groups to promote emergency medicine delivery models that increase quality and reduce costs in rural settings; 2) identify and promote existing training opportunities to help physicians and non-physicians in rural settings maintain their clinical skills; 3) develop a paper that identifies best practices and funding mechanisms to promote development of emergency medicine electives within emergency medicine residency programs; and 4) encourage research in rural emergency medicine by identifying funding sources to support research and cost savings in rural emergency medicine.

Substitute Resolution 19(08) Second Rural Workforce Task Force referred to the Board of Directors. The resolution called for the appointment of a second rural task force empowered to convene a second Rural Emergency Medicine Summit and develop recommendations for the ACEP Board.

Amended Resolution 37(05) Rural Emergency Medicine Workforce adopted. Directed ACEP to advocate for the inclusion of EM in the National Health Services Corps scholarship program, explore and advocate for various incentives for emergency medicine residency trained physicians to practice in in rural or underserved areas, explore funding sources for a new workforce study, and work with other emergency medicine organization to encourage the development and promotion of rural emergency medicine clerkships/rotations at medical schools and residency programs.

Amended Substitute Resolution 21(01) Rural Emergency Medicine Departments adopted. Directed ACEP to investigate the root causes related to the difficulty of securing board-certified emergency physician staffing for medically underserved and rural areas; the causes studies should include, but not be limited to, educational, financial, and resident candidate selection factors, and be it further resolved that ACEP investigate methods to improve educational opportunities in rural and underserved environments

Prior Board Action

January 2021, approved the legislative and regulatory priorities for the First Session of the 117th Congress that include several initiatives related to rural emergency care.

October 2020, filed the report of the Rural Emergency Care Task Force. ACEP's Strategic Plan was updated to include tactics to address recommendations in the report.

January 2020, assigned Referred Resolution 40(19) Advancing Quality Care in Rural Emergency Medicine to the Rural Emergency Task Force to review and provide recommendations to the Board to address rural emergency medicine issues.

Substitute Resolution 41(19) Establish a Rural Emergency Care Advisory Board adopted. Directed ACEP to work with stakeholders within the College including the Rural Emergency Medicine Section and chapters to provide a regular mechanism to seek input from rural physicians on legislation that impacts rural communities; and to seek rural physician representation on the State Legislative/Regulatory Committee and the Federal Government Committee.

June 2018, approved the revised policy statement "Resident Training for Practice in Non-Urban Underserved Areas;" reaffirmed April 2012 and October 2006; Originally approved in June 2000

August 2017, reviewed the information paper "Delivery of Emergency Care in Rural Settings."

June 2017, approved the policy statement "Definition of Rural Emergency Medicine."

April 2017, reaffirmed the policy statement "Definition of an Emergency Physician;" originally approved June 2011.

June 2015, accepted for information the report of the Rural Emergency Medicine Task Force.

June 2014, discussed the proposal from the Rural Emergency Medicine Section to support the Rural Emergency Medicine Education (REME) Program and appointed a Rural Emergency Medicine Task Force.

June 2009, took no further action on Referred Substitute Resolution 19(08) Second Rural Workforce Task Force because the intent of the resolution would be met by the Future of Emergency Medicine Summit.

Amended Resolution 37(05) Rural Emergency Medicine Workforce adopted.

September 2004, approved continuing the work of the Rural Task Force to complete their assigned tasks.

September 2003, approved the recommendations from the Rural Emergency Medicine Summit

February 2003, approved the development of a Rural Emergency Medicine Summit.

November 2002, approved convening a Rural Workforce Summit to identify specific needs of physicians practicing in rural emergency departments, explore solutions to staffing rural EDs, and make recommendations as to ACEP's role in this effort.

Amended Substitute Resolution 21(01) Rural Emergency Medicine Departments adopted.

Background Information Prepared by: Sandy Schneider, MD, FACEP
Senior Vice President, Clinical Affairs

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 66(21)

SUBMITTED BY: Howard K. Mell, MD, MPH, CPE, FACEP
Illinois College of Emergency Physicians

SUBJECT: ACEP Promotion of the Role of Emergency Physicians

PURPOSE: 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. 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.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, In 1966, the National Academy of Sciences published a white paper entitled "Accidental Death and Disability, the Neglected Disease of Modern Society" that described the poor state of emergency care in the U.S.; and

WHEREAS, In 1968, John Wiegenstein, MD, and John Rupke, MD, and six colleagues formed the American College of Emergency Physicians (ACEP) in Lansing, Michigan; and

WHEREAS, In 1972, the American Medical Association (AMA) recognized emergency medicine as a specialty and created the AMA Section of Interest on emergency medicine; key to this was a recognition that emergency medicine represented a unique body of knowledge that required specialty training to master; and

WHEREAS, The International Federation for Emergency Medicine (IFEM) defines emergency medicine as "a field of practice based on the knowledge and skills required for the prevention, diagnosis and management of acute and urgent aspects of illness and injury affecting patients of all age groups with a full spectrum of episodic undifferentiated physical and behavioral disorders; it further encompasses an understanding of the development of prehospital and in hospital emergency medical systems and the skills necessary for this development"; and

WHEREAS, In 1979, the American Board of Medical Specialties (ABMS) granted the American Board of Emergency Medicine (ABEM) specialty board approval as the 23rd medical specialty in the U.S.; and

WHEREAS, In 1980, the American Osteopathic Association (AOA) Bureau of Osteopathic Specialists authorized the American Osteopathic Board of Emergency Medicine (AOBEM) to begin administering certifying exams in emergency to osteopathic physicians as one of the now 18 medical specialty certifying boards that make up modern osteopathic medicine; and

WHEREAS, In 1986, after lobbying by multiple emergency physicians, the US Congress passed the Emergency Medical Treatment and Active Labor Act (EMTALA) as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA) requiring hospital Emergency Departments that accept payments from Medicare to provide an appropriate medical screening examination (MSE) to anyone seeking treatment for an emergency medical condition, regardless of citizenship, legal status, or ability to pay, in effect declaring that anyone who believed they were suffering from an emergency had the right to an assessment by a physician in the emergency department; and

WHEREAS, In 1988, the ability to accumulate the practice months and hours to take Emergency Medicine Certification Exam without completing a residency (known as the "Grandfather Clause") ended requiring that all

board-certified emergency physicians from that moment on would have to be residency trained in emergency medicine; and

WHEREAS, In 1989, ABEM was granted primary board status allowing the creation of subspecialties in emergency medicine; and

WHEREAS, It is widely accepted that there is a unique body of knowledge and a unique skillset that is required to professionally practice emergency medicine and board certification by ABEM or ABOEM is de facto evidence that an individual has acquired that knowledge and those skills; and

WHEREAS, Over the past decade, more than 15,000 nonphysician providers have been employed in emergency departments (more than 10,000 physician assistants and more than 5,000 nurse practitioners); and

WHEREAS, Nonphysician providers do not meet the requirements for board certification in emergency medicine by ABEM or ABOEM and in most cases are not required to have any specific training in emergency medicine as a requirement of licensure; and

WHEREAS, In many emergency departments, patients are examined and treated by nonphysician providers without direct involvement of a physician; therefore be it

RESOLVED, That ACEP publish and promote a policy explicitly stating that all patients presenting to an emergency department deserve to be assessed by an emergency physician and have an emergency physician directly oversee their care on an in-person basis; and be it further

RESOLVED, That ACEP reaffirm its role as a professional medical association dedicated to promoting the role of emergency physicians, instructing the ACEP staff and officers to promote the role of emergency physicians over all other models of emergency care.

Background

This resolution asks that ACEP create and disseminate a policy explicitly stating that all patients presenting to an emergency department (ED) deserve to be assessed by an emergency physician. Further, it states that all patients have the right to have an emergency physician directly oversee their care in-person. Finally, it asks that ACEP reaffirm its role as a professional medical association dedicated to promoting the role of emergency physicians and instruct ACEP staff and officers to promote the role of emergency physicians over all other models of care.

ACEP has existing policy defining an emergency physician as:

> *"…a physician who is certified (or eligible to be certified) by the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM) or an equivalent international certifying body recognized by ABEM or AOBEM in Emergency Medicine or Pediatric Emergency Medicine, or who is eligible for active membership in the American College of Emergency Physicians.[1]"*

> *"It should be noted that residents in an Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) approved residency in Emergency Medicine are "Emergency Medicine Resident Physicians.*[1]"

Several other policies exist that promote the role of the emergency physician:

> *"The emergency physician should serve as the leader of the ED team.[2]"*

> *"1. The ED should be emergency physician led and staffed by qualified personnel with knowledge and skills sufficient to evaluate and manage those who seek emergency care. The EDs should be designed*

and equipped to facilitate this work.

"2. Timely emergency care provided by an emergency physician and ED staff should be continuously available 24 hours per day, seven days per week, 365 days per year.[2]"

"The ED should have a designated medical director. The ED medical director†, in collaboration with the director of emergency nursing and with appropriate integration of other ancillary services, should ensure that quality, safety, and appropriateness of emergency care are continuously monitored and evaluated. The ED medical director should have oversight over all aspects of the practice of emergency medicine in the ED.[2]"

"The emergency physician is responsible for the medical care provided in the ED. This includes the medical evaluation, diagnosis, and recommended treatment and disposition of the emergency patient, as well as the direction and coordination of all other care provided to the patient.[2]"

"The ED director should direct the medical care provided in the ED. The medical director of the ED should be certified by the American Board of Emergency Medicine (ABEM), the American Osteopathic Board of Emergency Medicine (AOBEM) or should possess comparable qualifications as established through the privilege delineation policy.[2]"

"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.*[3]"

"The gold standard for care in an ED is that performed or supervised by a board-certified/board-eligible emergency physician.[4]"

PAs/NPs should not perform independent unsupervised care in the ED. This holds true regardless of state laws or hospital regulations. In the case of rural and underserved areas, supervision may require telehealth services or real-time off-site emergency physician consultation.
Emergency physicians must have the real-time opportunity to be involved in the care of any patient presenting to the ED and seen by a PA or NP.[4]"

"The American College of Emergency Physicians (ACEP) endorses the 2000 position statement of the Society for Academic Emergency Medicine (SAEM) on the "Qualifications for Unsupervised Emergency Department Care," and believes that the independent practice of emergency medicine is best performed by specialists who have completed American Board of Emergency Medicine (ABEM) or American Osteopathic Board of Emergency Medicine (AOBEM) certification, or have successfully "completed an Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) accredited emergency medicine residency, and is in the process of completing ABEM or AOBEM examinations.[5]"

"ACEP believes that advanced practice registered nurses or physician assistants should not provide unsupervised emergency department care.[5]"

ACEP believes that "unsupervised ED practice is best provided by fully trained emergency medicine specialists.[5]"

Through these policy statements, ACEP has stated the importance of the emergency physician in emergency care. Additional policy could be created to reaffirm this position and perhaps more clearly state value of an emergency physician. This resolution goes farther and requires that all patients be seen in person by an emergency physician.

Existing ACEP policy permits the supervision of NPs and PAs by either in person or telemedicine, particularly those

seen in rural settings. Therefore, all existing policies that permit supervision of NPs and PAs via telemedicine would need to be revised. Existing policy also permits the emergency physician to discuss a case with an NP/PA and at the discretion of the physician choose to personally see and assess the patient. If the intent of this resolution is for the physician to assess all patients in-person, these policies would need to be revised.

A new policy statement requiring in-person supervision will be difficult for many rural, frontier, and critical access hospitals. Many of these hospitals have difficulty attracting emergency physicians. In a survey of residents graduating in 2019, very few took positions in rural hospitals even though the compensation offered was close to $100,000 more per year, and there was often additional loan forgiveness. Preliminary data from a similar survey of residents graduating in 2021 suggests that trend has not changed.

There are several other resolutions submitted this year regarding the practice of NPs and PAs in the ED and the Council should ensure that these resolutions do not contradict each other.

ACEP's President Mark Rosenberg, DO, FACEP, has appointed an ED Accreditation Task Force to create an accreditation process designed to ensure that "a person's zip code does not define the emergency care they receive." Inherent in that charge is that all patients should be seen virtually or in person by an emergency physician (as defined by ACEP policy) for a facility to be accredited. In addition, the task force must incorporate ACEP policies which, as noted above, clearly call for patients to be seen by an emergency physician. The task force work is underway and plans to submit a final report with identified criteria and a business plan to the Board of Directors in June 2022. If the plan is approved by the Board, staff will begin implementation immediately so that accreditation of emergency departments can start by the end of 2022. Because this initiative is so important, the task force will provide regular updates to the Board, Council Officers, and if requested, to the Council, as well.

Accreditation by ACEP will need to be voluntary. However, through our other hospital-based accreditation programs, we have found significant interest in accreditation by hospitals. Larger institutions often use accreditation to increase market share and differentiate themselves from other institutions. Smaller rural facilities use accreditation to improve community trust and keep patients from traveling to larger facilities. Accreditation appears to be of interest to CEOs and Boards of Trustees as attested to by the plaques in the hallway of any administration wing.

Accreditation can be a more powerful tool than policy statements. We have seen some major changes by facilities to attain accreditation through our Geriatric ED Accreditation Program (GEDA), including the replacement of a non-physician staff by a staff of board-certified emergency physicians. As a bonus, accreditation programs can provide the College with non-dues revenue.

A public opinion poll performed in August 2021 demonstrated that the vast majority of patients (78%) most trust physicians to lead their medical care in an emergency. Additionally, people view 24/7 access to the ED as one of the most essential services the community can provide.[7]

References

[1]Definition of an Emergency Physician [policy statement]. Approved April 2017.
[2]Emergency Department Planning and Resource Guidelines [policy statement]. Approved April 2021.
[3]Physician Credentialing and Delineation of Clinical Privileges in Emergency Medicine [policy statement], Approved April 2017.
[4]Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department [policy statement]. Approved June 2020.
[5]Providers of Unsupervised Emergency Department Care [policy statement]. Approved January 2019
6Quigley L, Salsberg E, Richwine C. New emergency physicians: who are they, where they are working and their experience in the job market. Results from the survey of Emergency Medicine residents who completed training in 2019. Report to the ACEP Board of Directors
[7]ACEP. Poll: adults view 24/7 access to the ER essential and prefer care lead by physicians in a crisis. https://www.emergencyphysicians.org/

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum, including rural areas.
- Objective C – Promote the value of emergency medicine and emergency physicians as essential components of the health care system.

Goal 2 – Enhance Membership Value and Member Engagement

- Objective D – Increase ACEP brand awareness, growth, and impact internationally in a cost effective manner.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

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.

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.

Prior Board Action

April 2021, approved the revised policy statement "Emergency Department Planning and Resource Guidelines;" revised and approved April 2014, October 2007, June 2004, June 2001; reaffirmed September 1996; revised and approved June 1991; originally approved December 1985 titled "Emergency Care Guidelines."

June 2020, approved revisions to "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" policy statement, revised June 2013 as "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department", originally approved as "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" January 2007 by replacing two policy statements "Guidelines on the Role of Physician Assistants in the Emergency Department" and "Guidelines on the Role of Nurse Practitioners in the Emergency Department."

January 2019, reaffirmed the policy statement "Providers of Unsupervised Emergency Department Care;" revised and approved June 2013; reaffirmed October 2007; originally approved June 2001.

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."

April 2017, approved the revised policy statement "Definition of an Emergency Physician;" originally approved June 2011.

Background Information Prepared by: Sandy Schneider, MD, FACEP
Senior Vice President, Clinical Affairs

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 67(21)

SUBMITTED BY: Emergency Medicine Workforce Section

SUBJECT: Patient Informed Consent

PURPOSE: 1) Support patients' rights to choose who provides their medical care; 2) reaffirm that it is the gold standard for board-certified emergency physicians to be involved in every patient who presents to an ED; 3) support an informed consent form for patients to indicate their choice of clinician.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Patients should be allowed to make informed consent to their healthcare needs; and

WHEREAS, Patients should always be given the opportunity to see a physician in the emergency department; and

WHEREAS, Patients should be able to choose to see a physician over a non-physician practitioner; therefore be it

RESOLVED, That ACEP support patients' rights to choose who provides their medical care; and be it further

RESOLVED, That ACEP support the gold standard for board-certified emergency physicians to be involved in every patient who presents to an emergency department; and be it further

RESOLVED, That ACEP support an informed consent form to be documented in emergency department patients' charts regarding their choice to: 1) agree to care by non-physician practitioner not supervised by physician; 2) agree to care by a non-physician practitioner only supervised by a physician; or 3) agree to care only by a physician.

Background

This resolution asks ACEP to support patients' rights to choose who provides their medical care, reaffirm that it is the gold standard for board-certified emergency physicians to be involved in every patient who presents to an ED, and support an informed consent form for patients to indicate their choice of clinician.

ACEP' policy statement "Definition of an Emergency Physician" defines an emergency physician as "a physician who is certified (or eligible to be certified) by the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM) or an equivalent international certifying body recognized by ABEM or AOBEM in Emergency Medicine or Pediatric Emergency Medicine, or who is eligible for active membership in the American College of Emergency Physicians." ACEP has strong existing policy to affirm the gold standard in care in the ED is a board-certified emergency physician.[1,2] Our policy statements clearly state that all patient care shall be performed or supervised by a board-certified/board-eligible emergency physician. It further states that NPs/PAs should not perform independent unsupervised care in the ED regardless of state laws or hospital regulations.[2,3] Board certification is defined in another policy.[3]

There is little research on whether patients prefer NPs/PAs or MDs/DOs to care for them in the emergency setting and there is less research suggesting that the public strongly prefers physicians. One article from primary care showed that

55% of patients preferred a physician for their clinician, 21% preferred an NP/PA, and the rest had no preference. Those preferring physicians cited qualifications and technical skills, while those preferring NP/PAs cited bedside manner and convenience. Previous experience with the type of clinician was a major factor in their preference.[4] The Association of American Medical Colleges' Consumer Survey in 2012 showed that 50% of patients preferred to see a physician, but when offered that they could see an NP/PA sooner, most elected to see that type of clinician.[5] A systematic review of 25 articles largely in the US and UK showed that none showed that patient satisfaction with an NP/PA was not significantly different that an MD.[6]

An internet search on the subject yields a wealth of links, generally supplied by nursing, NPs, and PAs supporting the benefits of care from NPs and PAs.

ACEP can produce a model informed consent form but lacks the authority to require it for all institutions. The model consent form could be provided to our Medical Director's Section members and graduates of the ED Director's Academy. Mandating the use of this consent form would require state legislation.

References

1. ACEP. Emergency Department Planning and Resource Guidelines [policy statement]. Approved April 2021.
2. ACEP. Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department [policy statement]. Approved June 2020.
3. ACEP. Providers of Unsupervised Emergency Department Care [policy statement]. Approved January 2019.
4. ACEP. ACEP Recognized Certifying Bodies in Emergency Medicine [policy statement]. Approved February 2020.
5. Leach B, Gradison M, Morgan P, Everett C, Dill MJ, de Oliveira JS. Patient preference in primary care provider type. *Healthc (Amst).* 2018;6(1):13-6.
6. Dill MJ, Pankow S, Erikson C, Shipman S. Survey shows consumers open to a greater role for physician assistants and nurse practitioners. *Health Affairs*. 2013;32(6).
7. Hooker RS, Moloney-Johns AJ, McFarland MM. Patient satisfaction with physician assistant/associate care: an international scoping review. *Hum Resource Health*. 2019;17(1):104.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum, including rural areas.
- Objective C – Promote the value of emergency medicine and emergency physicians as essential components of the health care system.

Goal 2 – Enhance Membership Value and Member Engagement

- Objective D – Increase ACEP brand awareness, growth, and impact internationally in a cost effective manner.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

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.

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.

Prior Board Action

April 2021, approved the revised policy statement "Emergency Department Planning and Resource Guidelines;" revised and approved April 2014, October 2007, June 2004, June 2001; reaffirmed September 1996; revised and approved June 1991; originally approved December 1985 titled "Emergency Care Guidelines."

June 2020, approved revisions to "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" policy statement, revised June 2013 as "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department", originally approved as "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" January 2007 by replacing two policy statements "Guidelines on the Role of Physician Assistants in the Emergency Department" and "Guidelines on the Role of Nurse Practitioners in the Emergency Department."

January 2019, reaffirmed the policy statement "Providers of Unsupervised Emergency Department Care;" revised and approved June 2013; reaffirmed October 2007; originally approved June 2001.

April 2017, approved the revised policy statement "Definition of an Emergency Physician;" originally approved June 2011.

February 2020, approved the revised policy statement "ACEP Recognized Certifying Bodies in Emergency Medicine;" revised June 2014; reaffirmed April 2014, October 2008, October 2002; originally approved March 1998.

Background Information Prepared by: Sandy Schneider, MD, FACEP
Senior Vice President, Clinical Affairs

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 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(21)

SUBMITTED BY: Louisiana Chapter
Emergency Telehealth Section

SUBJECT: Patient's Right to Board Certified Emergency Physicians 24/7 (In-person or via Telehealth)

PURPOSE: 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.

FISCAL IMPACT: Budgeted staff resources.

WHEREAS, It is the position of the ACEP that board certified emergency physicians are the best suited person to provide emergency care; and

WHEREAS, According to the ACEP, the gold standard for care in an ED is that performed by a board certified/board-eligible emergency physician; and

WHEREAS, It is believed that the optimal scenario is having a board-eligible or board-certified emergency physician (BE/BC) present in-person to provide care to emergency patients but if having a BE/BC physician in person is not possible, having a BE/BC emergency physician available via telehealth is the next best thing for any non-emergency physician or non-physician to have access to a BE/BC EP for discussion of the emergency patient, and for consultation, recommendations, suggestions; and

WHEREAS, It is fair for everyone to have access to a board-certified emergency physician regardless of race, sex, gender, country of national origin, religion, age, profession, the location of the patient, time of day, or other "identifiers" so long as broadband is available; and

WHEREAS, There has been a goal to be able to have every patient who present to an emergency department anywhere in the country be seen by, have their care supervised by, or have the ability to see, a board certified emergency physician; and

WHEREAS, While there are still many areas where broadband is still not available or reliable, there is much greater penetration of broadband throughout the United States in the past few years and technology advancements and improvements in audiovisual telecommunications and equipment that enable reliable and valuable connectivity and communication, between patients and emergency physicians and allow reliable and thorough examinations; therefore be it

RESOLVED, That ACEP support legislation to require all facilities that wish to have an emergency department or designate an area as an emergency department or emergency room, to have a board eligible or board certified emergency physician present onsite preferentially, or via telehealth with an onsite non-emergency physician if on-site availability is not possible, 24 hours a day, 7 days a week to qualify to market to the public and bill for emergency services, with the only exception if broadband does not exist or is impossible to access with legitimate and reasonable efforts to do so, to have such a designation; and be it further

RESOLVED, That ACEP support legislation that if a facility does not currently have an onsite board eligible or board certified emergency physician available to see and treat emergency patients 24 hours a day, 7 days a week,

that facility must submit a plan to the licensing body that regulates them with specific actions the facility is making and will be making to become compliant with having 24/7 coverage by a board eligible or board certified emergency physician within 24 months; and be it further

RESOLVED, That ACEP support legislation to state: if a facility fails to achieve and maintain 24/7 coverage of any emergency facility by board eligible or board certified emergency physicians within 24 months, they must remove all signage and cease all marketing naming them as an ER or emergency department, emergency center, or expressly post in a conspicuous area on the sign in letters in the same font size as large or larger than the largest letters on signage that "THIS FACILITY DOES NOT ALWAYS STAFF OUR FACILITY WITH BOARD CERTIFIED EMERGENCY PHYSICIANS"; and be it further

RESOLVED, That ACEP encourage that facilities that do not have 24/7 coverage with board eligible or board certified emergency physicians cannot bill at the same rates as facilities (emergency departments, emergency centers, emergency rooms, etc.) that do have board eligible or board certified emergency physicians staffing their facilities 24/7.

Background

The resolution has requests ACEP to: 1) support legislation to require all facilities that wish to have an ED or designate an area as an ED or emergency room, to have a board eligible or board certified emergency physician onsite preferentially, or via telehealth with an onsite non-emergency physician if on-site availability is not possible, 24 hours a day, 7 days a week to qualify to market to the public and bill for emergency services, with the only exception if broadband does not exist or is impossible to access with legitimate and reasonable efforts to do so, to have such a designation; 2) support legislation that if a facility does not currently meet such criteria, that facility must submit a plan to the licensing body that regulates them with specific actions the facility is making and will be making to become compliant with having 24/7 coverage by a board eligible or board certified emergency physician within 24 months; 3) support legislation to state: if a facility fails to achieve and maintain 24/7 coverage of any emergency facility by board eligible or board certified emergency physicians within 24 months, they must remove all signage and case all marketing naming them as an ER or emergency department, emergency center, or expressly post in a conspicuous area on the sign in letters in the same font size as large or larger than the largest letters on signage that "THIS FACILITY DOES NOT ALWAYS STAFF OUR FACILITY WITH BOARD CERTIFIED EMERGENCY PHYSICIANS;" and 4) encourage that facilities that do not have 24/7 coverage with board eligible or board certified emergency physicians cannot bill at the same rates as facilities (EDs, emergency centers, emergency rooms, etc.) that do have board eligible or board certified emergency physicians staffing their facilities 24/7.

ACEP's policy statement, "Definition of an Emergency Physician" defines an emergency physician as "a physician who is certified (or eligible to be certified) by the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM) or an equivalent international certifying body recognized by ABEM or AOBEM in Emergency Medicine or Pediatric Emergency Medicine, or who is eligible for active membership in the American College of Emergency Physicians."

As outlined in the policy statement, "ACEP Recognized Certifying Bodies in Emergency Medicine," ABEM and AOBEM are recognized as the only primary emergency medicine certifying bodies recognized by the College. The policy also recognizes the American Board of Pediatrics (ABP) as an American Board of Medical Specialties (ABMS) certifying body in pediatrics that provides subspecialty certification for pediatricians in the subspecialty of pediatric emergency medicine. The College has also adopted the policy statement, "The Role of the Legacy Emergency Physician in the 21st Century," which states that "ACEP believes that physicians who begin the practice of emergency medicine in the 21st century must have completed an accredited emergency medicine residency training program and be eligible for certification by the American Board of Emergency Medicine (ABEM) or American Osteopathic Board of Emergency Medicine (AOBEM).

According to the National Study of the Emergency Physician Workforce, 2020, there were 48,835 clinically active emergency physicians in 2020. The most recent ACEP Emergency Medicine Statistical Profile (March 2019) indicates 36,920 emergency physicians are ABEM certified and 2,152 are AOBEM certified. This data suggests that

approximately 80% of all clinically active emergency physicians are board-certified. However, a 2017 analysis found that the supply of board-certified emergency physicians differed greatly by state, with some states fully able to staff an ED while at least 15 states were not able to meet 50% of demand.

The issues of ensuring that EDs are led and staffed by board-certified EPs and adapting emergency physician practice to evolving community needs are also key considerations identified in ACEP's Framework of Workforce Considerations aimed at addressing challenges related to the recent emergency physician workforce study projecting a surplus of emergency physicians over the next decade. Among the suggested actions is the promotion of policies and advocacy for regulations that ensure EDs are led and staffed by a board-certified EP, as well as a proposal to develop a "gold standard" that patients should expect from their emergency department and from those who are providing the care. To this end, ACEP established a task force to research and potentially establish an ED accreditation program that would define nationally recognized standards to provide the highest quality patient care. The task force will offer a proposed direction about pursuing an accreditation program at ACEP21.

Board eligibility or certification requirements may pose unique challenges for rural and underserved communities. The 2020 report issued by the ACEP Rural Emergency Care Task Force highlights particular challenges for rural hospitals, including current understaffing of rural EDs by EPs, that are only likely to worsen given the trend of a net loss of rural EDs and accelerating rural hospital closures. In the report, the Task Force lays out that "the gold standard for the care of ED patients is provision of care by EM residency trained and EM board-certified EPs, with board certification from [ABEM] and [AOBEM]." However, the task force specifically noted that restricting analyses to only emergency medicine trained or board certified EPs would exacerbate an already worrisome forecast of rural facility closures. The report encouraged ACEP to better support emergency physicians working in rural EDs, regardless of their training or board certification status, and to work with rural hospitals to pursue strategies to avoid further rural ED closures. The task force also surveyed emergency medicine residency program directors through CORD-EM, with one of the most commonly cited barriers by respondents were the ACGME requirement that trainees be supervised by EM board eligible/certified physicians in rural EDs.

Recent years have also witnessed the proliferation of delivery models and legislative proposals that would address perceived shortages of available board certified, residency trained emergency physicians by loosening requirements for onsite physician supervision and expanding the scope of practice of APRNs and PAs to permit either independent practice or lower levels of mandated supervision. These trends are not unique to emergency medicine and often reflect either efforts to reduce costs based on the argument that physician training is not always required in a practice environment or to expand the professional roles of non-physician health care practitioners. Additionally, proponents of these trends contend that in rural areas onsite physician care is not always available, meaning that the only choice is between nonphysician care and no care at all.

ACEP's origins are rooted in the establishment of emergency medicine as a medical specialty, and the College's historical development coincides with the rising availability of residency training and board certification for physicians that would hold themselves out as emergency physicians. Whereas the early decades of ACEP are characterized by expansion of the specialty and of specialized care in contrast to non-specialist physicians practicing in emergency departments, challenges are now increasingly arising from nonphysician practitioners arguing that their training suffices for an expanded scope of practice to include unsupervised practice. In contrast to this trend, ACEP policy for freestanding emergency departments, including those operated by hospitals, states that any such emergency department "that presents itself as an ED" should be "staffed by appropriately qualified emergency physicians." Given the array of emergent medical conditions that present at emergency departments, whether remote or rural, at any given time, the training and experience of an emergency physician is crucial for a viable, functioning emergency department team.

As stated in ACEP's policy statement "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department," ACEP opposes the independent practice of emergency medicine by NPs and PAs. ACEP has assisted many state chapters as they confronted legislation that legalized the independent practice by NPs. While independent practice for NPs has passed in several states, efforts by National ACEP and the state chapters helped defeat legislation in many states.

Without question, NPs and PAs are valuable members of the emergency care team and are used effectively in many physician-led care models. However, ACEP has always believed that emergency care should be led by emergency physicians. ACEP has never supported the independent practice by NPs or PAs. In 2018, ACEP created a small workgroup composed of several members of the ACEP Board of Directors to discuss issues around the emergency medicine workforce. From the discussions of that group, two task forces were created: the NP/PA Utilization Task Force and the EM Physician Workforce Task Force.

ACEP's policy statement "Freestanding Emergency Departments" reinforces that any FSED facility that presents itself as an ED should be staffed by appropriately qualified emergency physicians. Additionally, the policy states that "ACEP encourages all states to have regulations regarding FSEDs that are developed in close relationship with the ACEP chapter in that state."

Regarding the last resolved requesting that ACEP encourage lower payments for facilities that do not exclusively staff with board eligible or board-certified emergency physicians, it is important to note that the Medicare statute requires payments for services under the physician fee schedule to be the same regardless of the specialty of the provider delivering the service (Section 1848(C)(6) of the Social Security Act). For example, an emergency physician must be paid the same amount as an orthopedic surgeon reporting the same Current Procedural Terminology (CPT) code. However, non-physician practitioners, such as nurse practitioners and physician assistants, are only reimbursed at 85 percent of the Medicare physician fee rate for a reported code.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective C – Promote the value of emergency medicine and emergency physicians as essential components of the health care system.
- Objective F – Develop and implement solutions for workforce issues that promote and sustain quality and patient safety.

Fiscal Impact

Budgeted staff resources.

Prior Council Action

Resolution 44(19) Independent ED Staffing by Non-Physician Providers referred to the Board of Directors. Directed ACEP to review and update the policy statement "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department," and to develop tools and strategies to highlight importance of EP staffing of EDs, oppose independent practice by non-physician providers (NPPs), and work to require on-site supervision of NPPs 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.

Resolution 9(16) Accreditation Standards for Freestanding Emergency Centers adopted. Directed ACEP to explore the feasibility of setting minimum accreditation standards for FEC's.

Substitute Resolution 23(12) Free-Standing Emergency Departments adopted. Directed ACEP to study the emergence and proliferation of free-standing EDs and facilities including: applicable federal and state regulatory and accreditation issues; the potential impact on the emergency medicine workforce; the potential fiscal impact on hospital-based EDs; and provide informational resources to the membership.

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.

Amended Resolution 15(09) Emergency Medicine Workforce Solutions adopted. It directed ACEP to investigate broadening access to ACGME or AOA accredited emergency medicine residency programs to physicians who have previously trained in another specialty.

Resolution 38(98) Recognition of Certifying Bodies adopted. It directed the Board of Directors to review prior actions on recognition of certifying bodies in emergency medicine.

Resolution 51(95) Criteria for Assessment of EPs adopted. The resolution stated: "ACEP believes that multiple criteria can be used to assess the professional competency and quality of care provided by individual emergency physicians. These include professional credentials such as board certification, objective measurement of care provided, experience, prior training, and evidence of continuing medical education (CME). In general, no single criterion should provide the sole basis for decisions regarding an individual's emergency medicine practice."

Resolution 37(94) Criteria for Certifying Bodies and Recognition of the BCEM not adopted. It called for ACEP to meet with leaders of BCEM to obtain the necessary information to consider recognition of the BCEM and for ACEP to adopt the "Criteria for Recognition of Certifying Bodies" with amendments that would allow ACEP to grant similar recognition and/or acknowledgement of BCEM.

Resolution 35(94) Certifying Boards not adopted. It called for rescinding current ACEP policies regarding certifying boards and that the College reaffirm its ongoing support for ABEM by continuing its role as a parent organization, while acknowledging that other certifying boards exist.

Resolution 33(93) Recognition of Certifying Bodies in Emergency Medicine adopted. It directed ACEP to study the implications and possible criteria for College recognition of certifying bodies in emergency medicine.

Amended Resolution 32(88) Recognition of the American Osteopathic Board of Emergency Medicine adopted. The resolution acknowledged the American Osteopathic Board of Emergency Medicine as a certifying body for osteopathic emergency physicians.

Resolution 39(87) American Osteopathic Board of Emergency Medicine. The resolution acknowledged the American Osteopathic Board of Emergency Medicine as a certifying body for osteopathic emergency physicians. The resolution was not adopted by the Board in November 1987

Substitute Resolution 47(79) Recognize the American Board of Emergency Medicine adopted. It recognized and supported ABEM as the sole certifying body for emergency medicine.

Prior Board Action

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.

June 2020, approved revisions to "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" policy statement, revised June 2013 as "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department", originally approved as "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" January 2007 by replacing two policy statements "Guidelines on the Role of Physician Assistants in the Emergency Department" and "Guidelines on the Role of Nurse Practitioners in the Emergency Department."

April 2020, approved revised policy statement "Freestanding Emergency Departments;" originally approved June 2014.

February 2020, approved revised policy statement, "ACEP Recognized Certifying Bodies in Emergency Medicine;" reaffirmed April 2014, October 2008, and October 2002; originally approved March 1998.

April 2019, discussed two options from the task force regarding accreditation of Freestanding Emergency Centers. Approved partnering with the Center of Improvement in Healthcare Quality, which has deeming authority with CMS, to provide accreditation services for FECs.

January 2019, reaffirmed the policy statement "Providers of Unsupervised Emergency Department Care;" revised and approved June 2013; reaffirmed October 2007; originally approved June 2001.

September 28, 2018, discussed the feasibility for ACEP to proceed with implementing an accreditation program for freestanding emergency centers. The Board directed the task force to explore models and develop a business plan.

May 2018, accepted the report of the Freestanding Emergency Centers Accreditation Task Force, which included accreditation standards, and requested additional information about The Joint Commission's accreditation of FECs.

February 2018, approved the policy, "The Role of the Legacy Emergency Physician in the 21st Century;" reaffirmed April 2018 and April 2012; originally approved June 2006.

August 20167, reviewed the Policy Resource & Education Paper (PREP) "Guidelines for Credentialing and Delineation of Clinical Privileges in Emergency Medicine;" originally reviewed June 2006. This PREP is an adjunct to the policy statement "Physician Credentialing and Delineation of Clinical Privileges in Emergency Medicine."

April 2017, approved the policy, "Definition of an Emergency Physician;" reaffirmed April 2017; originally approved June 2011.

April 2017, approved the revised policy statement "Physician Credentialing and Delineation of Clinical Privileges in Emergency Medicine;" revised October 2014, June 2006, and June 2004; reaffirmed October 2014; revised with current title September 1995 and June 1991; originally approved April 1985 titled "Guidelines for Delineation of Clinical Privileges in Emergency Medicine."

Resolution 9(16) Accreditation Standards for Freestanding Emergency Centers adopted.

November 2015, reviewed the information paper "Freestanding Emergency Departments and Urgent Care Centers."

July 2013, reviewed the revised information paper "Freestanding Emergency Departments;" originally developed in August 2009.

Substitute Resolution 23(12) Free-Standing Emergency Departments adopted.

Amended Resolution 15(09) Emergency Medicine Workforce Solutions adopted.

September 2000, rescinded the policy statement "ACEP Criteria for Recognizing Certifying Bodies in Emergency Medicine" and supported development of a new policy acknowledging that ACEP has no criteria for recognizing certifying bodies and will only recognize certifying bodies approved by ABMS or AOA.

Resolution 38(98) Recognition of Certifying Bodies adopted.

Resolution 51(95) Criteria for Assessment of EPs adopted.

September 1994, approved the policy, "Criteria for Recognition of Board Certifying Bodies in Emergency Medicine."

Resolution 33(93) Recognition of Certifying Bodies in Emergency Medicine adopted.

Resolution 32(88) Recognition of the American Osteopathic Board of Emergency Medicine adopted.

Substitute Resolution 47(79) Recognize the American Board of Emergency Medicine adopted.

Background Information Prepared by: Ryan McBride, MPP
Senior Congressional Lobbyist

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 69(21)

SUBMITTED BY: Louisiana Chapter

SUBJECT: Workforce Transparency

PURPOSE: Calls for ACEP to ensure that all providers, clinicians, practitioners, and others who might be perceived as practicing medicine should use exact language to introduce themselves including the phrase "I am not a medical doctor" when appropriate.

FISCAL IMPACT: Budgeted staff resources. Unbudgeted additional unknown costs for state lobbying initiatives. A public education campaign could potentially have costs of $50,000 – 100,000.

WHEREAS, There is more and more confusion amongst the public understanding the education, training, and credentials of the person who may be obtaining their personal and confidential health information, examining them, and treating their medical complaints and conditions; and

WHEREAS, There are many non-physicians in emergency departments and other health settings who may not clearly identify themselves to patients; and

WHEREAS, It is of utmost importance for there to be clarity, honesty, and avoidance of confusion or appearance of deceitfulness in healthcare; therefore be it

RESOLVED, That all physicians, physician assistants, nurse practitioners or any person who might be reasonably be referred to as a provider, clinician, or practitioner, or any person who practices, or could reasonably be interpreted as practicing medicine including the authority to write orders or prescriptions that interacts with a patient, must state their name and then clearly state "I am a medical doctor (MD)," (to include doctors of osteopathic medicine, or the doctor of osteopathic medicine could say "I am a doctor of osteopathic medicine (DO)") or "I am not a medical doctor" depending on the education and training of that individual.

Background

This resolution calls for ACEP to ensure that all providers, clinicians, practitioners, and others who might be perceived as practicing medicine should use exact language to introduce themselves including the phrase "I am not a medical doctor" when appropriate.

ACEP's policy statement "Use of the Title 'Doctor' in the Clinical Setting" states:

"The American College of Emergency Physicians (ACEP) believes that a physician is an individual who has received a "Doctor of Medicine," "Doctor of Osteopathic Medicine," or an equivalent degree (e.g., Bachelor of Medicine, Bachelor of Surgery 'MBBS') following successful completion of a prescribed course of study from a school of allopathic or osteopathic medicine.

ACEP strongly opposes the use of the term "doctor" by other professionals in the clinical setting, including by those with independent practice, where there is strong potential to mislead patients into perceiving they are being treated by a physician.
Therefore, ACEP recommends that anyone in a clinical environment including, but not limited to, a hospital, free-standing emergency department, urgent care, or retail clinic who has direct contact with a

> *patient and presents himself or herself to the patient as a "doctor," and who is not a "physician" according to the definition above, must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree*."

Since this existing policy already recommends the introduction referred to in the resolution, staff contacted the primary author to clarify whether additional measures are needed to fulfill this resolution. The author suggested that ACEP advocate for the passage of legislation requiring the use of such an introduction and that ACEP would promote this requirement to the public. The author additionally suggested a reporting mechanism should a provider, clinician, practitioner, or any other person described in this resolution not provide the proper introduction during a medical encounter. The suggested legislative action would need to specify whether it would pertain to all medical encounters or just those in the emergency setting. Federal legislation to address this resolution could be difficult to achieve and it is likely that state legislative would need to be pursued. ACEP could support chapters in the development of model legislation and advocacy efforts for passage of state laws mandating such disclosure. Such laws would need to allow for some exceptions and define the extent to whom such disclosures are mandated.

Creating a reporting mechanism indicates there would be some type of adverse action associated with failure to properly identify oneself – either as a physician or not as a physician. It should be noted that this approach could open up yet another avenue for plaintiff lawyers seeking to show there were "errors" made during a patient visit.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective A – Promote/advocate for efficient, sustainable, and fulfilling clinical practice environments.
- Objective C – Promote the value of emergency medicine and emergency physicians as essential components of the health care system.

Fiscal Impact

Budgeted staff resources. Unbudgeted additional unknown costs for state lobbying initiatives. A public education campaign could potentially have costs of $50,000 – 100,000.

Prior Council Action

Substitute Resolution 30(13) Use of the Title "Doctor" in the Clinical Setting adopted. The resolution directed ACEP to affirm the degrees that would define a physician and require those in patient contact in hospital environments who have doctorate degrees but are not physicians to declare themselves a "non-physician" and identify the nature of their doctorate degrees.

Prior Board Action

February 2020, approved the revised policy statement "Use of the Title "Doctor" in the Clinical Setting;" originally approved April 2014

Substitute Council Resolution 30(13) User of the title "Doctor" in the Clinical Setting adopted.

Background Information Prepared by: Sandra Schneider, MD, FACEP
Senior Vice President, Clinical Affairs

Harry J. Monroe, Jr.
State Legislation Director

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 70(21)

SUBMITTED BY: Government Services Chapter

SUBJECT: Creation of Specialized Scope Expansion Advocacy Teams for State Level Advocacy

PURPOSE: 1) Create a toolkit for use at the state level addressing efforts to expand practice scope; 2) create a tracking system for unsupervised practice efforts in each state; 3) create "strike teams" of advocacy experts in EM scope expansion to help states actively engaged on the issue; and 4) partner with the AMA's Scope of Practice Partnership, the Physicians for Patient Protection, and similar groups to address scope expansion efforts nationally.

FISCAL IMPACT: Budgeted committee and staff resources. Any specific actions and/or the use of paid experts would require unbudgeted funds.

WHEREAS, ACEP affirms that nurse practitioners and physician assistants are an important part of a physician led emergency department care team; and

WHEREAS, The American Academy of Nurse Practitioners has made unsupervised practice a top legislative priority; and

WHEREAS, The American Academy of Physician Assistants have recently voted to change their name to dissociate themselves with their supervising physicians and are actively pursuing unsupervised practice in many states; and

WHEREAS, Both of these organizations have well-funded advocacy teams that are working at the state level to advance these initiatives; and

WHEREAS, The American Medical Association (AMA) has developed scope of practice resources that may be used by their members when fighting scope expansion; and

WHEREAS, Emergency physicians have few resources specific to emergency medicine to engage with their state legislators to address these scope expansion efforts; therefore be it

RESOLVED, That ACEP create a toolkit for members to use at the state level to address practice scope expansion efforts that emphasizes the importance of a physician led team for optimal patient safety; and be it further

RESOLVED, That ACEP's advocacy team create a tracking system for unsupervised practice efforts in each state to ensure that the voice of emergency physicians can be heard for this important patient safety topic; and be it further

RESOLVED, That ACEP's advocacy team create a "strike team" of advocacy experts in emergency medicine scope expansion issues that can be tasked to help engage states who are actively involved in scope expansion legislation and support the state chapters and physicians at the local level; and be it further

RESOLVED, That ACEP partner with the American Medical Association Scope of Practice Partnership, Physicians for Patient Protection, and other like-minded groups to address scope expansion efforts on a national basis.

References

1. https://www.acep.org/what-we-believe/actions-on-council-resolutions/councilresolution/?rid=B8843987-1776-EB11-A9C2-995F1D3A2B04
2. https://www.acep.org/what-we-believe/actions-on-council-resolutions/councilresolution/?rid=B387D103-F175-EB11-A9C2-995F1D3A2B04
3. https://www.acep.org/what-we-believe/actions-on-council-resolutions/councilresolution/?rid=C977F9A7-8C72-E911-A9AD-9BD2C184F805
4. https://www.acep.org/what-we-believe/actions-on-council-resolutions/councilresolution/?rid=B0120C61-9572-E911-A9AD-9BD2C184F805
5. https://www.acep.org/what-we-believe/actions-on-council-resolutions/councilresolution/?rid=98FDB3F0-1F81-EB11-A9C2-995F1D3A2B04
6. https://www.acep.org/what-we-believe/actions-on-council-resolutions/councilresolution/?rid=C99E0612-EB93-EB11-A9C2-995F1D3A2B04

Background

The resolution calls for ACEP to: 1) Create a toolkit for use at the state level addressing efforts to expand practice scope; 2) create a tracking system for unsupervised practice efforts in each state; 3) create "strike teams" of advocacy experts in EM scope expansion to help states actively engaged on the issue; and 4) partner with the AMA's Scope of Practice Partnership, the Physicians for Patient Protection, and similar groups to address scope expansion efforts nationally.

Going back to the late 20th Century, nurse practitioners and physician assistants have advocated at the state level for the purpose of expanding their respective scopes of practice and allowing for varying levels of decreased supervision or independent practice. ACEP has assisted many state chapters as they confronted legislation that legalized the independent practice by NPs. While independent practice for NPs has passed in several states, efforts by National ACEP and the state chapters helped defeat legislation in many states.

ACEP has long held out board certification and residency training in emergency medicine as the gold standard for emergency departments. Obviously, those who are not physicians of any sort lack this level of education and training needed for the emergency department.

While the issue has been percolating and growing for many years, the problem was worsened exponentially during the COVID crisis, when governors looking for any and all available resources accepted their staff recommendations to allow independent practice without prior vetting of the issue. This has opened doors for nurse practitioner organizations to argue that such scope expansions should be made permanent.

ACEP's "Code of Ethics for Emergency Physicians" has several provisions related to relationships with non-physician practitioners in the emergency department, including the following:

> "The practice of emergency medicine requires multidisciplinary cooperation and teamwork. Emergency physicians interact closely with a wide variety of other health care professionals, including emergency nurses, emergency medical technicians, and physicians from other specialties. General ethical principles governing these interactions include honesty, respect, appreciation of other professionals' perspectives and needs, and an overriding duty to maximize patient benefit."

ACEP's current policy statement, first created in 2001, "Providers of Unsupervised Emergency Department Care," clearly states that ACEP believes that the independent practice of emergency medicine is best performed by specialists who have completed American Board of Emergency Medicine (ABEM) or American Osteopathic Board of Emergency Medicine (AOBEM) certification, or have successfully "completed an Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) accredited emergency medicine residency, and is in the process of completing ABEM or AOBEM examinations." Additionally, the policy includes the statement that "ACEP believes that advanced practice registered nurses or physician assistants should not provide unsupervised emergency department care" and ACEP believes that "unsupervised ED practice is best provided by fully trained emergency medicine specialists.

ACEP' s policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the

Emergency Department" provides clear guidance on the scope of practice for PAs and NPs.

In 2018, ACEP invited other national emergency medicine organizations to participate in a task force to examine the future of the emergency medicine work force in the United States. Among the considerations that the task force addressed was to "ensure appropriate use of NPs and PAs to protect the unique role of emergency physicians." The task force report was presented to the ACEP Board in June 2020, which noted that it was a consensus document and it was filed for information. In August 2021 the "Emergency Medicine Physician Workforce: Projections for 2030" was published in *Annals of Emergency Medicine*. In anticipation of that report, ACEP developed a multi-faceted work group to address many of the identified issues. The ACEP website has many resources about the Emergency Medicine Workforce of the Future.

In April 2021, ACEP joined the AMA's Scope of Practice Partnership.

ACEP has developed an array of materials related to scope of expansion and offers them to states in a manner designed to meet state specific needs. The Communications Department is currently at work on a more formal toolkit to assist member.

At the request of ACEP's president elect and senior staff, a "strike team" of advocacy experts is currently in the process of being formed. ACEP's State Legislative/Regulatory Committee is also tasked with furthering this work. In addition, ACEP's State Legislation Director tracks legislation on a variety of subjects of concern to emergency medicine, including scope expansion.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective D – Promote quality and patient safety, including continued development and refinement of quality measures and resources.

Fiscal Impact

Budgeted committee and staff resources. Any specific actions and/or the use of paid experts would require unbudgeted funds.

Prior Council Action

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 and survey states and hospitals on where independent practice by NPs is permitted.

Prior Board Action

April 2021. approved joining the AMA's Scope of Practice Partnership at the Steering Committee level.

June 2020, filed the final report of the Emergency PA/NP Utilization Task Force.

June 2020, approved the revised policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department;" revised June 2013 as "Guidelines Regarding the Role of Physician

Assistants and Advanced Practice Registered Nurses in the Emergency Department;" originally approved as "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" January 2007 by replacing two policy statements "Guidelines on the Role of Physician Assistants in the Emergency Department" and "Guidelines on the Role of Nurse Practitioners in the Emergency Department."

January 2019, reaffirmed the policy statement "Providers of Unsupervised Emergency Department Care;" revised and approved June 2013; reaffirmed October 2007: originally approved June 2001.

September 2018, accepted the final report from the ACEP Board Emergency Medicine Workforce Workgroup and initiated the recommendations to proceed with the NP/PA Utilization Task Force and the Emergency Medicine Workforce Task Force.

August 2018, approved the final report from the ACEP Board Emergency Medicine Workforce Workgroup and initiated the recommendations therein to appoint a task force to consider the evolution of the role and scope of practice of advanced practice providers in the emergency department.

January 2017, approved the revised policy statement "Code of Ethics for Emergency Medicine;" revised June 2016, June 2008; reaffirmed October 2001; revised June 1997 with the current title; originally approved January 1991 titled "Ethics Manual."

Background Information Prepared by: Harry Monroe
State Legislation Director

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 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: 71(21)

SUBMITTED BY: Emergency Medicine Workforce Section

SUBJECT: Emergency Medicine Workforce by Non-Physician Practitioners

PURPOSE: 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.

FISCAL IMPACT: Budgeted committee and staff resources to develop a new policy statement and/or revise existing policy statements. Unknown additional costs depending on the scope of any action taken beyond policy development.

WHEREAS, The ACEP workforce study has predicted a significant oversupply of board-certified emergency physicians by the year 2030; and

WHEREAS, In the documented workforce study, the non-physician practitioners are estimated to be supplying 20% of emergency care in emergency departments nationwide; and

WHEREAS, Given the oversupply of emergency physicians, non-physician practitioners will not be needed to staff emergency departments; therefore be it

RESOLVED, That ACEP support a reduction in non-physician practitioner emergency department staffing over the next three years to eliminate the use of non-physician practitioners in the ED, unless the supply of emergency physicians for the location is not adequate for the staffing needs.

Background

This resolution calls 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.

ACEP's policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" states:

> *"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."*
>
> *"The gold standard for care in an ED is that performed or supervised by a board-certified/board-eligible emergency physician."*
>
> *"PAs/NPs should not perform independent unsupervised care in the ED. This holds true regardless of state laws or hospital regulations. In the case of rural and underserved areas, supervision may require telehealth services or real-time off-site emergency physician consultation."*
>
> *"The use of PAs and NPs in the ED should be determined at the site level by local ED leadership, who are responsible for PA/NP hiring, staffing and supervision.*[1]"

ACEP's policy statement "Providers of Unsupervised Emergency Department Care" states:

> *"ACEP believes that advanced practice registered nurses or physician assistants should not provide unsupervised emergency department care."*
>
> *ACEP believes that "unsupervised ED practice is best provided by fully trained emergency medicine specialists."*[2]

ACEP supports the use of other non-physician staff in the ED, such as emergency pharmacists and social workers.[3,4] It is presumed that the intent of this resolution is limited to nurse practitioners (NPs), advanced practice registered nurses (APRNs), and PAs. The intent of the resolution will need to be clarified in the final language of the resolution if it is adopted.

It should be noted that many policies and articles written by ACEP and others do not distinguish between NPs and APRNs. Indeed, the Emergency Nurses Association (ENA) and the American Nurses Association combine these two groups together when they seek to promote independent practice. However, NPs are only one of four types of APRNs with the others being clinical nurse specialist (largely focused on patient education, administration, and program development), nurse anesthetist, and nurse midwife.[5,6]

In September/October 2020, a survey of ACEP members was performed by Ed Salsberg and associates from the Fitzhugh Mullan Institute for Health Workforce Equity, George Washington University School of Public Health. The respondents represented 8% of our membership and appeared to be representative of the membership as a whole. In that survey, most respondents reported working with PAs (83.5%) and NPs (74.9%). At that time, 66% reported that NPs and PAs had a "moderate" or "strong" positive impact on their productivity (only 11.2% indicted they had a "moderate" or "strong" negative impact - the remainder indicated "no or very little impact"). 57.2% of respondents indicated that NPs and PAs had a positive impact on their job satisfaction (only 16.5% indicated that NPs and PAs had a negative impact). The impact on quality of care were more mixed but was slightly more positive than negative. The respondents were concerned about a negative impact on resident education.[7]

There has been concern regarding the increased use of NPs and PAs in EDs.[8] Productivity by NPs and PAs has been estimated to be about half that of physicians.[9] The volume of services provided by NPs/PAs increased from 4.1% in 1995[9] to 20.2% during 2010-2017.[10] However, physicians continued to be involved with nearly 90% of all ED visits from 2010-2017.[10] Bai's analysis of Medicare claims data showed the proportion of services provided by physicians decreased from 88% in 2012 to 85% in 2015.[11] Patients cared for by NPs and PAs are associated with lower patient acuity[9,11] and therefore lower reimbursement.

Extrapolating from Salsberg's projections, removal of all NPs and PAs from their current positions would increase demand for emergency physicians in 2030 by about 10,000, making supply roughly equal to demand at that time. However, this would assume that graduating residents and those seeking new employment opportunities would be willing to provide the services currently supplied by NPs/PAs. This would include lower acuity patients, and more importantly, services in rural and semi-rural areas. Salsberg's reported that NPs independent billing occurs twice as frequently in rural areas.[12]

The recent workforce study by Bennet showed an increase in emergency physicians in all areas of the country, except for rural, where the number of physicians appeared to decrease. It should be noted that rural emergency physicians are older than those practicing in urban conditions.[13] Salsberg's survey of graduating residents 2019 (pre-pandemic) indicated that very few new graduates took jobs in rural areas, despite a greater salary in rural areas of nearly $100,000 plus, in many cases, loan forgiveness.[12] Preliminary results from this year's survey of graduating residents show that, once again, few entered rural practice, and that the salary difference demonstrated in 2019 remains true today. Despite a tightening job market, higher salaries and loan forgiveness, few graduating residents take jobs in rural areas.

It is not clear from the resolution exactly how ACEP would affect this change in practice. NPs and PAs are integrated into many practices and as studies done during the pandemic indicate, most physicians like practicing with NPs/PAs. In addition, ACEP policy states that decisions on staffing are made by the local emergency department medical

director to "*achieve operational efficiency while maintaining clinical quality and physicians-directed or supervised care.*"[15]

Note: This resolution needs to be considered in context with other 2021 resolutions that seek to retain NPs/PAs in the ED.

Background References

[1]Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department [policy statement]. Approved June 2020.
[2]Providers of Unsupervised Emergency Department Care [policy statement]. Approved January 2019.
[3]Clinical Pharmacist Services in the Emergency Department [policy statement]. Approved January 2021.
[4]Social Work and Case Management in the Emergency Department [policy statement]. Approved October 2020.
[5]https://nursinglicensemap.com/advanced-practice-nursing/clinical-nurse-specialist-cns/
6https://www.onlinefnpprograms.com/faqs/clinical-nurse-specialist-versus-nurse-practitioner/
[7]Salsberg E, Masselink L, Westergaard S, Quigley L Richwine C. The Emergency Medicine Physician Workforce: Findings from the 2020 survey of emergency medicine physicians. Report to the ACEP Board of Directors and Workforce Task Force Partners.
[8]Salsberg E, Richwine C, Quigley L, Masselink L, Westergaard S. Projecting the supply and demand for emergency physicians in 2030. Report to the ACEP Board of Directors and Workforce Task Force Partners.
[9]Pines JM, Zocchi MS, Ritsema T, Polansky M, Bedolla J, Venkat A; US Acute Care Solutions Research Group. The Impact of Advanced Practice Provider Staffing on Emergency Department Care: Productivity, Flow, Safety, and Experience. *Acad Emerg Med*. 2020;27(11):1089-99.
[10Wu] F, Darracq MA. Physician assistant and nurse practitioner utilization in U.S. emergency departments, 2010 to 2017. *Am J Emerg Med*. 2020;38(10):2060-4.
[11]Bai G, Kelen GD, Frick KD, Anderson GF. Nurse practitioners and physician assistants in emergency medical services who billed independently, 2012–2016. *Am J Emerg Med*. 2019 May 1;37(5):928-32.
[12]Bennett CL, Sullivan AF, Ginde AA, Rogers J, Espinola JA, Clay CE, Camargo CA Jr. National Study of the Emergency Physician Workforce, 2020. *Ann Emerg Med*. 2020 Dec;76(6):695-708. doi: 10.1016/j.annemergmed.2020.06.039. Epub 2020 Aug 1. PMID: 32747085.
[13]Quigley L, Salsberg E, Richwine C. New Emergency Medicine Physicians: Who They Are, Where They Are Working and Their Experience in the Job Market: Results from the Survey of Emergency Medicine Residents Who Completed Training in 2019. Report to the ACEP Board of Directors and Workforce Task Force Partners.
[14]Bennett CL, Sullivan AF, Ginde AA, Rogers J, Espinola JA, Clay CE, Camargo CA Jr. National Study of the Emergency Physician Workforce, 2020. *Ann Emerg Med*. 2020 Dec;76(6):695-708.
[15]Staffing Models and the Role of the Emergency Department Medical Director.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum, including rural areas.
  - Tactic 1 – Advocate for ACEP's principles for healthcare reform in current and future legislation that supports the practice of emergency physicians.

- Objective F – Develop and implement solutions for workforce issues that promote and sustain quality and patient safety.
  - Tactic 4 – Assess the needs and explore development of means to improve rural health care. Develop recommendations on opportunities to improve rural emergency care including possible accreditation programs, incentives, and policies. Provide several models of successful rural care practices.

Fiscal Impact

Budgeted committee and staff resources to develop a new policy statement and/or revise existing policy statements. Unknown additional costs depending on the scope of any action taken beyond policy development.

Prior Council Action

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 44(14) Support for Clinical Pharmacists as Part of the Emergency Medicine Team adopted. It called for ACEP to develop a policy statement in support of clinical pharmacy services in the ED, promote safe and effective medication delivery practices, conduct related clinical research, and foster support for pharmacy residency training in emergency medicine.

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 2021, discussed the emergency medicine workforce data that was presented at the Emergency Medicine Workforce Summit held earlier that day.

January 2021, approved the revised policy statement "Clinical Pharmacist Services in the Emergency Department;" originally approved June 2015.

January 2021, discussed the preliminary report of the emergency medicine workforce data from the Emergency Physician Workforce Task Force.

October 2020, approved the revised policy statement "Social Work and Case Management in the Emergency Department;" revised and approved April 2019; reaffirmed June 2013; originally approved October 2007 titled "Patient Support Services."

October 2020, reviewed the "Social Work and Case Management in the Emergency Department" PREP.

June 2020, approved the revised policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department;" revised June 2013 as "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department;" originally approved as "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" January 2007 by replacing two policy statements "Guidelines on the Role of Physician Assistants in the Emergency Department" and "Guidelines on the Role of Nurse Practitioners in the Emergency Department."

June 2020, filed the final report of the Emergency NP/PA Utilization Task Force.

October 2019, reviewed an interim report from the Emergency NP/PA Utilization Task Force.

January 2019, reaffirmed the policy statement "Providers of Unsupervised Emergency Department Care;" revised and approved June 2013; reaffirmed October 2007: originally approved June 2001.

August 2018, approved the final report from the ACEP Board Emergency Medicine Workforce Workgroup and initiated the recommendations therein to appoint a task force to consider the evolution of the role and scope of practice of advanced practice providers (APP) in the emergency department (ED).

Resolution 44(14) Support for Clinical Pharmacists as Part of the Emergency Medicine Team.

June 2012, reviewed the information paper, "Physician Assistants and Nurse Practitioners in Emergency Medicine."

June 2011, approved the Emergency Medicine Practice Committee's recommendation that ACEP not conduct a survey to determine the state of NP practice in emergency care and to take no further action on Resolution 27(10)

Emergency Department (ED) Staffing by Nurse Practitioners.

May 2001, recommendations of the Staffing Task Force presented to the Board.

September 1999, approved dissemination of survey results from the MLP/EMS Task Force recommendations.

Background Information Prepared by: Sandra Schneider, MD, FACEP
Senior Vice President, Clinical Affairs

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 72(21)

SUBMITTED BY: Louisiana Chapter

SUBJECT: Fair Compensation to Emergency Physicians for Collaborative Practice Agreements & Supervision

PURPOSE: Calls for ACEP to: 1) provide a means whereby emergency physicians can have a choice to supervise or collaborate with non-physicians; 2) provide a means for emergency physicians to be fairly compensated to supervise physician assistants and/or collaborate with nurse practitioners; and 3) that this compensation be in addition to the compensation that emergency physicians receive for practicing without supervision and collaborating.

FISCAL IMPACT: Budgeted staff resources.

WHEREAS, Many emergency physicians provide supervision of physician assistants; and

WHEREAS, Many emergency physicians have collaborative agreements with nurse practitioners; and

WHEREAS, Non-physician practitioners can offer valuable services as part of an emergency physician led team under the appropriate supervision; and

WHEREAS, This supervision and collaborative agreements require time, effort and energy and often distract from the emergency physician attention; and

WHEREAS, This supervision and collaboration is very valuable to patient care and to employers' ability to staff emergency departments with lesser educated and trained non-physicians; and

WHEREAS, The emergency physician often does not receive compensation for the EP's supervision and collaboration; and

WHEREAS, The supervision and collaboration often interferes in the EP's ability to see patients; and

WHEREAS, The supervision and collaboration often results in significantly more interruptions and a higher risk for medical decision errors and liability to the emergency physician; therefore be it

RESOLVED, That emergency physicians have the choice as to whether to supervise or collaborate with non-physicians; and be it further

RESOLVED, That emergency physicians be fairly compensated to supervise physician assistants and/or collaborate with nurse practitioners; and be it further

RESOLVED, That the fair compensation for supervision and collaborating with non-physicians is in addition to the compensation that the emergency physician receives for practicing emergency medicine without supervision and collaborating.

Background

This resolution asks ACEP to provide a means whereby emergency physicians can have a choice as to whether to

supervise or collaborate with non-physicians. Further it asks that ACEP provide a means by which emergency physicians can be fairly compensated to supervise physician assistants (PAs) and/or collaborate with nurse practitioners (NPs)and that this compensation is in addition to the compensation that emergency physicians receive for practicing without supervision and collaborating.

Currently, the requirement to supervise non-physicians is a contractual matter between the physician and their employee or between the group and their employee. ACEP has several policy statements and a Policy Resource & Education Paper (PREP) regarding compensation arrangements for emergency physicians.[1-7] None of these resources contain language that addresses supervision of non-physicians or additional payment for the supervision of such individuals.

In creating such a policy, it would be necessary to be explicit regarding the terms "supervision" and "non-physicians." In some settings, the physician may be deemed to have some supervision over other team members besides NPs and PAs.

CMS, who covers Medicare and Medicaid, allows the physician to report a split or shared service if a non-physician practitioner (physician assistant or nurse practitioner) and the physician both interact with the patient during a given encounter with the requirement of a documented "substantive portion" chosen by the physician to demonstrate their involvement. Typically, that would be the medical decision making. Alternatively, an appropriate physician attestation statement would suffice to demonstrate the physician participation without the need to duplicate previous documentation by the non-physician provider. The claim would then be paid at 100% of the physician fee schedule rate. If the non-physician provider claim is submitted without being a split or shared service, it is typically paid at 85% of the physician fee schedule amount. There is no separate payment for supervising a non-physician practitioner in the emergency department setting because "incident to" policy does not apply in the facility. There is no provision for a split or shared procedure except under teaching physician rules. A current reimbursement FAQ on this topic is available on the ACEP website.

Unless reimbursement is possible through CMS and/or private insurance, any payment for such services would be from the group or employer.

Background References

[1]Compensation Arrangements for Emergency Physicians. [policy statement]. Approved April 2021.
[2]Fair Payment for Emergency Department Services. [policy statement]. Approved April 2016.
[3]Emergency Physician Compensation Transparency. [policy statement]. Approved October 2020.
[4]Emergency Physician Rights and Responsibilities. [policy statement]. Approved April 2021.
[5]Protecting Emergency Physician Compensation During Contract Transitions. [policy statement]. Approved February 2020.
[6]Emergency Physician Contractual Relationships. [policy resource and education paper]. Approved July 2018.
[7]Emergency Physician Contractual Relationships. [policy statement]. Approved April 2021.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective E – Pursue strategies for fair payment and practice sustainability to ensure patient access to care is silent on this specific issue.
- Objective F – Develop and implement solutions for workforce issues that promote and maintain patient safety.

Fiscal Impact

Budgeted staff resources.

Prior Council Action

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

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. 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. 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

April 2021, approved the policy statement "Compensation Arrangements for Emergency Physicians;" revised and approved April 2015; Reaffirmed October 2008; revised and approved April 2002, June 1997; reaffirmed April 1992; originally approved June 1988.

April 2021, approved the revised policy statement, "Emergency Physician Contractual Relationships;" revised and approved June 2018, October 2012, January 2006, March 1999, August 1993. Originally approved October 1984 titled, "Contractual Relationships between Emergency Physicians and Hospitals."

April 2021, approved the revised policy statement "Emergency Physician Rights and Responsibilities;" revised and approved October 2015, April 2008, and July 2001; originally approved September 2000.

October 2020, approved the policy statement "Emergency Physician Compensation Transparency."

June 2020, approved revisions to "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" policy statement, revised June 2013 as "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department", originally approved as "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" January 2007 by replacing two policy statements "Guidelines on the Role of Physician Assistants in the Emergency Department" and "Guidelines on the Role of Nurse Practitioners in the Emergency Department."

June 2020, filed the final report of the Emergency NP/PA Utilization Task Force.

February 2020, approved the policy statement "Protecting Emergency Physician Compensation During Contract Transitions."

October 2019, reviewed an interim report from the Emergency NP/PA Utilization Task Force.

January 2019, reaffirmed the policy statement "Providers of Unsupervised Emergency Department Care;" revised and approved June 2013; reaffirmed October 2007; originally approved June 2001.

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 "Emergency Physician Contractual Relationships" PREP.

April 2016, approved the revised policy statement "Fair Payment for Emergency Department Services;" originally approved April 2009.

June 2011, approved the Emergency Medicine Practice Committee's recommendation that ACEP not conduct a survey to determine the state of NP practice in emergency care and to take no further action on Resolution 27(10) Emergency Department (ED) Staffing by Nurse Practitioners.

September 2006, reviewed the report of the NP/PA Task Force and approved appointing a new task force to focus efforts on development of a curriculum, invite participants from other organizations, and explore funding opportunities for training programs and curriculum development. In January 2007, the National Commission on Certification for Physician Assistants (NCCPA) requested ACEP and SEMPA to participate in a joint task force to further develop the specialty recognition program. An initial meeting of the workgroup was held in May 2007. In June 2007, NCCPA requested ACEP to reappoint its representatives to the NCCPA Workgroup on Specialty Recognition for PAs in Emergency Medicine. Resolution 44(19) Independent ED Staffing by Non-Physician Providers Page 6

April 2006, reviewed the survey responses from NP and PA organizations regarding developing a curriculum for NPs and PAs in emergency care.

June 2005, reviewed the work of the Mid-Level Providers Task Force and approved moving forward with a multidisciplinary task force to include mid-level provider organizations to address certification and curriculum issues.

Amended Resolution 23(04) Specialized Emergency Medicine Training for Midlevel Providers Who Work in Emergency Departments adopted. A task force was appointed to review the available information and provide a recommendation to the Board regarding ACEP' s potential involvement in the development of specialized training curricula for PAs and NPs that work in the ED.

May 2001, accepted the report of the Staffing Task Force.

September 1999, approved dissemination of survey results from the MLP/EMS Task Force recommendations.

Background Information Prepared by: Sandra Schneider, MD, FACEP
Senior Vice President, Clinical Affairs

David McKenzie, CAE
Reimbursement Director

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 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(21)

SUBMITTED BY: Emergency Medicine Residents' Association
Ohio Chapter
Pennsylvania College of Emergency Physicians
Young Physicians Section

SUBJECT: Offsite Supervision of Nurse Practitioners and Physician Assistants

PURPOSE: 1) Revise the policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" to remove "offsite" supervision, including via telephone, telehealth, or video, as a type of indirect supervision of PAs and NPs in the ED. 2) Oppose staffing EDs with PAs and NPs without onsite emergency physician supervision.

FISCAL IMPACT: Budgeted committee and staff resource.

WHEREAS, The American College of Emergency Physicians (ACEP) defines an emergency physician as a physician who is certified (or eligible to be certified) by the American Board of Emergency Medicine (ABEM), the American Osteopathic Board of Emergency Medicine (AOBEM), or an equivalent international certifying body recognized by ABEM or AOBEM in emergency medicine or pediatric emergency medicine, or who is eligible for active membership in the American College of Emergency Physicians; and

WHEREAS, 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 their patients; and

WHEREAS, The facility management must provide sufficient support to ensure high quality emergency care and patient safety; and

WHEREAS, ACEP has long supported physician-led teams in the emergency department, where emergency nurses (RNs), nurse practitioners (NPs), physician assistants (PAs), pharmacists, and others play an integral role as part of a multidisciplinary team; and

WHEREAS, ACEP has a policy statement, "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" (revised June 2020 with current title; approved June 2013 titled, "Guidelines on the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department;" originally approved January 2007 titled, "Guidelines on the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" replacing "Guidelines on the Role of Physician Assistants in Emergency Departments" (2002) and "Guidelines on the Role of Nurse Practitioners in the Emergency Department" (2000)); and

WHEREAS, The 2021 ACEP Emergency Physician Workforce of the Future Report suggested a looming surplus of emergency physicians; therefore be it

RESOLVED, That the ACEP policy statement, "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department," be revised to remove "offsite" supervision, including via telephone, telehealth, or video, as a type of indirect supervision of physician assistants and nurse practitioners in the emergency department; and be it further

RESOLVED, That ACEP oppose staffing of emergency departments with physician assistants and nurse practitioners without onsite emergency physician supervision.

References
1. https://www.acep.org/patient-care/policy-statements/emergency-physician-rights-and-responsibilities/
2. https://www.acep.org/who-we-are/ACEPLately/acep-lately-blog-articles/may-2021/
3. https://www.acep.org/contentassets/c3cef041efd54af48b71946c0cb658f0/final---board-report---2020-rural-emergency-care-task-force-oct-2020---provider-002.mcw-final-edits-002.pdf
4. https://www.acep.org/life-as-a-physician/workforce/

Background

This resolution asks ACEP to revise the policy statement, "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department," to remove "offsite" supervision, including via telephone, telehealth, or video, as a type of indirect supervision of physician assistants (PAs) and nurse practitioners (NPs) in the emergency department (ED). Further it asks that ACEP oppose staffing of EDs with PAs and NPs physician without onsite emergency physician supervision.

ACEP has several policies that oppose the independent practice by PAs/NPs:[1,2]

> *"PAs/NPs should not perform independent unsupervised care in the ED. This holds true regardless of state laws or hospital regulations. In the case of rural and underserved areas, supervision may require telehealth services or real-time off-site emergency physician consultation.*[1]"
>
> *"ACEP believes that advanced practice registered nurses or PAs should not provide unsupervised ED care.*
>
> *ACEP believes that "unsupervised ED practice is best provided by fully trained emergency medicine specialists."*[2]

Many rural hospitals struggle to survive financially. According to the Rural Emergency Medicine Task Force Report, in 2020 a net of 55 rural EDs have closed in the past 17 years. Some rural hospitals struggle to support a board-certified physician practice model. Rural EDs represent 53% of the hospitals in the U.S. but only 24% of the volume.[3,4] Additionally, according to the Rural Emergency Medicine Task Force report, a recent study found that only 8% of all emergency physicians (not necessarily ABEM/ AOBEM certified) work in rural EDs and only about 2% work in very low volume ED's. Even as the job market has tightened for emergency physicians, few graduates choose to staff rural facilities. In a survey of new emergency medicine resident/fellow graduating in 2019, only 8.4% of graduates took positions in semi-rural areas, despite incentives of loan forgiveness and a salary difference of over $100,000 (greater in rural areas).[5] Bennet et al showed that although the total number of clinically active emergency physicians in the U.S. increased by almost 10,000 from 2008-2020, the number of emergency physicians in rural areas actually decreased.[6]

There are several suggestions on ways to provide emergency physician coverage to rural areas. One suggestion, supported by many, is to increase the number of residencies that include a rural rotation. However, an analysis of the Salsberg data suggests there is no difference in the number of residents who chose rural practice after graduation based on whether their residency promotes rural exposure. [7]

It remains to be seen whether a tightening job market and greater concern for a future emergency physician surplus will increase the number of physicians who provide care in a rural area. However, data suggests that graduates do not want to work in a rural area, even if there is a financial incentive to do so. Preliminary results from this year's survey of graduating residents show that, once again, few entered rural practice, and that the salary difference demonstrated in 2019 ($100K + greater in rural areas) remains true today. Despite a tightening job market, higher salaries and loan forgiveness, and residency rural experience, few graduating residents take jobs in rural areas.

Providing care to very rural facilities is already challenging. Several facilities support very rural practices via telehealth today, including the University of Mississippi, University of South Dakota, and the Mayo system in Minnesota. In those models, NPs/PAs staff very small emergency departments but have their care "supervised" remotely by board certified emergency physicians. Were ACEP to oppose offsite supervision via telehealth, either

those facilities would need to be staffed by board certified emergency physicians or those hospitals would likely ignore ACEP policy and staff their facilities with NPs/PAs practicing independently. There are already significant financial incentives for physicians to staff rural hospitals – and they are not working. There are already many residencies that emphasize rural emergency medicine, yet their graduates do not take rural jobs. Removing telemedicine supervision may have the unintended consequence of moving rural jobs permanently into independent NP/PA staffing.

It should be noted that the resolution "Rural Provider Support and a Call for Data" submitted this year specifically calls for support of rural practices with telehealth. There are several other resolutions submitted this year regarding the practice of NPs and PAs in the ED and the Council should ensure that these resolutions do not contradict each other.

Background References

[1]Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department [policy statement]. Approved June 2020.
[2]Providers of Unsupervised Emergency Department Care [policy statement]. Approved January 2019.
[3]Ginde AA, Sullivan AF, Camargo CA Jr. National study of the emergency physician workforce, 2008. *Ann Emerg Med*. 2009; 54: 349-359.
[4]Sullivan AF, Richman IB, Ahn CJ, et al. A profile of U.S. emergency departments in 2001. *Ann Emerg Med.* 2006; 48: 694-701.
[5]Leo Quigley, Edward Salsberg, Chelsea Richwine. New Emergency Medicine Physicians: Who They Are, Where They Are Working, and Their Experience in the Job Market: Results from the Survey of Emergency Medicine Residents Who Completed Training in 2019. The Fitzhugh Mullan Institute for Health Workforce Equity. George Washington University School of Public Health. February 2020. Report to the ACEP Board of Directors and Workforce Task Force Partners.
[6]Bennett CL, Sullivan AF, Ginde AA, et al. National study of the emergency physician workforce, 2020. *Ann Emerg Med*. 2020; Published July 31, 2020.
[7]Personal Communication. Ed Salsberg. 2021

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective F – Develop and implement solutions for workforce issues that promote and sustain quality and patient safety.
  - Tactic 4 – Assess the needs and explore development of means to improve rural health care. Develop recommendations on opportunities to improve rural emergency care including possible accreditation programs, incentives, and policies. Provide several models of successful rural care practices.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

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 2021, discussed the emergency medicine workforce data that was presented at the Emergency Medicine Workforce Summit held earlier that day.

January 2021, discussed the preliminary report of the emergency medicine workforce data from the Emergency Physician Workforce Task Force.

October 2020, filed the report of the Rural Emergency Medicine Task Force and included recommendations for implementation in ACEP's Strategic Plan.

June 2020, approved revisions to "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" policy statement, revised June 2013 as "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department", originally approved as "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" January 2007 by replacing two policy statements "Guidelines on the Role of Physician Assistants in the Emergency Department" and "Guidelines on the Role of Nurse Practitioners in the Emergency Department."

June 2020, filed the final report of the Emergency PA/NP Utilization Task Force.

October 2019, reviewed an interim report from the Emergency NP/PA Utilization Task Force.

January 2019, reaffirmed the policy statement "Providers of Unsupervised Emergency Department Care;" revised and approved June 2013; reaffirmed October 2007; originally approved June 2001.

August 2018, approved the final report from the ACEP Board Emergency Medicine Workforce Workgroup and initiated the recommendations therein to appoint a task force to consider the evolution of the role and scope of practice of advanced practice providers in the emergency department.

May 2001, recommendations of the Staffing Task Force presented to the Board.

September 1999, approved recommendations from the MLP/EMS Task Force to disseminate the results of the surveys.

Background Information Prepared by: Sandy Schneider, MD, FACEP
Senior Vice President, Clinical Affairs

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 74(21)

SUBMITTED BY: Emergency Medicine Workforce Section

SUBJECT: Regulation by State Medical Boards of All Who Engage in Practice of Medicine

PURPOSE: Support a federal definition of practice of medicine and support that anyone engaged in such practice be regulated by state medical boards that regulate the practice of medicine.

FISCAL IMPACT: Budgeted staff resources.

WHEREAS, The practice of medicine has been defined in the US back to 1907 as the application of medical or surgical agencies for the purpose of preventing, relieving, or curing disease, or aiding natural functions, or modifying or removing the results of physical injury, (Hutchins, Harry B "What is the practice of Medicine?" Mich L. Rev (1906):373-9); and

WHEREAS, In general, a person practices medicine when he or she tries to diagnose or cure an illness or injury, prescribes drugs, performs surgery, or claims he or she is a doctor; and

WHEREAS, States are responsible for providing medical licenses, and each state has a slightly different legal definition for the practice of medicine; therefore be it

RESOLVED, That ACEP support a federal definition of the practice of medicine to include the ordering of tests, diagnosing, prescribing of medications, and/or ordering of treatments on human beings; and be it further

RESOLVED, That ACEP support that anyone, physicians or non-physician practitioners, who engage in the practice of medicine be regulated by the respective state medical boards that regulate the practice of medicine.

Background

The resolution calls for the College to support a federal definition of the practice of medicine and support that anyone engaged in such practice be governed by state medical boards that regulate the practice of medicine. Under the United States Constitution, jurisdiction on various issues is divided between the national government and the individual states. Historically, the practice of medicine as a profession has fallen to the jurisdiction of the states. Similarly, various types of specialties that also are involved in providing health care services to individual people are authorized and regulated at the state level. While various organizations have pursued model laws and related resources that would promote a high degree of uniformity in this patchwork of state regulation, there nonetheless exists a degree of variability in the licensure and regulation of these professions.

Beyond that variation, in recent years changes in terminology, training, and regulation have resulted in increasing ambiguity with regard to what constitutes the practice of medicine as opposed to the practice of providing various sorts of health care services that either do not rise to the level of constituting the practice of medicine or that until recently could only be provided under the supervision of a licensed physician. What constitutes supervision has also varied from state to state. Some organizations representing various health care groups have promoted such ambiguity to argue in favor of unrestricted, or at least less restrictive, practice. Among physicians, this increase in the scope of practice of persons lacking the education and training of physicians has created concerns about patient safety and quality of care.

The Federation of State Medical Boards' workgroup on Team-based Regulation notes that states have adopted a variety of strategies in order to address the regulation of physicians and other practitioners, including the use of joint rulemaking, joint committees, and interagency advisory committees. Coordinated complaint intake and shared investigation data are also used in many states in order to facilitate the handling of complaints. Given that the goals of this resolution would not seem to involve, or at least not require, the elimination of various licensing boards, such coordinating efforts would continue to be required and may become more complex.

ACEP's "Code of Ethics for Emergency Physicians" has several provisions related to relationships with non-physician practitioners in the emergency department, including the following:

> "The practice of emergency medicine requires multidisciplinary cooperation and teamwork. Emergency physicians interact closely with a wide variety of other health care professionals, including emergency nurses, emergency medical technicians, and physicians from other specialties. General ethical principles governing these interactions include honesty, respect, appreciation of other professionals' perspectives and needs, and an overriding duty to maximize patient benefit."

In 2018, ACEP invited other national emergency medicine organizations to participate in a task force to examine the future of the emergency medicine work force in the United States. Among the considerations that the task force addressed was to "ensure appropriate use of NPs and PAs to protect the unique role of emergency physicians." The task force report was presented to the ACEP Board in June 2020, which noted that it was a consensus document and it was filed for information. In August 2021 the "Emergency Medicine Physician Workforce: Projections for 2030" was published in *Annals of Emergency Medicine*. In anticipation of that report, ACEP developed a multi-faceted work group to address many of the identified issues. The ACEP website has many resources about the Emergency Medicine Workforce of the Future.

This resolution would address some of these varied concerns by calling for ACEP to work in favor of a standardized federal definition of the practice of medicine that would then be enforced in a more uniform manner by the states.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective D – Promote quality and patient safety, including continued development and refinement of quality measures and resources.

Fiscal Impact

Budgeted staff resources.

Prior Council Action

Resolution 24(15) Interstate Medical Licensure Compact Legislation and Opposition to National Medical License referred to the Board of Directors.

Prior Board Action

June 2020, filed the final report of the Emergency PA-NP Utilization Task Force.

June 2020, approved the revised policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department;" revised June 2013 as "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department;" originally approved as "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" January 2007 by replacing two policy statements "Guidelines on the Role of Physician Assistants in the Emergency Department" and "Guidelines on the Role of Nurse Practitioners in the Emergency Department."

April 2021, discussed the emergency medicine workforce data that was presented at the Emergency Medicine Workforce Summit held earlier that day.

January 2021, discussed the preliminary report of the emergency medicine workforce data from the Emergency Physician Workforce Task Force.

January 2017, approved the revised policy statement "Code of Ethics for Emergency Medicine;" revised June 2016, June 2008; reaffirmed October 2001; revised June 1997 with the current title; originally approved January 1991 titled "Ethics Manual."

October 2016, approved the recommendation of the State Legislative/Regulatory Committee to distribute resources to chapters to address Referred Resolution 24(15) Interstate Medical Licensure Compact Legislation and Opposition to National Medical License.

Background Information Prepared by: Harry Monroe
State Legislation Director

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 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(21)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: Required Clinical Experience for Emergency Nurses

PURPOSE: 1) Contact ENA to explore the potential for a joint Emergency Workforce collaboration, with the goal of sharing the task force's identified goals and working together on ensuring consistency in nursing training, supporting practicing nurses to encourage rewarding practice in all communities, and setting the standard for emergency medicine so that every patient has access to an experienced emergency nurse. 2) Collaborate with ENA to advocate for a minimum level of nursing experience prior to working in the ED. 3) Collaborate with ENA in advocating for improved incentives and compensation to further recruit and retain nurses with the skills and experience necessary for the breadth of patients and pathology seen in EDs.

FISCAL IMPACT: Budgeted committee and staff resources. Approximately $20,000 to hold an in person meeting.

WHEREAS, Emergency departments provide care to patients across the spectrum of age, acuity, and both medical and surgical pathology; and

WHEREAS, Emergency medicine involves providing care to undifferentiated patients; and

WHEREAS, ACEP has a history of collaborating with the Emergency Nurses Association (ENA), going back to the early stages of both organizations[1]; and

WHEREAS, ENA passed a resolution as early as 1978 "recommending one year medical/surgical clinical practice and an in-depth orientation including advanced clinical skills to work in the ED"[1] and

WHEREAS, In 1980, the ENA established an emergency nursing core curriculum[1]; and

WHEREAS, The ENA acknowledges that emergency nursing requires "a skill-set well beyond that necessary for nursing licensure"[2]; and

WHEREAS, It has been shown that there is a workforce of experienced nurses potentially available to work in emergency departments in times of surge or disasters[3]; and

WHEREAS, Other national nursing organizations, such as the American Association of Critical-Care Nurses, are taking efforts to combat the noted and growing gap between nursing experience and complexity of patient care[4]; therefore be it

RESOLVED, That ACEP contact the Emergency Nurses Association to explore the potential for a joint Emergency Workforce collaboration, with the goal of sharing the task force's identified goals and working together on ensuring consistency in nursing training, supporting practicing nurses to encourage rewarding practice in all communities, and setting the standard for emergency medicine so that every patient has access to an experienced emergency nurse; and be it further

RESOLVED, That ACEP collaborate with the Emergency Nurses Association to advocate for a minimum level of nursing experience prior to working in the emergency department given the variety of acuity and pathology seen in undifferentiated patients presenting to the ED; and be it further

RESOLVED, That ACEP and the Emergency Nurses Association collaborate in advocating for improved incentives and compensation to further recruit and retain nurses with the skills and experience necessary for the breadth of patients and pathology seen in emergency departments across the country.

References

1. Emergency Nurses Association. ENA 50th Anniversary Timeline. https://rise.articulate.com/share/-3p7YsoNuSI-UWMziOsf-AE33NGHuAiK#/lessons/go2rlSWiE4Gc8w_9gbMcnYJiebGMDOcU
2. Emergency Nurses Association. Position Statement: Emergency Nurse Orientation. https://www.ena.org/docs/default-source/resource-library/practice-resources/position-statements/emergencynurseorientation
3. Castner J, Bell SA, Castner M, Couig MP. National Estimates of the Reserve Capacity of Registered Nurses Not Currently Employed in Nursing and Emergency Nursing Job Mobility in the United States. *Annals of Emergency Medicine*. Volume 0, Issue 0. Published: June 12, 2021. DOI: https://doi.org/10.1016/j.annemergmed.2021.03.006
4. American Association of Critical-Care Nurses. The Experience-Complexity Gap: The Long and Short of Staffing Numbers. https://www.aacn.org/blog/the-experience-complexity-gap-the-long-and-short-of-staffing-numbers

Background

This resolution asks that ACEP contact the Emergency Nurses Association (ENA) to explore the potential for a joint Emergency Workforce collaboration, with the goal of sharing the task force's identified goals and working together on ensuring consistency in nursing training, supporting practicing nurses to encourage rewarding practice in all communities, and setting the standard for emergency medicine so that every patient has access to an experienced emergency nurse. It further asks ACEP to collaborate with ENA to advocate for a minimum level of nursing experience prior to working in the emergency department (ED) given the variety of acuity and pathology seen in undifferentiated patients presenting to the ED. Finally, it asks that ACEP and ENA collaborate in advocating for improved incentives and compensation to further recruit and retain nurses with the skills and experience necessary for the breadth of patients and pathology seen in EDs across the country.

ACEP has existing policy dating back to 2006 that advocates for ENA's efforts to promote certified emergency nurses (CENs).[1] Additional ACEP policy states:

> *"The American College of Emergency Physicians (ACEP) supports emergency department (ED) nurse staffing systems that provide adequate numbers of registered nurses who are trained and experienced in the practice of emergency nursing.[2]"*

> *"Each nurse working in the ED should provide evidence of adequate previous ED or critical care experience or have completed an emergency care education program. The CEN credential is an excellent benchmark.[3]"*

ENA has a very robust program to support emergency nurses, including an annual conference, an Academy of Emergency Nurses, the Certified Emergency Nurse (CEN) program, a journal, and extensive educational materials. The requirements for a CEN include two years' experience (recommended but not required) and an examination. Study materials have also been developed.

There is currently a severe nursing shortage, made worse by the current pandemic.[4] It is estimated that one million nurses will be required to meet healthcare needs in 2030, even without accounting for any increased attrition due to the pandemic.[5] The average RN in the U.S. is now 50 years old.[6] Much more stringent a requirements for emergency nurses could increase the shortage in EDs as nurses choose alternative careers.

Background References

[1] Advocating for Certified Emergency Nurses (CENs) in Departments of Emergency Medicine [policy statement]. Approved February 2018.
[2] Emergency Department Nurse Staffing [policy statement]. Approved October 2016.
[3] Emergency Department Planning and Resource Guidelines [policy statement]. Approved April 2021.
[4] https://www.nytimes.com/2021/08/21/health/covid-nursing-shortage-delta.html
[5] https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/nchwa-hrsa-nursing-report.pdf
[6] https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/nssrn-summary-report.pdf

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective C – Promote the value of emergency physicians as essential components of the health care system.
  - Tactic 1 – Develop and promote resources that demonstrate the value of emergency medicine, working with appropriate other entities as needed.

Fiscal Impact

Budgeted committee and staff resources. Approximately $20,000 for an in-person meeting.

Prior Council Action

Substitute Resolution 53(05) Emergency Department Nurse Staffing Model adopted. It directed ACEP to work with ENA and other appropriate organizations to develop and promote an emergency nurse staffing model that lawmakers and hospital administrators could reference.

Amended Resolution 23(04) Specialized Emergency Medicine Training for Midlevel Providers Who Work in Emergency Departments adopted. Directed the College to continue working with respective specialty organizations of midlevel providers to establish or expand emergency medicine curricula and training programs and to encourage the certifying body of each discipline to develop certification examinations in emergency care.

Prior Board Action

April 2021, approved the revised policy statement "Emergency Department Planning and Resource Guidelines;" revised and approved April 2014, October 2007, June 2004, June 2001 with the current title; reaffirmed September 1996; revised and approved June 1991; originally approved December 1985 titled "Emergency Care Guidelines."

February 2018, reaffirmed the policy statement "Advocating for Certified Emergency Nurses (CENs) in Departments of Emergency Medicine;" reaffirmed April 2012; originally approved October 2006.

October 2016, approved the revised policy statement "Emergency Department Nurse Staffing;" reaffirmed September 2005; originally approved June 1999.

Substitute Resolution 53(05) Emergency Department Nurse Staffing Model adopted.

Amended Resolution 23(04) Specialized Emergency Medicine Training for Midlevel Providers Who Work in Emergency Departments adopted.

May 2001, recommendations of the Staffing Task Force presented to the Board.

September 1999, the MLP/EMS Task Force recommendations were presented to the Board. The Board approved dissemination of the results of the surveys.

Background Information Prepared by: Sandy Schneider, MD, FACEP
Senior Vice President, Clinical Affairs

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 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(21)

SUBMITTED BY: District of Columbia Chapter
Maryland Chapter

SUBJECT: Standards for Non-Residency Trained Physicians and Mid-Levels to Work in Emergency Medicine

PURPOSE: Requests ACEP to: 1) object to the practice of any graduate of any unaccredited school be it MD, DO, NP, PA supervised or unsupervised as a medical practitioner at any level in an ED; 2) object to the use of unsupervised assistant physicians as medical practitioners at any level in an ED; 3) create a working group to recommend the minimum qualifications and clinical experience necessary to work in an ED as a supervised advanced practice provider; 4) establish a separate standard for advanced practice providers in states that do not require a collaborative agreement; and 5) establish an objective standard for recertification to continue to practice in emergency medicine for all advanced practice providers.

FISCAL IMPACT: Budgeted committee and staff resources. Unbudgeted expenses of $20,000 – $30,000 for an in-person working group meeting depending on the size of the group.

WHEREAS, Excellent health care outcomes, access to high-quality physician-led emergency care and patient safety are goals of all U.S. Emergency Departments; and

WHEREAS, The medical school and residency paradigm has provided the highest caliber medical practitioners for over a century; and

WHEREAS, Recent trends in education, corporate policy and legislation have created pathways that do not meet an acceptable level of training and experience to justify provision of care outside of physician-led care; and

WHEREAS, State legislation in Missouri has created a practice path called “Assistant Physician” that does not require residency; and

WHEREAS, A substantial proportion of the practitioners in this category are not affiliated with residency trained physicians and demonstrate an unacceptable failure rate on licensing exams (Step 1 with a 30% failure rate, Step 2 with a 58% failure rate for clinical knowledge and 50% fail rate for skills, Step 3 with a 34% failure rate); and

WHEREAS, Nurse practitioners are an increasing percentage of health care professionals rendering care in emergency departments; and

WHEREAS, 23 states now do not require a collaborative agreement with a senior supervising physician; and

WHEREAS, Nurse practitioners once were expected to have thousands of hours of clinical practice prior to starting a nurse practitioner course; and

WHEREAS, There are an increasing number of nurse practitioner schools that do not require any previous clinical experience and there are an increasing number of online and in-person programs with truncated clinical requirements for completion, currently 600 hours (5 blocks of 120 hours each); and

WHEREAS, Unaccredited nurse practitioner programs are growing in number and graduating students who

enter the workforce unimpeded; and

WHEREAS, Nurse practitioner programs will often require their students to set up their own practicums without a robust quality assurance evaluation of those practicums; and

WHEREAS, The nurse practitioner paradigm does not require post-graduate training such as a medical residency; and

WHEREAS, All four certification bodies for nurse practitioners – the American Nurses Credentialing Center (ANCC), Pediatric Nursing Certification Board (PNCB), National Certification Corporation NCC), and the American Academy of Nurse Practitioners Certification Program (AANPCP) – do not require any recertification testing, though they offer it as an option; and

WHEREAS, The three certification bodies that might certify nurse practitioners who could work in an emergency department setting, offer no testing renewal of licensure with ANNC: in a 5-year span – 1,000 hours of clinical practice total with 150 CME; PNCB: in a 7-year span – 30 credits of CME and pediatric updates; and AANPCP: in a 5-year period – 1,000 clinical hours total and 100 CME; therefore be it

RESOLVED, That ACEP object to the practice of any graduate of any unaccredited school be it MD, DO, NP, PA supervised or unsupervised as a medical practitioner at any level in an emergency department; and be it further

RESOLVED, That ACEP object to the use of unsupervised assistant physicians as medical practitioners at any level in an emergency department; and be it further

RESOLVED, That ACEP create a working group to recommend the minimum qualifications and clinical experience necessary to work in an emergency department as a supervised advanced practice provider; and be it further

RESOLVED, That ACEP establish a separate standard for advanced practice providers in states that do not require a collaborative agreement; and be it further

RESOLVED, That ACEP establish an objective standard for recertification to continue to practice in emergency medicine for all advanced practice providers.

Background

The resolution asks ACEP to: 1)object to the practice of any graduate of any unaccredited school be it MD, DO, NP, PA supervised or unsupervised as a medical practitioner at any level in an ED; 2) object to the use of unsupervised assistant physicians as medical practitioners at any level in an ED; 3) create a working group to recommend the minimum qualifications and clinical experience necessary to work in an ED as a supervised advanced practice provider; 4) establish a separate standard for advanced practice providers in states that do not require a collaborative agreement; and 5) establish an objective standard for recertification to continue to practice in emergency medicine for all advanced practice providers

ACEP does not have existing policy covering the medical school graduates from non-accredited schools. Many U.S. students attend medical school outside of the U.S., most often in the Caribbean. Several of these schools have "approval from state agencies, such as the New York State Education Department and the Florida Department of Education, recognition from the Medical Board of California, and accreditations from major accrediting bodies like the Caribbean Accreditation Authority for Education in Medicine and Other Health Professions (CAAM-HP) or the Accreditation Commission on Colleges of Medicine (ACCM)."[1] Other schools may have CAAM-HP/ACCM accreditation but may not have state approval. However, there are several Caribbean schools that are not accredited by CAAM/ACCM.

It is estimated that there are more than 247,000 physicians licensed in the U.S. who graduated from a U.S. medical school.[2] The Liaison Committee on Medical Education currently accredits 155 U.S. schools as well as four in Puerto Rico and 17 in Canada. New medical schools receive preliminary accreditation and are eligible for full accreditation after the graduation of their first class.

There are two organizations that currently accredit graduate nursing programs – the Commission on Collegiate Nursing Education and the Accreditation Commission for Education in Nursing. There is an additional program that accredits nurse midwifery programs. Accreditation is voluntary. Non-accredited programs exist, but graduation from an accredited school is required for certification. Certification is required by all but three states and is required by all major insurers. Graduation from an accredited physician assistant program is required to take the PA certifying examination, so most, if not all schools, are accredited.

Assistant physicians (in some states called associate physicians or graduate registered physicians) are graduates of a medical school but have not completed a residency program. Individuals who work as assistant physicians are composed of unmatched graduates of U.S. medical schools, U.S. citizens who attended international medical school (mostly the Caribbean schools), and foreign medical schools. All assistant physicians are required to pass the United States Medical Examination (USMLE) or COMLEX to obtain an Assistant Physician Medical License. Assistant physician licenses are currently issued in several states but are required to be supervised by a collaborating physician. Depending on the state regulation, assistant physicians are often limited to primary care in medically underserved areas. However, in Arkansas, assistant physicians can work in any setting if permitted by their supervising physician and the policies of the facility.[3] There is currently no ACEP policy that addresses assistant/associate physicians.

ACEP has existing policy about unsupervised care in the ED by NPs and PAs.

> *"PAs/NPs should not perform independent unsupervised care in the ED. This holds true regardless of state laws or hospital regulations. In the case of rural and underserved areas, supervision may require telehealth services or real-time off-site emergency physician consultation."*[4]

> *"Emergency physicians must have the real-time opportunity to be involved in the care of any patient presenting to the ED and seen by a PA or NP. Local physician leadership should create guidelines for the types of supervision required or provided for specific categories of conditions, patients, and clinical scenarios"*[4]

> *"The American College of Emergency Physicians (ACEP) endorses the 2000 position statement of the Society for Academic Emergency Medicine (SAEM) on the "Qualifications for Unsupervised Emergency Department Care," and believes that the independent practice of emergency medicine is best performed by specialists who have completed American Board of Emergency Medicine (ABEM) or American Osteopathic Board of Emergency Medicine (AOBEM) certification, or have successfully "completed an Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) accredited emergency medicine residency, and is in the process of completing ABEM or AOBEM examinations."*[5]

> *"Residents-in-training or other physicians who do not meet these criteria are less likely to possess the cognitive and technical skill set necessary for rendering unsupervised care for the tremendous breadth and acuity of situations encountered in an ED."*[5]

> *"ACEP believes that advanced practice registered nurses or physician assistants should not provide unsupervised emergency department care."*[5]

> *"ACEP believes that "unsupervised ED practice is best provided by fully trained emergency medicine specialists."* [5]

Several ACEP policies affirm that the staffing of an ED, including the use of NPs and PAs is a decision of the local ED medical director. [4,6,7] A recent task force on the utilization of NPs and PAs in the ED came to the same decision.

There are, as noted in the resolution, several different organizations that offer a certifying exam for NPs who are graduates of accredited institutions. NPs must recertify (usually every five years) and keep the same certifying boards throughout their career. Several of the certifying boards require only CME combined with practice hours OR retaking the examination. It is not clear whether all institutions require current certification. The American Academy of Nurse Practitioners Certification Board has developed the Emergency Nurse Practitioner certification (ENP-C) conjunction with the American Academy of Emergency Nurse Practitioners. At this time, this examination is only open to individuals who are certified as a family nurse practitioner. Recertification is required every five years.

A PA who graduates from a program accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) can take the Physician Assistant National Certifying Examination (PANCE) for certification administered by the National Commission on Certification of Physician Assistants (NCCPA). All states, the District of Columbia, and Guam require that a candidate pass the PANCE exam for full authorization to practice as a physician assistant. Recertification and proof of 100 hours CME every two years is required. PAs can obtain a Specialty Certificate of Added Qualifications (CAQs) in Emergency Medicine by proof of 3000 hours of practice experience within six years, 150 hours of CME, and passing an examination. "NCCPA's specialty CAQ process is predicated on a strong belief in the value and importance of the physician-PA team, and in support of the procedures and patient case requirement, each applicant must provide attestation from a supervising physician who works in the specialty and is familiar with the PA's practice and experience." [7] Recertification is required every six years.

Background References

1. Three tiers of Caribbean medical schools. https://www.auamed.org/blog/3-tiers-caribbean-medical-schools/
2. Foreign-trained doctors are critical to servicing many US communities. https://www.americanimmigrationcouncil.org/sites/default/files/research/foreign-trained_doctors_are_critical_to_serving_many_us_communities.pdf
3. Assistant physicians: a new breed of provider. https://thriveap.com/blog/assistant-physicians-a-new-breed-of-provider.
4. ACEP. Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department [policy statement]. Approved June 2020.
5. ACEP. Providers of Unsupervised Emergency Department Care. Approved January 2019.
6. ACEP. Staffing Models and the Role of the Emergency Department Medical Director [policy statement]. Approved April 2020.
7. ACEP. Emergency Department Planning and Resource Guidelines [policy statement]. Approved April 2021.
8. https://www.sempa.org/professional-development/nccpas-caq-in-emergency-medicine/

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum, including rural areas.
  - Tactic 1 – Advocate for ACEP's principles for healthcare reform in current and future legislation that supports the practice of emergency physicians.
- Objective C – Promote the value of emergency medicine and emergency physicians as essential components of the health care system.
  - Tactic 1 – Develop and promote resources that demonstrate the value of emergency medicine, working with appropriate other entities as needed.

Fiscal Impact

Budgeted committee and staff resources. Unbudgeted expenses of $20,000 – $30,000 for an in-person working group meeting depending on the size of the group.

Prior Council Action

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 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, 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. Called for the College 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

April 2021, approved revisions to "Emergency Department Planning and Resource Guidelines" policy statement, also revised April 2014, October 2007, June 2004, June 2001. Reaffirmed September 1996, revised June 1991, originally approved December 1985 titled "Emergency Care Guidelines."

June 2020, approved revisions to "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" policy statement, revised June 2013 as "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department", originally approved as "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" January 2007 by replacing two policy statements "Guidelines on the Role of Physician Assistants in the Emergency Department" and "Guidelines on the Role of Nurse Practitioners in the Emergency Department."

April 2020, approved policy statement "Staffing Models and the Role of the Emergency Department Medical Director."

January 2019, reaffirmed the policy statement "Providers of Unsupervised Emergency Department Care;" revised and approved June 2013; reaffirmed October 2007; originally approved June 2001.

June 2011, approved taking 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. In January 2007, the National Commission on Certification for Physician Assistants (NCCPA) requested ACEP and SEMPA to participate in a joint task force to further develop the specialty recognition program. An initial meeting of the workgroup was held in May 2007. In June 2007, NCCPA requested ACEP to reappoint its representatives to the NCCPA Workgroup on Specialty Recognition for PAs in Emergency Medicine and advised they would contact the workgroup representatives regarding next steps.

April 2006, reviewed the survey responses from NP and PA organizations regarding developing a curriculum for NPs and PAs in emergency care.

June 2005, reviewed the work of the Mid-Level Providers Task Force and approved moving forward with a multidisciplinary task force to include mid-level provider organizations to address certification and curriculum issues.

Amended Resolution 23(04) Specialized Emergency Medicine Training for Midlevel Providers Who Work in Emergency Departments adopted. A task force was appointed to review the available information and provide a

recommendation to the Board regarding ACEP's potential involvement in the development of specialized training curricula for PAs and NPs that work in the ED.

May 2001, accepted the report of the Staffing Task Force.

September 1999, approved recommendations from the MLP/EMS Task Force to disseminate the results of the surveys.

Background Information Prepared by: Sandy Schneider, MD, FACEP
Senior Vice President, Clinical Affairs

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 77(21)

SUBMITTED BY: Louisiana Chapter

SUBJECT: Workforce Fairness

PURPOSE: 1) ACEP hold accountable employers of emergency physicians for the right of any emergency physician practicing at any facility that utilizes non-physicians where the physician is expected to supervise or have a collaborative agreement with any non-physician to raise a concern regarding the care, professional behavior, knowledge, procedural skills or ability of a non-physician that interferes with optimal patient care by a non-physician or the emergency physician's ability to properly oversee the non-physician and assure the best care with the staffing model that the physician does not control; 2) support that emergency physicians should not be forced to supervise or have a collaborative practice agreement with any non-physician which the emergency physicians who practice clinically at the location in question, in the emergency physicians' sole determination, does not feel comfortable doing so i.e., the non-physician poses a risk to patient care, does not receive suggestions or teaching well, failure to follow reasonable patient care related instructions etc.; 3) support that no emergency physician who raises concerns regarding a non-physician's care, professional behavior, knowledge, or procedural skills should receive any negative consequences or retribution by an employer or any entity in any way i.e., financial, vacation time, type or number of shifts, etc. as a result of raising concerns.

FISCAL IMPACT: Budgeted committee and staff resources to develop new policy statements and/or revise existing policy statements. Unknown potential legal costs depending on the number of cases that ACEP would "support."

WHEREAS, Healthcare must be physician led and emergency medicine must be emergency physician led to provide the best trained and educated personnel involved in patent care; and

WHEREAS, It is important to have the input, involvement and leadership of the emergency physicians who are responsible for patient care and the leaders of the patient care teams involved; and

WHEREAS, Emergency physicians are often required to supervise or have collaborative practice agreements with non-physicians i.e. physician assistants, nurse practitioners, etc., that the EP did not train, hire, or have say as to whether that non-physician practices at an acceptable level; therefore be it

RESOLVED, That ACEP support contract management groups, other employers, persons or entities who have employment or independent contract work agreements with emergency physicians be held accountable to any emergency physician who practices at any facility that utilizes non-physicians and is expected to supervise or have a collaborative agreement with any non-physician that raises a concern regarding the care, professional behavior, knowledge, procedural skills or ability of a non-physician that interferes with optimal patient care by a non-physician or the emergency physician's ability to properly oversee the non-physician and assure the best care with the staffing model that the physician does not control; and be it further

RESOLVED, That ACEP support emergency physicians not being forced to supervise or have a collaborative practice agreement with any non-physician which the emergency physicians who practice clinically at the location in question, in the emergency physicians' sole determination, do not feel comfortable doing so i.e., the non-physician poses a risk to patient care, does not receive suggestions or teaching well, failure to follow reasonable patient care related instructions etc.; and be it further

RESOLVED, That ACEP support that no emergency physician who raises concerns regarding a non-physician's care, professional behavior, knowledge, or procedural skills receive any negative consequences or

retribution by an employer or any entity in any way i.e., financial, vacation time, type or number of shifts, etc., as a result of raising concerns.

Background

This resolution asks that ACEP hold accountable employers of emergency physicians for the right of any emergency physician who practices at any facility that utilizes non-physicians where the physician is expected to supervise or have a collaborative agreement with any non-physician to raise a concern regarding the care, professional behavior, knowledge, procedural skills or ability of a non-physician that interferes with optimal patient care by a non-physician or the emergency physician's ability to properly oversee the non-physician and assure the best care with the staffing model that the physician does not control. Further, it asks that ACEP support that emergency physicians should not be forced to supervise or have a collaborative practice agreement with any non-physician which the emergency physicians who practice clinically at the location in question, in the emergency physicians' sole determination, does not feel comfortable doing so i.e., the non-physician poses a risk to patient care, does not receive suggestions or teaching well, failure to follow reasonable patient care related instructions etc. Finally, it asks that ACEP support that no emergency physician who raises concerns regarding a non-physician's care, professional behavior, knowledge, or procedural skills should receive any negative consequences or retribution by an employer or any entity in any way i.e., financial, vacation time, type or number of shifts, etc. as a result of raising concerns.

ACEP has existing policy regarding the use of nurse practitioners (NPs) and physician assistants (PAs) in the emergency department (ED) and is clear that the use of non-physicians and the hiring/firing/staffing of such staff is to be determined by the local ED medical director (required to be an emergency physician as defined by ACEP policy).

> *"The use of PAs and NPs in the ED should be determined at the site level by local ED leadership, who are responsible for PA/NP hiring, staffing and supervision. These physician leaders, along with the PA and/or NP leadership, should be responsible for establishing processes and practice standards that ensure both sufficient physician availability for PA and NP supervision as well as adequate physician opportunity to supervise.[1] "*

ACEPs policy acknowledges the presence of other non-physicians who provide some level of care to the patient in the ED, such as clinical pharmacists and social workers; however, the policies regarding supervision, hiring, firing, and staffing is not addressed for these individuals.

This resolution has multiple parts. First, it asks for protection of the individual physician who, for whatever reason, raises concern regarding the practice by a non-physician at their facility. ACEPs current policy states"

> *"Emergency physician autonomy in clinical decision making should be respected and should not be restricted other than through reasonable rules, regulations, and bylaws of his or her medical staff or practice group."*
>
> *"Emergency physician autonomy should not be unduly restricted by value based or other cost-saving guidelines, contracts, rules, or protocols. The physicians must have the ability to do what they believe in good faith is in the patient's best interest."*
>
> *"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."*
>
> *"Emergency physicians are entitled to due process before any adverse final action with respect to employment or contract status, the effect of which would be the loss or limitation of medical staff privileges or their ability to see patients. Emergency physicians' medical and/or clinical staff privileges should not be reduced, terminated, or otherwise restricted except for grounds related to their competency, health status, limits placed by professional practice boards or state law.[2]"*

This resolution does not indicate specific action ACEP would take to support a physician engaged in a dispute over supervision of a non-physician. ACEP recognizes that there are multiple staffing models and ACEP policy states that the local medical director should determine which model to utilize. It is not clear how ACEP would adjudicate between an ED medical director and an individual physician who had concerns about the model utilized in a given facility.

The second resolved asks that an emergency physician should not be "forced" to work with a non-physician about whom they have concerns. ACEP policy again states that staffing of a department should be at the discretion of the local ED medical director. Creating an arbitration system or providing assistance for any possible litigation could be time-consuming and costly for ACEP.

The third resolved asks that ACEP ensure that no physician who raises concerns regarding a non-physician should be adversely affected. ACEP could develop a policy statement to address this issue and this information could be added to the checklist that ACEP has developed for physicians seeking employment.[3]

Background References

[1]Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department [policy statement]. Approved June 2020.
[2]Emergency Physician Rights and Responsibilities [policy statement]. Approved April 2021.
[3]https://www.acep.org/life-as-a-physician/career-center/negotiating-the-best-employment-contract/

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Member Engagement

- Objective A – Improve the practice environment and member well-being.

Fiscal Impact

Budgeted committee and staff resources to develop new policy statements and/or revise existing policy statements. Unknown potential legal costs depending on the number of cases that ACEP would "support."

Prior Council Action

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. 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 2021, discussed the emergency medicine workforce data that was presented at the Emergency Medicine Workforce Summit held earlier that day.

January 2021, discussed the preliminary report of the emergency medicine workforce data from the Emergency Physician Workforce Task Force.

April 2021, approved the revised policy statement "Emergency Physician Rights and Responsibilities;" revised and approved October 2015, April 2008, and July 2001; originally approved September 2000.

June 2020, approved revisions to "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" policy statement, revised June 2013 as "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department", originally approved as "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" January 2007 by replacing two policy statements "Guidelines on the Role of Physician Assistants in the Emergency Department" and "Guidelines on the Role of Nurse Practitioners in the Emergency Department."

June 2020, filed the final report of the Emergency PA/NP Utilization Task Force.

October 2019, reviewed an interim report from the Emergency NP/PA Utilization Task Force.

August 2018, approved the final report from the ACEP Board Emergency Medicine Workforce Workgroup and initiated the recommendations therein to appoint a task force to consider the evolution of the role and scope of practice of advanced practice providers (APP) in the emergency department (ED).

June 2011, approved the Emergency Medicine Practice Committee's recommendation that ACEP not conduct a survey to determine the state of NP practice in emergency care and to take no further action on Resolution 27(10) Emergency Department (ED) Staffing by Nurse Practitioners.

Background Information Prepared by: Sandy Schneider, MD, FACEP
Senior Vice President, Clinical Affairs

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 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: 78(21)

SUBMITTED BY: Florida College of Emergency Physicians
Diversity, Inclusion, & Health Equity Section

SUBJECT: In Memory of Leon L. Haley, Jr., MD, MHSA, CPE, FACEP, FACHE

WHEREAS, Leon L. Haley, Jr., MD, MHSA, CPE, FACEP, FACHE, was an active member of the American College of Emergency Physicians and an outstanding servant leader who provided high quality and compassionate care throughout his career; and

WHEREAS, Dr. Haley was a past Executive Associate Dean for Clinical Services and Chief Medical Officer for Emory Medical Care Foundation; and

WHEREAS, Dr. Haley rose to the position of Senior Vice President for Medical Affairs and Chief of Emergency Medicine Affairs at Emory University-Grady Hospital; and

WHEREAS, Dr. Haley was the first African American Dean and Vice-President of Health Affairs for the University of Florida College of Medicine-Jacksonville; and

WHEREAS, Dr. Haley was the first African American appointed CEO of UF Health Jacksonville, a major academic health science center; and

WHEREAS, Dr. Haley served as a board member of the Accreditation Council of Graduate Medical Education, the American Board of Emergency Medicine, and the Society of Academic Emergency Medicine; and

WHEREAS, Dr. Haley served on the Institute of Medicine Committee on Health Insurance Status; and

WHEREAS, Dr. Haley was a member of the American College of Healthcare Executives, the American College of Physician Executives, and the National Association of Health Services Executives; and

WHEREAS, Dr. Haley served in leadership/volunteer positions for a number of professional, business, national, and local organizations during his career and received several honors and awards; and

WHEREAS, Dr. Haley served as an outstanding role model for under-represented minorities in emergency medicine and an advocate for serving the most vulnerable and promoting diversity, equity, and inclusion throughout his career; and

WHEREAS, Dr. Haley was a skilled bridge-builder who transformed people, organizations, and communities by creating a vision that inspired all who interacted with him; and

WHEREAS, Dr. Haley was a dedicated and devoted father, colleague, and friend who inspired all of those who knew him; therefore be it

RESOLVED, That the American College of Emergency Physicians remembers with honor and appreciation the accomplishments and contributions of a gifted emergency physician, Leon L. Haley, Jr., MD, MHSA, CPE, FACEP, FACHE, and extends condolences and gratitude to his parents Leon and Elizabeth Ann, his children Grant, Wesley, and Nichelle, his sister Lisa, family, friends, and colleagues for his remarkable service to the specialty of emergency medicine, patient care, and the communities he served so well.

American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

Memorandum

To: 2021 Council

From: Sonja Montgomery, CAE
Governance Operations Director

Date: September 22, 2021

Subj: Compensation Committee Report

The Compensation Committee has not yet developed their recommendations for Board member and officer stipends for FY 2021-22. The committee will hold a conference call soon to discuss their recommendations. The committee's recommendations will be discussed by the Board at their meeting on October 22. The Compensation Committee's report will be distributed to the Council as soon as it is available. The Council will also be informed if the Board does not adopt the Compensation Committee's recommendations.

The basis for the Compensation Committee resides in the ACEP Bylaws, Article XI – Committees, Section 7 – Compensation Committee:

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

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

The current officer and non-officer stipends are:

President	$139,933
President-Elect	$101,759
Chair	$ 33,713
Vice President	$ 33,713
Secretary-Treasurer	$ 33,713
Immediate Past President	$ 33,713
Speaker	$ 33,713
Vice Speaker	$ 17,371
Non-Officer Board Members	$ 10,428

HEADQUARTERS
Post Office Box 619911
Dallas, Texas 75261-9911

4950 W Royal Ln
Irving, TX 75063-2524

972-550-0911
800-798-1822
www.acep.org

American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

President-Elect Candidates

Scientific Assembly BOSTON 21

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2021 President-Elect Candidates

Christopher S. Kang, MD, FACEP

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer
- CV

Aisha T. Terry, MD, MPH, FACEP

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer
- CV

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2021 PRESIDENT-ELECT CANDIDATE WRITTEN QUESTIONS

Christopher S. Kang, MD, FACEP, FAWM

Question #1: **What is your view of ACEP's strategy regarding workforce, scope of practice, and College sustainability?**

ACEP's current framework of workforce considerations established the necessary initial strategy to mitigate the projected surplus of emergency physicians by 2030 as well as the foundation for our specialty's evolution and sustained success. As the Board of Directors liaison to the Emergency Physician Assistant/Nurse Practitioner Utilization and Emergency Medicine Workforce Task Forces, I ensured that physicians remain the leaders of the care team and are not to be treated as replaceable by other degrees.

Emergency medicine became a leader in the house of medicine because our founders and the College fought together for their patients and specialty. However, as experienced by other specialties, the emergency medicine workforce could not grow unbridled indefinitely. The COVID-19 pandemic served as a stress test, accelerated this maturation process, and exposed needed changes. We have further lost ground as we have had to stand on the defensive from both outside of and within our ranks. Instead of assigning blame, ACEP stepped up and moved forward with organizations wishing to collaborate on solutions.

Since chairing the 2018 workgroup that recommended the task forces and the inclusion of all emergency care organizations, I have increasingly gained essential awareness of the issues we face every day. Because of my service on both task forces, I now have critical knowledge of past, current, and potential future workforces and the opportunities for continued partnership with the other stakeholder organization. It is with this unique insight that I helped define the core tenets of the current framework of workforce considerations, including,

- uphold the incontrovertible expertise and role of emergency physicians as THE leaders of the emergency care team;
- promote quality-controlled emergency medicine residency training programs – continue to recruit the best and provide them with the contemporary clinical, administrative, operational, advocacy, and leadership skills to succeed;
- support emergency physicians in whatever setting they are employed – inside and outside the emergency department, rural to urban, emergency medicine to subspecialty, clinical to education to administration, and contractor to employee to partner;
- transform emergency care to better meet the needs of our patients, communities, and professions – expand and enhance patient access to the full spectrum of specialized acute care provided, coordinated, and led by emergency physicians; and
- ensure that business interests do not supersede patient care – the needs of patients and the workforce must be reprioritized.

But strategies must adapt over time as transformation is not often rapid or easy. As the emergency medicine workforce will be a principal issue for years to come, we must proactively advance our strategy to sustain the integrity, health, and success of our specialty. These subsequent steps will be challenging as we navigate dynamic market forces, and engage stakeholders outside of our profession. As the team leader, we must fulfill several additional inherent responsibilities, including,

- procure sufficient resources, opportunities to thrive, and healthier, supportive, and more secure environments for us, our team, and our patients;
- advocate that emergency physicians are equitably employed by groups, hospitals, healthcare systems, and government agencies, and valued by the healthcare community and the public to include fair reimbursement;
- challenge the monopolization of health care services by hospital systems as well as insurers; and
- include those non-physician providers committed to emergency care as members of our team, and engage in their training, hiring and credentialing, onboarding, clinical practice, and continuing education.

At this next turning point in our history, we have a prodigious opportunity to once again define emergency medicine and forge ahead. To do so, we must reaffirm our common belief in each other, commit to our leadership role and responsibilities, and fight together with our College for our patients and the advancement of our workforce and specialty.

Question #2: **Given the challenges facing emergency physicians, how will you lead the transformation of our specialty to continue making use of our unique skill sets and expertise in alternate care delivery models?**

After years of prosperity, emergency medicine stands at a watershed moment as we face a number of external and internal challenges from other competing healthcare stakeholders. Because of this increasing opposition, some of our colleagues have become disheartened and disillusioned. For its future success, our specialty must continue to grow. However, our College needs a leader who understands that this growth can no longer occur simply through further expansion. Emergency medicine needs to evolve the

scope of care and work it provides. I am that leader who has the requisite personal and professional principles, experience, familiarity with the current and future capabilities of our organization, and the vision and strategy to transform our specialty to better utilize our unique skill sets and meet the needs of our patients.

- My personal principles include integrity, preparedness, collaboration, and respecting others' perspectives coupled with passion and devotion to our specialty. Professionally, I believe in servant leadership, accountability, and stewardship.
- I have sponsored innovation through the first Scientific Assembly experience in Seattle, Code Black and InnovatED, five new sections, Limited Resource Chapter workgroup, chapter leader orientation program, COVID EngagED platform, and, most recently, the reassessment and modernization of the leadership culture and operations of your Board of Directors.
- I have served at every level of College leadership, from chapter president, section officer. committee chair, workgroup leader, task force liaison, representative to other specialty organizations, to national treasurer, and I am the current Chair of your national Board of Directors and the only current Board member with this experience.

I will effect three changes to transform the utilization of our unique skill sets and expertise in alternate care delivery models.

- Our identity and mindset as we continue to celebrate our diversity, but also reaffirm our common belief in each other and founding principles, and commit to our leadership role and responsibilities;
- Our organization as we modernize the mission, operations, communications, chapter relations and support, and leadership culture and development of the professional and advocacy resource we share and lead; and
- Our specialty as it must evolve to better meet the future needs of our patients, communities, and workforce by embracing and leading the coordination of care from prehospital access through post-acute care follow-up.
    - Staying true to its roots, emergency departments will continue to serve as the "healthcare system's safety net"
    - With expanded resources and responsibilities, emergency departments will become the new "setting" that leads the modern "coordination of care among multiple clinicians and community resources"
    - Instead of filling in gaps, we should proactively redefine, delineate, and govern the full spectrum of acute outpatient care, which will then enable us to establish what we and our patients need, determine the most constructive metrics, and improve employment and career opportunities.
        - Prehospital and paramedicine, including physicians in the field similar to practices in France and Japan,
        - Urgent care clinics and freestanding emergency departments,
        - Telehealth – from triage to non-physician consultation and oversight to transfers,
        - Observation units,
        - Improved collaboration with hospitalists – the coordinators of inpatient care,
        - Regionalization of medical operations,
        - Transitional services – such as those emerging for substance use disorders and needed for mental health,
        - Post-emergency department follow-up clinics, and
        - Hospital administration and public health, exemplified by several colleagues leading government agencies.

Question #3: **How do you advance the planned initiatives of the College in the face of volatile legislative, regulatory, and public health threats?**

As emergency medicine issues grow in number and complexity, I believe strongly that key principles can drive our renewed focus, dedication, and advocacy to better navigate volatile legislative, regulatory, and public health threats.

First, steadfast commitment to our patients and to our credentials as the best educated, trained, and qualified to provide and coordinate acute care, and the leaders of the emergency care team.

Next, core organizational values that include,

- Clarity – mission, vision, and conduct;
- Character – integrity, preparedness, leading by example, accountability, and stewardship;
- Culture – collegiality, diversity, chapter relations, mentorship, and leadership development;
- Communication – to those within and outside of the College; and
- Collaboration – an inherent responsibility of being the team leader and because if we do not stand and work together, we will ultimately fail our patients, ourselves, and our future.

And, courage of our convictions because our shared commitment and values are just. Although differing perspectives will always be welcome and enrich discussions, they should not eclipse our commonalities. Furthermore, we cannot continue to be sensitized to and bullied by specious critics and allow the tail to wag the dog.

We must resume proactively charting our own course to do what we believe is right, the right way, and for the right reasons.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DATA SHEET

Christopher S. Kang, MD, FACEP, FAWM

Contact Information

2184 Bobs Hollow Lane, DuPont, WA 98327
Phone: Residence: (253) 964-1445; Cell: (253) 677-4247
E-Mail: Christopher.s.kang@gmail.com

Current and Past Professional Position(s)

Clinical/Academic
Attending Physician, Core EM Residency Faculty, 2001-Current
Madigan Army Medical Center
Joint Base Lewis-McChord, WA

Attending Physician, 2007-Current
Olympia Emergency Physicians, PLLC
Providence St. Peter Hospital
Olympia, WA

Assistant Professor, Clinical, 2006-Current
Department of Emergency Medicine
University of Washington

Assistant Professor, Adjunct, 2008-Current
Military and Emergency Medicine
Uniformed Services University of the Health Sciences

Associate Professor, 2018-Current
Physician Assistant Program
Baylor University

Attending Physician, 2004-2005
Mt. Rainier Emergency Physicians, PLLC
Good Samaritan Hospital
Puyallup, WA

Attending Physician, 2000-2001
Emergency Medical Services
121st General Hospital
U.S. Army Yongsan Garrison
Seoul, Republic of Korea

Military
52nd Medical Battalion
Battalion (Flight) Surgeon
U.S. Army Yongsan Garrison
Seoul, Republic of Korea

Joint Task Force Bravo
Flight Surgeon/Emergency Treatment Physician
Soto Cano Air Base, Honduras

U.S. Army's First Stryker Brigade
296th Brigade Support Battalion, 1-14 Cavalry Squadron, 5-20 Battalion
Samarra and Tal 'Afar, Iraq

Education (include internships and residency information)

Undergraduate: 1993, Northwestern University, Evanston, IL
Weinberg College of Arts and Sciences
Bachelor of Arts, History

Graduate: 1996, Northwestern University, Chicago, IL
Feinberg School of Medicine
Doctor of Medicine

Residency: 2000, Northwestern University, Chicago, IL
Emergency Medicine (PGY1-4)

Specialty Board Certifications (e.g., ABEM, AOBEM, AAP, etc.) and dates certified and recertified)

American Board of Emergency Medicine: 2001, 2011, 2021

Professional Societies

American College of Emergency Physicians
- Washington Chapter
- Government Services Chapter

American Academy of Emergency Medicine
American Medical Association
- Washington State Medical Association

Society of Academic Emergency Medicine
United States Army Society of Flight Surgeons
Wilderness Medical Society

National ACEP Activities – List your most significant accomplishments

BOARD OF DIRECTORS (2015-Current)

Office Position(s)
- Chair, 2020-2021
- Treasurer, 2019-2020
- Social Media Communications Group, Board Liaison, 2017-2019

Task Force
- Emergency Medicine Residency Engagement, Member, 2018-2020
- Board of Directors Work Group, EM Workforce, Chair, 2018
- Emergency Physician Assistant/Nurse Practitioner Utilization, Liaison, 2019-2020
- Emergency Medicine Physician Workforce, Liaison, 2019-2021

Committee Liaison
- Audit Committee, 2019-2020
- Finance Committee, 2019-2020
- Disaster Preparedness and Response Committee, 2015-Current
- Ethics Committee, 2017-2019

Section Liaison
- Aerospace Medicine Section, 2019-Current
- Air Medical Transport Section, 2017-Current
- Disaster Medicine Section, 2015-Current
- Event Medicine Section, 2017-2019
- Undersea and Hyperbaric Medicine Section, 2017-2019
- Wilderness Medicine Section, 2015-Current

Chapter Visits
- Coastal Conference (GA, NC, SC), EMerald Coast Conference (AL, AR, LA, MO, MS, TN), GS, HI, NM, Symposium by the Sea/FL, TX

Residency Visits
- IL, MI, NY

Other Organizations
- American College of Surgeons Committee on Trauma, Liaison, 2016-Current
- Emergency Medicine Foundation, Board of Trustees, 2020-Current
- National Trauma Institute, Board of Directors, 2018-2020

Other Activities
- Annals of Emergency Medicine, Manuscript Reviewer, 2013-Current
- Leadership and Advocacy, Faculty/Presenter, 2018
- ACEP16, Faculty/Presenter, 2016
- Code Black, InnovatED, 2015-2017
- National Chapter Relations Committee, Member, 2014-2015
- Disaster Preparedness and Response Committee, Chair, 2013-2015
- Disaster Medical Section, Chair Elect, 2013-2015
- Steering Committee, Member, 2013-2014
- Council Resolution Committee, Member, 2012
- Emergency Medicine Basic Research Skills Course, Advisor, 2012-Current
- Disaster Preparedness and Response Committee, Member, 2010-2015
- Project Medical Director/Site Survey Team/Faculty Moderator, Department of Homeland Security Community Healthcare Disaster Preparedness Assessment, 2006-2012

ACEP Chapter Activities – List your most significant accomplishments
Washington Chapter
- Officer: Secretary/Treasurer, President Elect, President, Immediate Past President (2011-2015)
- Board of Directors: 2010-Current
- Councillor: 2010-2015
- Education Committee: 2010-Current

Practice Profile
Total hours devoted to emergency medicine practice per year: **2040** Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.
Direct Patient Care **70** % Research **5** % Teaching **20** % Administration **5** %
Other: _____ %

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)
Madigan Army Medical Center, Department of Emergency Medicine, Tacoma, WA
- Federal Employee, Staff Attending Physician
- Single Hospital – Defense Health Agency Medical Facility
  - Tertiary/Regional Medical Center
  - Washington State Level II Trauma Center
  - STEMI Center
- Core Faculty Member, Residency in Emergency Medicine
- Faculty Advisor, Physician Assistant Fellowship Program in Emergency Medicine

Olympia Emergency Physicians, PLLC, Providence St. Peter Hospital, Olympia, WA
- Part-Time Employee, Attending Physician
- Single Emergency Department/Hospital Group
  - Washington State Level III Trauma Center

- Washington State STEMI Center
- Washington State Stroke 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.)

Madigan Army Medical Center

Current Position(s)
- Core Faculty, Residency in Emergency Medicine
- Institutional Review Board
- ALS Instructor
- PALS Instructor

Past Position(s)
- Research Director, Residency in Emergency Medicine, 2006-2015
- Residency Order of Merit Selection Committee, 2006-2014
- Pandemic Influenza Committee, 2005-2007
- Patient Decontamination, Chair, 2003
- Assistant Chief of ED Operations, 2002-2003
- Physician, NBC Special Medical Augmentation Response Team, 2002-2003
- Safety/Environment of Care Committee, 2001-2003
- Patient Safety Committee, 2001-2003

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 DISCLOSURE STATEMENT

Christopher S. Kang, MD, FACEP, FAWM

1. Employment – *List current employers with addresses, position held and type of organization.*

Employer: Department of the Army, Madigan Army Medical Center
Address: 9040A Jackson Avenue
Joint Base Lewis McChord, WA 98431
Position Held: Attending Physician
Type of Organization: Defense Health Agency / Regional Medical Center

Employer: Olympia Emergency Physicians, PLLC
Address: 415 Lilly Road NE
Olympia, WA 98506
Position Held: Attending Physician
Type of Organization: PLLC, Single Emergency Department/Hospital Group

2. Board of Directors Positions Held – *List all organizations and addresses for which you have served as a board member – including ACEP chapter Board of Directors. Include type of organization and duration of term on the board.*

Organization: American College of Emergency Physicians - Board of Directors
Address: 4950 W. Royal Lane
Irving, TX 75063-2524
Type of Organization: Medical Specialty Professional Society/Organization
Duration on the Board: 2015-Current

Organization: Washington Chapter, ACEP – Board of Directors
Address: 2001 6th Ave, Ste 7200
Seattle, WA 98121
Type of Organization: Medical Specialty Professional Society/Organization
Duration on the Board: 2011-Current

Organization: National Trauma Institute

Address: 9901 IH West, Suite 720

San Antonio, TX 78230

Type of Organization: 501(c)3 Nonprofit Corporation – Trauma Research

Duration on the Board: 2018-2020

Organization: Emergency Medicine Foundation

Address: 4950 W. Royal Lane

Irving, TX 75063-2524

Type of Organization: 501(c)3 Nonprofit Corporation – Emergency Medicine Research

Duration on the Board: 2020-Current

I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

☒ NONE
☐ If YES, Please Describe:

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) a an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☒ NONE
☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☒ NONE
☐ If YES, Please Describe:

5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE
☐ If YES, Please Describe:

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO
☐ If YES, Please Describe:

I certify that the above is true and accurate to the best of my knowledge:

Christopher S. Kang Date 9 July 2021

July 5, 2021

RE: Endorsement for Christopher Scott Kang, MD, FACEP
President Elect

Dear Councillors:

The Washington Chapter of the American College of Emergency Physicians (WA-ACEP) and Disaster Medicine Section of ACEP would like to provide our wholehearted support of **Christopher Scott Kang, MD, FACEP** for national ACEP President-Elect. It is without reservation and with considerable enthusiasm that we endorse Dr. Kang's candidacy, as we know his leadership skills, exceptional ability to collaborate, and extreme poise, will immensely benefit our college.

Dr. Kang's involvement in ACEP is nothing short of thorough. He is currently finishing a year as Chair of the Board, a position in which he led with reason and steadfast direction. He previously served in many roles, including Chair of the Disaster Preparedness and Response Committee, the National Chapter Relations Committee, and member of the Disaster Medicine Section/ Chair-Elect from 2013-2015, at which time he was elected to the ACEP Board of Directors. He also serves as the ACEP Board Liaison for the Disaster Committee, as well as sections of Disaster Medicine, Air Medical Transport, Wilderness Medicine, Event Medical and others. He was instrumental as a section leader in the success of the ACEP Disaster Section Code Black production in 2015-2017 and navigated financial storms first as WA-ACEP Treasurer, then as Treasurer for National ACEP during Covid. Having accomplished so much in these roles, Dr. Kang is ready for more challenges.

Dr. Kang's career spans more than 20 years, ranging from military service to community and academic medicine. He has served as a bedside ED physician, Flight Surgeon, and as an Associate Professor of Emergency Medicine. Dr. Kang has currency on issues in EM and speaks eloquently on the nuances and history of our college. As a colleague, he is approachable and engaging, striving to find opportunities for all who yearn to achieve. We are still facing the economic and emotional toll of Covid, including workforce concerns. In addition, Emergency Medicine is again facing assaults on the position and place of our specialty in the house of medicine. In this climate of stress and uncertainty, Dr. Kang is a natural and much needed presence, made evident through his demonstrated leadership skills, innovation in multiple sections and committees, and on the Board for ACEP.

Dr. Kang's deep involvement in ACEP shows a strong enthusiasm for the college, and his success in these varied positions demonstrates an aptness for leadership. It is rare to find a combination of these attributes in an individual and it is what makes Dr. Kang uniquely qualified for President-Elect.

While he is dynamic in his qualifications, what elevates Dr. Kang as the epitome of valued leadership is team building. Throughout his involvement with ACEP, Dr. Kang has stood out in his ability to build and mentor amazing teams, thereby elevating and supporting those around him. Additionally, his one-on-one mentoring skills are par none. He has worked closely with six Horizon Award winners in their early years and has coordinated and nominated the last 3 winners of the ACEP Team award.

WA-ACEP's rise in recent years in leading National ACEP's policies & esteem, is very much attributed to Dr. Kang's ability to facilitate connection and communication while establishing excellent morale. This quality made him an asset to the ACEP Workforce Task Force, where he helped produce recommendations around controversial topics by motivating diverse groups to work together. ***To be led by Dr. Kang is to be empowered, motivated and unified.***

We welcome the opportunity to talk with you to discuss our enthusiastic support of Dr. Chis Kang to serve as ACEP President-Elect. We are proud to stand behind him as he aims to advance Emergency Medicine through our valuable organization.

Sincerely,

C. Ryan Keay

C. Ryan Keay, MD, FACEP
WA-ACEP President

Kathy Lehman-Huskamp

Kathy Lehman-Huskamp, MD, FACEP, FAAP
Chair ACEP Disaster Section

Christopher S. Kang, MD, FACEP, FAWM

Dear Colleagues,

In my final year of service on your Board of Directors, it is a privilege to be a candidate for your next President Elect.

After a challenging year for each of you, your vote will set the tone and the next steps in the history and future of our College as we are confronted by a number of external and internal challenges not previously faced.

The following three concepts have been hallmarks of my service, and will attest to my continued leadership over the next three years.

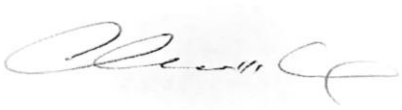
Integrity. I base every decision upon my unwavering belief in you, emergency physicians. I value every idea and treat everyone with respect. As a result, I will not ask you to complete an assignment without sufficient guidance and resources. When successful, you receive the credit. When not successful, it is my responsibility.

Experience. I have served at every level of College leadership thus far – chapter president, section officer, committee chair, workgroup chair, task force liaison, representative to other professional organizations, national Secretary/Treasurer, and, currently, the Chair of your national Board of Directors. I know the expertise of the staff and each Board member as well as the current strengths and limitations of our College. I know how we can operate better.

Opportunity. I always seek to be proactive, collaborate, and move forward. Although we face unprecedented uncertainty, I believe that we have a remarkable opportunity to evolve and become stronger and more vibrant. To do so, our College needs a leader who will reaffirm our founding principles and common belief in each other, reassess our College's mission and priorities, and has the vision and a plan for us to redefine emergency medicine and navigate a brighter future.

With your vote and my leadership, the College will become better prepared to face on-going and future, even unforeseen, challenges and will emerge with renewed focus and dedication, increasingly efficient operations, and a more effectual leadership culture that will foster continued and greater successes for the next decade.

Sincerely,



Christopher Kang, MD, FACEP, FAWM

INTEGRITY. EXPERIENCE. OPPORTUNITY.

CHRISTOPHER KANG

MD, FACEP, FAWM

for President-Elect
2021 ACEP Board of Directors

REDEFINING EMERGENCY MEDICINE
FOR THE FUTURE.

KEY

- = PAST
- = PRESENT
- = FUTURE

CHAPTER-NATIONAL RELATIONSHIP

- Member of the Limited Chapter Resources Work group
- Diligently Monitoring the Impact of COVID-19
- Improve Communication and Mentorship

COLLEGE

- Member of 12 Sections/5 Committees
- Immediate Past Treasurer and Current Chair of the Board
- With Executive Director, advance Staffing and Member-Centric Operations

COLLABORATION

- Supported past six Council Teamwork Award Recipients
- Liaison to ACS COT and Partner with ENA
- Strengthen partnerships with AMA, ENA, and EM organizations

CULTURE

- Counseled by Past Leaders, Young Physicians, and Residents
- Liaison to NP/PA and EP Workforce Task forces
- Foster and Synergize Leadership at Section, Chapter, and Board Levels

2184 BOB'S HOLLOW LANE • DUPONT, WA 98327
PHONE (253) 964-1445
E-MAIL(W): CHRISTOPHER.S.KANG.CIV@MAIL.MIL
E-MAIL(P):CHRISTOPHER.S.KANG@GMAIL.COM
NOVEMBER 2020

CHRISTOPHER S. KANG

EDUCATION

2001, 2011 American Board of Emergency Medicine
Board Certification in Emergency Medicine

1996 – 2000 Northwestern University Medical School Chicago, IL
Accredited Residency in Emergency Medicine

1992-1996 Northwestern University Medical School Chicago, IL
Accredited Medical School, Doctor of Medicine

1989-1996 Northwestern University Evanston & Chicago, IL
Honors Program In Medical Education, Bachelor of Arts

LICENSURE AND CERTIFICATIONS

Medical License, Washington	2003 – Pres
Medical License, Illinois	1996 - Pres
Basic /Advanced Disaster Life Support (Instructor)	2008 - 2010
Advanced Wilderness Life Support (Instructor since 2008)	2007 – Pres
Advanced Cardiac Life Support (ACLS Instructor since 2000)	1996 – Pres
Advanced Pediatric Life Support (Instructor since 2000)	1996 – Pres

PROFESSIONAL EXPERIENCE

Current Employment (Military)
Madigan Army Medical Center (MAMC) 2001 – Pres
Department of Emergency Medicine, Attending Physician
Tacoma, Washington

Positions and Responsibilities

- Residency Core Faculty/Attending and Resident Advisor 2001 – Pres
- Residency Research Director 2006 - 2015
- Institutional Review Board 2006 – Pres
- Residency Order of Merit Selection Committee 2006 – 2014
- Institution Pandemic Influenza Committee, Member 2005 – 2007
- Institution, Patient Decontamination Subcommittee, Chair 2003
- Assistant Chief, ED Operations 2002 - 2003
- Acute Care Physician, Western Regional Medical Command 2002 - 2003
  NBC Special Medical Augmentation Response Team
- MAMC Safety/Environment of Care Committee 2001 - 2003

- MAMC Patient Safety Committee 2001 – 2003

Current Employment (Civilian)

Providence St Peter Hospital, Attending Physician 2007 – Pres
Olympia, Washington

Current Faculty Appointments

Associate Professor, Physician Assistant Program 2018 – Pres
Baylor University

Assistant Professor, Adjunct, Military and Emergency Medicine 2008 - Pres
Uniformed Services University of the Health Sciences

Assistant Professor, Clinical, Emergency Medicine 2006 – Pres
University of Washington

Previous Faculty Appointments

Assistant Professor, Physician Assistant Program, Baylor 2008 - 2018
Baylor University

Clinical Instructor, Military and Emergency Medicine 2002 - 2006

Previous Employment (Civilian)

Good Samaritan Hospital, Attending Physician 2004 - 2005
Puyallup, Washington

Other Employment (Military)

U.S. Army's First Stryker Brigade 2003 - 2004
296th Brigade Support Battalion, 1-14 Cavalry Squadron, 5-20 Battalion
Samarra & Tal'Afar, Iraq - Operation Iraqi Freedom

Joint Task Force-Bravo 2002
Flight Surgeon, Emergency Treatment Physician
Soto Cano Air Base, Honduras

121st General Hospital 2000 - 2001
Emergency Medical Services Attending Physician
Yongsan Garrison, Seoul, Republic of Korea

52nd Medical Battalion 2000 - 2001
Battalion (Flight) Surgeon
Yongsan Garrison, Seoul, Republic of Korea

ADDITIONAL PROFESSIONAL AND LEADERSHIP POSITIONS AND ACTIVITIES

Leadership

American College of Emergency Physicians (ACEP)

- Board of Directors 2015 - Pres
- Board of Directors, Chairperson 2020 - Pres
- Board of Directors, Secretary/Treasurer 2019 – 2020
- Board of Directors, Liaison, Audit Committee 2019 - Pres
- Board of Directors, Liaison, Finance Committee 2019 - Pres
- American College of Surgeons Committee on Trauma, Liaison 2016 - Pres
- Board of Directors Liaison, Disaster Preparedness and Response 2015 - Pres
- Board of Directors Liaison to Ethics Committee 2017 - 2019
- Council Steering Committee 2013 - 2014
- Disaster Preparedness and Response Committee, Chair 2013 - 2015
- Disaster Preparedness and Response Committee 2010 – 2015
- National Chapter Relations Committee 2014 - 2015
- Disaster Medicine Section, Chair Elect 2013 - 2015
- Council Resolution Committee C 2012
- Disaster Medicine Section, Secretary 2011 - 2013
- Advisor, Emergency Medicine Basic Research Skills Course 2009 – Pres
- Site Survey Team, Faculty Moderator, Project Medicine Director 2006 - 2012
  Department of Homeland Security (DHS) Community Healthcare Disaster Preparedness Assessment (CHDPA)
- Emergency Medicine Basic Research Skills Course, Graduate 2008 – 2009
- Teaching Fellowship, Graduate 2007

Washington Chapter, American College of Emergency Physicians (WA ACEP)

- Immediate Past President 2014 - 2015
- President 2013 - 2014
- President-Elect 2012 - 2013
- Secretary-Treasurer 2011 – 2012
- Board of Directors 2010 – Pres
- Education Committee – Summit to Sound Northwest Emergency Medicine Assembly (S2S NEMA) 2008 - Pres
- Education Committee, Chair – S2S NEMA 2011 - 2012

Northwest Regional Healthcare Response Network

- Disaster Clinical Advisory Council 2013 – Pres

National Trauma Institute

- Board of Directors 2018 - Pres

ADDITIONAL PROFESSIONAL AND LEADERSHIP POSITIONS AND ACTIVITIES

Activities

American College of Emergency Physicians (ACEP)

- Disaster Medicine Forum, Leadership and Advocacy Faculty 2014
  Washington, D.C.
- ACEP-DHS Hospital Evacuation. Workgroup 2009
  Dallas, Texas
- CDC-ACEP In A Moment's Notice: Surge Capacity for Terrorist 2009
  Use of Explosives Workgroup
  Boston, Massachusetts
- ACEP and CDC Terrorism Injuries: Information, Dissemination, 2008
  Exchange (TIIDE) Project, Task Force
  Dallas, Texas

Annals of Emergency Medicine

- Manuscript Reviewer 2013 – Pres

Journal of Wilderness and Environmental Medicine (JWEM)

- Manuscript Reviewer 2008 – Pres

Western Journal of Emergency Medicine (WJEM)

- Section Co-Editor, Disaster Medicine 2007 – Pres
- Manuscript Reviewer 2007 – Pres

Wilderness Medical Society (WMS)

- Advanced Wilderness Life Support, Faculty 2007 - 2014
  Moab/Park City, UT; Chehalis/Mt. Rainier, WA; Whistler, Canada
- Advanced Wilderness Life Support, Course Director 2009
  Park City, UT

Department of Army (DA)

- Advanced Officer Course 2004
- US Army Safety Center Accident Investigation Board, Iraq 2004
- Flight Surgeon Primary Course Critical Task Selection Board 2003
- Medical Management of Chemical and Biological Casualties Course 2003
- Medical Effects of Ionizing Radiation 2003
- Primary Flight Surgeon Course 2000
- Officer Basic Course, Commander's List Graduate 1993

Department of Defense/Veterans Affairs (DoD/VA)

- Clinical Practice Guidelines Workgroup, Acute Stroke/TIA 2006
- Clinical Practice Guidelines Workgroup, COPD 2005

HONORS AND AWARDS

American Medical Association (AMA)

- Physician's Recognition Award w Commendation 2002, 2005, 2008, 2011, 2014

Annals of Emergency Medicine

- Top Manuscript Reviewer 2018, 2019

Department of the Army (DA)

- Civilian Achievement Award 2010
- Meritorious Service Medal 2004
- Army Commendation Award 2001, 2003, 2004
- Army Achievement Award 2001, 2002 x 3
- National Defense Service Medal 1993, 2011
- Global War on Terrorism Expeditionary Medal 2003
- Korean Defense Service Medal 2001
- Global War on Terrorism Service Medal 2001
- Combat Medical Badge 2004
- Flight Surgeon Badge 2000

Madigan Army Medical Center (MAMC)

- F.M. Burke Award – Outstanding Teacher 2002, 2015, 2018
  Emergency Medicine Residency 2002, 2015, 2018

Western Journal of Emergency Medicine (WJEM)

- Top Section Editor 2010
- Top Manuscript Reviewer 2009, 2010

Wilderness Medicine Society

- Academy of Wilderness Medicine, Fellow

PUBLICATIONS AND PRESENTATIONS

PEER REVIEWED

2020 Scott S, Langenohl R, Cristosomowynne T, Kang CS. Dorsal Vein Rupture Seen on Emergency Department Ultrasound Case. Western Journal of Emergency Medicine. (Clinical Image)

Tobin M, Hartline J, Sullivan S, Devita D, Kang C. Utility of Nonspecific Laboratory Testing for Psychiatric Patients Undergoing Medical Screening in a Military Emergency Department. J Mil Med (Study)

Miller GA, Buck CR, Kang CS, Aviles JM, Younggren BN, Osborn S, Keay CR. COVID-19 in Seattle – Early Lessons Learned. J ACEP Open. (Concepts)

Couperus K, Young S, Walsh R, Kang C, Skinner C, Essendrop R, Fiala K, Phelps J, Sletten Z, Esposito MT, Bothwell J, Gorbatkin C. Immersive Virtual Reality Medical Simulator: Autonomous Trauma Training Simulator. Cureus. (Study)

Schmitz GR, McNeilly C, Hoebee S, Blutinger E, Fernandez J, Kang C, Schneider S. Cardiopulmonary Resuscitation and Skill Retention in Emergency Physicians. Am J Emerg Med. (Study)

2019 Couperus K, Kmiecik K, Kang C. IV DripAssist: An Innovative Way to Monitor Intravenous Infusions Away From An Outlet? J Mil Medicine (Study)

2018 Booms Z, Stein J, Kang C, Rosenberg M. Interim Safety Analysis: Intravenous Lidocaine versus Ketorolac for Known or Suspected Renal Colic. Annals of Emergency Medicine, Research Forum Supplement (Study - Abstract)

Cornelius A, Knox A, Ajayi R, Cvek U, Cornelius B, Kilgore P, Trutschl M, Kang C. What and How are EM Residents Being Taught to Respond to the Next Disaster? American Journal of Disaster Medicine. (Study)

2017 Couperus K, Kmicek K, Kang C. A Better Way to Monitor Intravenous Infusions Away from an Outlet. Annals of Emergency Medicine, Research Forum Supplement. (Study - Abstract)

2016 Weyand J, Junck E, Heiner J, Kang CS. Emergency Department Security: Violent Events and Anticipated Surge Capabilities of Emergency Departments in Washington State. Western Journal of Emergency Medicine. (Study)

Moffett PM, Cartwright L, Grossart EA, O'Keefe D, Kang CS. Intravenous Ondansetron and the QT Interval in Adult Emergency Department Patients: An Observational Study. Acad Emerg Med. (Study)

Hansoti B, Kellogg DS, Aberle S, Broccoli MC, Feden J, French A, Little CM, Moore B, Sabato Jr MD, Sheets T, Weinberg R, Elmes P, Kang C. Preparing Emergency Physicians for Acute Disaster Response: A Review of Current Training Opportunities in the US. Prehospital and Disaster Medicine. (Review Article)

2015 Meyers L, Frawley T, Goss S, Kang C. Ebola Virus Outbreak 2014: Clinical

Review for Emergency Physicians. Annals of Emergency Medicine. (Review Article)

2014 Cookman L, Bothwell J, Laselle B, Skinner C, Della-Giustina D, Kang CS. Impact of Decontamination Therapy of Ultrasound Visualization of Ingested Pills. Western Journal of Emergency Medicine. (Study–Publication).

Weyand J, Junck E, Heiner J, Kang CS. ED Security in WA State. Annals of Emergency Medicine, Research Supplement. (Abstract)

2013 Walsh R, Heiner J, Kang C, Hile D, Deering S. Emergency Physician Evaluation of a Novel Surgical Cricothryoidotomy Tool in Simulated Combat and Clinical Environments. Journal of Military Medicine. (Study)

Patterson J, Seeley E, Walsh R, Kang C. Delayed Presentation of an Alkali Corneal Injury. Annals of Emergency Medicine. (Clinical Image)

Matlock AG, Cashin B, Reynolds P, Wills BK, Kang CS. Effect of Hydroxocobalamin on Surface Oximetry. Prehospital and Disaster Medicine. (Study)

Hartline J, Mierek C, Knutson T, Kang C. Hantavirus Infection in North America: A Clinical Review. The American Journal of Emergency Medicine. (Review Article)

2012 Gower L, Gatewood M, Kang CS. Emergency Department Management of Delirium in the Elderly. Western Journal of Emergency Medicine. (Review Article)

Walsh R, Harper H, McGrane O, Kang C. Too Good to be True? Our Experience with the Cunningham Method of Dislocated Shoulder Reduction. American Journal of Emergency Medicine. (Correspondence)

2011 Hopkins G, McGrane O, Nielson A, Kang CS. Procedural Sedation with Propofol: A Retrospective Review of the Experiences of an Emergency Medicine Program 2005-2010. American Journal of Emergency Medicine. (Study)

Simmons J, Cookman L, Kang C, Skinner C. Three Cases of "Spice" Exposure. Clinical Toxicology. (Case Series)

Matlock AG, Allan N, Wills BK, Kang CS, Leikin G. A Continuing Black Hole? The FDA Boxed Warning: An Appeal to Improve Its Clinical Utility. Journal of Clinical Toxicology. (Correspondence)

Simmons J, Williams J, Skinner C, Schwartz MD, Wills BK, Kang CS. Intoxication from Smoking 'Spice'. Annals of Emergency Medicine. (Correspondence)

2010 Moffett P, Baker B, Wills BK, Kang CS. Topical Patient Decontamination. Journal of Military Medicine. (Study)

Jones RA, Wills BK, Kang CS. Chlorine Gas: An Evolving Hazardous Material Threat and Unconventional Weapon. Western Journal of Emergency Medicine. (Article)

Um D, Heiner J, Kang CS. Spinal Arachnoid Cyst as an Atypical Insidious Cause of Back Pain. American Journal of Emergency Medicine. (Case Report)

Stone J, Knutson T. Kang CS. Renal Failure Secondary to Bilateral Renal Stones. American Journal of Emergency Medicine. (Case Report)

Allan N, Cashin B, Kang CS. Wells Syndrome. Western Journal of Emergency Medicine. (Clinical Image)

Heiner JD, Dunbar JL, Harrison T, Kang CS. Current Emergency Medicine Residency Education of Documentation, Coding, and Reimbursement: Fitting the Bill? Annals of Emergency Medicine, Research Supplement. (Abstract)

Cashin BV, Matlock AG, Kang CS, Reynolds PS, Wills BK. Effect of Hydroxocobalamin on Surface Oximetry in Non-Exposed Humans. Annals of Emergency Medicine, Research Supplement. (Abstract)

Smith SB, Kang CS, Kuykendall W. The Practicality of Backcountry Water Purification Units for Wound Irrigation. Journal of Wilderness and Environmental Medicine. (Abstract)

2009 Johnson J, McBride DF, Crandall S, Kang C. Ultrasound Confirmed Frontal Bone Fracture. Western Journal of Emergency Medicine. (Clinical Image)

Moffett P, Baker B, Wills BK, Johnson M, Kang CS. Topical Patient Decontamination. Annals of Emergency Medicine, Research Supplement. (Abstract)

2008 Merchant EE, Johnson SW, Nguyen P, Kang CS, Mallon WK. Takotsubo Cardiomyopathy: A Case Series and Review of the Literature. Western Journal of Emergency Medicine. (Case Series)

Mazzoncini J, Crowell CB, Kang CS. Human Metapneumovirus, Journal of Emergency Medicine. (Review Article)

2007

2006 Nielson AS, Kang CS. Strangulation, Annals of Emergency Medicine. (Clinical Image)

2005 Ashworth SW, Levsky M, Marley C, Kang CS. Bradycardia-Associated Torsades de Pointes and the Long-QT Syndromes – A Case Report and Review of the Literature. Journal of Military Medicine (Case Report).

Ashworth SW, Hurtado TR, Wedmore IS, Kang CS. Puzzling Groin Pain in a 15 Year Old Boy. Journal of Emergency Medicine. (Case Report)

2004 Marley C, Levsky M, Talbot TS, Kang CS. SARS and Its Impact on Current and Future Emergency Department Operations. Journal of Emergency Medicine. (Article)

Brandt AL, Westhoff JL, Martyak N, Kang CS. West Nile Virus. Journal of Military Medicine. (Article)

<u>NON-PEER REVIEWED</u>

2020 Tomich EB, Merchant EE, Kang CS. Cardiomyopathy, Takotsubo. eMedicine.com. (Article)

2019 Bulger EM, Perina DG, Qasim Z, Beldowicz B, Brenner M, Guyette F, Rowe D, Kang CS, Gurney J, DuBose J, Joseph B, Lyon R, Kaups K, Friedman VE, Eastridge B, Stewart R. Clinical Use of Resuscitative Endovascular Balloon Occlusion of the Aorta (REBOA) in Civilian Trauma Systems in the USA, 2019: A Joint Statement from the American College of Surgeons Committee on Trauma, the American College of Emergency Physicians, the National Association of Emergency Medical Services Physicians and the National Association of Emergency Medical Technicians. Trauma Surg Acute Care (Clinical Statement)

Tomich EB, Merchant EE, Kang CS. Cardiomyopathy, Takotsubo. eMedicine.com. (Article)

2018 Perina DG, Kang CS, Bulger EM, Stewart RM, Winchell RJ, Brenner M, Henry S, Weireter LJ, Chang MC, Rotondo MF. Authors' Response to Letter to the Editor by Allen *et al* regarding Joint statement from the American College of Surgeons Committee on Trauma (ACS COT) and the American College of Emergency Physicians (ACEP) regarding the clinical use of Resuscitative Endovascular Balloon Occlusion of the Aorta (REBOA) by Brenner *et al*. Trauma Surgery & Acute Care. (Clinical Statement)

Brenner M, Bulger EM, Perina DG, Henry S, Kang CS, Rotondo MF, Chang MC, Weireter LJ, Coburn M, Winchell RJ, Steward RM. Joint Statement from the American College of Surgeons Committee on Trauma (ACS COT) and the American College of Emergency Physicians (ACEP) Regarding the Clinical Use of Resuscitative Endovascular Balloon Occlusion of the Aorta (REBOA). Trauma Surgery & Acute Care. (Clinical Statement)

Tomich EB, Merchant EE, Kang CS. Cardiomyopathy, Takotsubo. eMedicine.com. (Article)

2017 Tomich EB, Merchant EE, Kang CS. Cardiomyopathy, Takotsubo. eMedicine.com. (Article)

2016 Tomich EB, Merchant EE, Kang CS. Cardiomyopathy, Takotsubo. eMedicine.com. (Article)

2015 Stein M, Kang C, Ball V. ED Evaluation of Hip and Thigh. Emerg Med Clinics North America (Review Article)

Tomich EB, Merchant EE, Kang CS. Cardiomyopathy, Takotsubo. eMedicine.com. (Article)

2014 Tomich EB, Merchant EE, Kang CS. Cardiomyopathy, Takotsubo. eMedicine.com. (Article)

2013 Kang CS. Zoobiquity: What Animals Can Teach Us About Health and the Science of Healing, Annals of Emergency Medicine (Book Review)

Tomich EB, Merchant EE, Kang CS. Cardiomyopathy, Takotsubo. eMedicine.com. (Article)

2012 Snyder B, Moore G, Kang CS. Liability of Ancillary Staff in the Emergency Department: Legal Case Studies of Nurses and Physician Assistants. ED Legal Letter. (Review Article)

Moffett P, Kang CS. The Impaired Physician. Ethical Problems in Emergency Medicine. (Book Chapter)

Kang CS, Harrison BP. Anxiety and Panic Disorders, Adams' Emergency Medicine, 2nd Ed. (Textbook Chapter)

Kang CS, Wedmore IS. Chemical and Radiologic/Nuclear Agents. Adams' Emergency Medicine, 2nd Ed. (Textbook Chapter)

Tomich EB, Merchant EE, Kang CS. Cardiomyopathy, Takotsubo. eMedicine.com. (Article)

2011 Tomich EB, Merchant EE, Kang CS. Cardiomyopathy, Takotsubo. eMedicine.com. (Article)

Advanced Wilderness Life Support, 7th Ed. (Textbook Chapter)

2010 Tomich EB, Merchant EE, Kang CS. Cardiomyopathy, Takotsubo. eMedicine.com. (Article)

2009 Tomich EB, Merchant EE, Kang CS. Cardiomyopathy, Takotsubo. eMedicine.com. (Article)

2008 Kang CS, Harrison BP. Anxiety and Panic Disorders, Adams' Emergency Medicine, 1st Ed. (Textbook Chapter)

2007 Deboard RH, Rondeau DF, Kang CS, Sabbaj A, McManus JG. Principles of Basic Wound Evaluation and Management in the Emergency Department. Emerg Med Clinics North America. (Review Article)

Contributor to PEER VII (Board Review Book)

2003 Vandenberg V, Kang CS. Pemphigus, Rosen and Barkin's 5-Minute Emergency Medicine Consult, 2nd Ed. (Textbook Chapter)

2000 Contributor to Questions of the Day and Cases of the Month for the National Center for Emergency Medicine Informatics website http://www.ncemi.org

ORAL PRESENTATION

2019 Kang C. Personal Finance for Emergency Physicians, NY ACEP Emergency Medicine Residency Career Day, New York, NY.

Kang C. Update on Emergency Medicine Issues and ACEP Activities. NY ACEP Emergency Medicine Residency Career Day, New York, NY.

Kang C. Personal Finance for Emergency Physicians, Michigan State University Management and Education Center Emergency Medicine Residency Education Day, Troy, MI.

Kang C. Atypical Headaches. Michigan State University Management and Education Center Emergency Medicine Residency Education Day, Troy, MI.

Kang C. Update on Emergency Medicine Issues and ACEP Activities. Michigan State University Management and Education Center Emergency Medicine Residency Education Day, Troy, MI.

Anderson S, Kang C. Update on Emergency Medicine Issues and ACEP Activities, WA ACEP Summit to South Northwest Emergency Medicine Assembly, Seattle, WA

Gruehn B, Kang C, Ketcham E, Rosenberg M. How an ACEP Resolution Became Law. Leadership and Advocacy Conference, Washington, DC.

2018 Booms Z, Stein J, Kang C, Rosenberg M. Interim Safety Analysis: Intravenous Lidocaine versus Ketorolac for Known or Suspected Renal Colic. ACEP18 Research Forum, San Diego, CA

Kang C. Personal Finance for Emergency Physicians, IL ACEP Emergency Medicine Residency Career Day, Chicago, IL

Kang C. Credentialing, Clinical Privileges, Certification, and Continuing Education. 2018 EMSAPS, Ocean Shores, WA.

Anderson S, Kang C. Update on Emergency Medicine Issues and ACEP Activities, WA ACEP Summit to South Northwest Emergency Medicine Assembly, Seattle, WA

2017 Couperus K, Kmicek K, Kang C. A Better Way to Monitor Intravenous Infusions Away from an Outlet. ACEP17 Research Forum, Washington, D.C.

Kang C. Personal Wellness and Resiliency. ACEP17 Wellness Center. Washington, D.C.

Kang C. Introduction to Disaster Medicine. HI ACEP Annual Meeting. Honolulu, HI.

Kang C. Update on Emergency Medicine Issues and ACEP Activities. HI ACEP Annual Meeting. Honolulu, HI.

Anderson S, Friedman V, House H, Kang C. Update on Emergency Medicine Issues and ACEP Activities. WA ACEP 2017 Summit to Sound Northwest Emergency Medicine Assembly. Seattle, WA.

2016 Birnbaumer D, Kang C. Quiet Leadership: Introverts in an Emergency Medicine Extroverted World. ACEP16. Las Vegas, NV.

Kang C. Professional Medical Organizations, Why Get Involved. IL ACEP Resident Career Day 2016. Chicago, IL.

Kang C. Current Emergency Medicine Issues: An Update for EPs. Community Health Systems. Webinar.

2015 Moffett PM, Cartwright L, Grossart EA, O'Keefe D, Kang CS. Intravenous Ondansetron and the QT Interval in Adult Emergency Department Patients: An Observational Study. ACEP15 Research Forum, Boston, MA.

2014 Weyand J, Junck E, Heiner J, Kang CS. ED Security in WA State. ACEP14

Research Forum, Chicago, IL

Weyand J, Heiner J, Kang CS. ED Security in WA State. Western Region SAEM Conference, ACEP14 Research Forum, Irvine, CA

2013 SteelFisher G, Krug SE, Kang CS. Emergency Preparedness: Understanding Physicians' Concerns and Readiness to Respond. CDC Clinician Outreach and Communication Activity Webinar, 12 Feb 2013. http://www.bt.cdc.gov/coca/calls/2013/callinfo_021213.asp

Murray RA, Kang CS. Updated: In A Moment's Notice – Patient Surge Response to Terrorism Event. Hospital Preparedness for Bombings and Mass Casualty Events Expert Panel Meeting. CDC, Atlanta, GA.

Course Instructor/Presenter: HEENT Injuries, Medical Cases and Infectious Disease Cases in the Wilderness, AWLS, Mt. Rainier, WA.

Meyers M, Bothwell JD, Skinner CG, Della-Giustina DA, Kang CS. Impact of Gastric Decontamination of Ultrasound Visualization of Ingested Pills. Society for Academic Emergency Medicine, Atlanta, GA.

2012 Walsh R, Heiner J, Kang C, Hile D, Deering S. Emergency Physician Evaluation of a Novel Surgical Cricothryoidotomy Tool in Simulated Combat and Clinical Environments. MAMC Research Day
Selected as the Top Institutional Simulation Research Project

Course Instructor/Presenter: Animal Attacks/Bites, Medical Cases and Infections Disease Cases in the Wilderness. AWLS, Mt. Rainier, WA.

Course Instructor/Presenter: Medical Cases and Infectious Disease Cases in the Wilderness, Patient Packaging, Practical Exercises. AWLS, Whistler, British Columbia, Canada.

2011 Course Instructor/Presenter: Water Purification, Medical Kits, Medical Cases and Infections Disease Cases in the Wilderness, Patient Packaging, Practical Exercises. AWLS, Mt. Rainier, WA.

2010 Course Instructor/Presenter: Water Purification, Medical Kits, Medical Cases and Infectious Disease Cases in the Wilderness, Patient Packaging, Practical Exercises. AWLS, Chehalis, WA.

2009 Presenter: CRBNE Explosive Blast Injuries. U.S. Army 31st Annual Gary B. Wratten Surgical Symposium, Tacoma, WA.

Presenter: Patient Evacuation, Unified Command; Community Tabletop Exercise Moderator. ACEP and DHS/FEMA Community Healthcare Disaster Preparedness Assessment Training, Baton Rouge, LA.

Course Instructor/Presenter: Primary Patient Assessment, Patient Packaging, Practical Exercises. AWLS, Park City, UT.

Course Instructor/Presenter: HEENT Emergencies in the Backcountry, Medical Kits, Medical Cases and Infections Disease Cases in the Wilderness, Wound and Burn Management, Practical Exercises. AWLS, Moab, UT; Mt. Rainier, WA.

2008 Presenter: Regional Agreements, Memorandum of Agreements;

Community Tabletop Exercise Moderator. ACEP and DHS/FEMA Community Healthcare Disaster Preparedness Assessment Training, Las Vegas, NV.

Course Instructor/Presenter: HEENT Emergencies in the Backcountry, Medical Kits, Medical Cases and Infectious Disease Cases in the Wilderness, Wound and Burn Management, Practical Exercises. AWLS, Moab, UT; Mt. Rainier, WA.

2007 Course Instructor/Presenter: HEENT Emergencies in the Backcountry, Dermatological Problems in the Wilderness, Medical Kits, Medical Cases and Infectious Disease Cases in the Wilderness, Practical Exercises. AWLS, Moab, UT.

2002 Faculty and Presenter, Advances in Wound Management. ACEP Scientific Assembly, Seattle, WA.

POSTER PRESENTATION

2018 Booms Z, Stein J, Kang C, Rosenberg M. Interim Safety Analysis: Intravenous Lidocaine versus Ketorolac for Known or Suspected Renal Colic. ACEP18 Research Forum, San Diego, CA

2017 Couperus K, Kmicek K, Kang C. A Better Way to Monitor Intravenous Infusions Away from an Outlet. Military Health System Research Symposium, Kissimmee, FL.

Couperus K, Kmicek K, Kang C. A Better Way to Monitor Intravenous Infusions Away from an Outlet. 2017 WA ACEP Summit to Sound Northwest Emergency Medicine Assembly, Seattle, WA.

2016 Hartline JR, Kmecik KJ, Sullivan SB, Devita D, Kang CS. Clinical Utility of Routine Screening Laboratory Tests in Active Duty Military Adult Psychiatric Patients Presenting to the Emergency Department for Medical Clearance: An Interim Analysis. WA ACEP Summit to Sound Northwest Emergency Medicine Assembly, Seattle, WA.

2015 Meyers M, Stremick J, Kang C. Cervical Spine Injuries after Syncope. Leadership in Emergency Military Medicine, Tacoma, WA.

2014 Weyand J, Heiner J, Kang CS. ED Security in WA State. GS ACEP Assembly, San Antonio, TX

Weyand J, Heiner J, Kang CS. ED Security in WA State. ACEP14 Research Forum, Chicago, IL

2013 Weyand J, Heiner J, Kang CS. ED Security in WA State. WA ACEP Summit to Sound Northwest Emergency Medicine Assembly, Seattle, WA

2012 Walsh R, Heiner J, Kang C, Hile D, Deering S. Emergency Physician Evaluation of a Novel Surgical Cricothryoidotomy Tool in Simulated Combat and Clinical Environments. WA ACEP Summit to Sound Northwest Emergency Medicine Assembly, Seattle, WA.

2011 Hopkins G, McGrane O, Nielson A, Kang CS. Procedural Sedation with Propofol: Experiences of an Emergency Medicine Program. WA ACEP Summit to Sound Northwest Emergency Medicine Assembly, Seattle, WA.

Cronin A, Cunningham C, Kang CS, LaSelle B. Supraclavicular Approach to Subclavian Central Venous Access: Ultrasound Guidance vs. Landmark Approach with a Simulation Model. WA ACEP Summit to Sound Northwest Emergency Medicine Assembly, Seattle, WA.

Simmons J, Cookman L, Kang CS, Skinner C, Hurley W. Spice Intoxication. WA ACEP Summit to Sound Northwest Emergency Medicine Assembly, Seattle, WA.

Hopkins G, McGrane O, Nielson A, Kang CS. Procedural Sedation with Propofol: A Retrospective Review of the Experiences of an Emergency Medicine Program 2005-2010. GS ACEP, San Antonio, TX.

Cronin A, Cunningham C, Kang CS, LaSelle B. Supraclavicular Approach to Subclavian Central Venous Access: Ultrasound Guidance vs. Landmark Approach with a Simulation Model. GS ACEP San Antonio, TX. **Selected as the Top Conference Research Poster Presentation**

2010 Heiner JD, Dunbar JL, Harrison T, Kang CS. Current Emergency Medicine Residency Education of Documentation, Coding, and Reimbursement: Fitting the Bill? ACEP SA Research Forum, Las Vegas, NV.

Cashin BV, Matlock AG, Kang CS, Reynolds PS, Wills BK. Effect of Hydroxocobalamin on Surface Oximetry in Non-Exposed Humans. ACEP SA Research Forum, Las Vegas, NV.

2009 Heiner JD, Strode CA, Kang CS, Harrison BP, Jones RA, Merchant EE, Dunbar JL. Impact of Documentation Training on Emergency Medicine Billing and Resident Education. CORD EM Conference, Las Vegas, NV.

Smith S, Kang CS, Wedmore IS. Effectiveness of Water Filter Pump for Wound Irrigation. Wilderness Medicine Society Summer Meeting. Snowmass, CO.

Moffett P, Baker B, Wills BK, Johnson M, Kang CS. Topical Patient Decontamination. ACEP SA Research Forum. Boston, MA.

2008 Jones RA, Kang CS, Wills BK. Chlorine Blast Exposure, WA ACEP Emergency Medicine Without Borders Conference, Vancouver, B.C.

Jones RA, Kang CS, Wills BK. Chlorine Blast Exposure. ACEP DHS-FEMA Clinical Applications of Disaster Planning, Dallas, TX.

PROFESSIONAL MEMBERSHIPS

American College of Emergency Physicians

American Academy of Emergency Medicine

Society for Academic Emergency Medicine

Wilderness of Medical Society, Academy of Wilderness Medicine, Fellow

American Medical Association

Washington State Medical Association

U.S. Army Society of Flight Surgeons, Lifetime Member

Boy Scouts of America, Eagle Scout and Order of the Arrow

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2021 PRESIDENT-ELECT CANDIDATE WRITTEN QUESTIONS

Aisha T. Terry MD, MPH, FACEP

Question #1: **What is your view of ACEP's strategy regarding workforce, scope of practice, and College sustainability?**

These challenges offer welcomed disruption and tremendous opportunity to shape a bright future for our specialty and livelihoods. Now is the appointed time for ACEP to do what it was designed to do, and that is, to unapologetically continue to lead! These issues share the common thread of being critical to the mission of ACEP and are inextricably tied to the value of the emergency physician (EP). Thus, as we together tackle these unprecedented issues, I will lead with visionary strength and make the re-affirmation of our value the fulcrum of the strategy.

Workforce - As Chair of ACEP's Membership Task Force in 2008/2009, I recall studying Carlos Camargo's 2005 study which predicted that board-certified EPs would *not* satisfy workforce needs until the year 2038. Today, it is predicted that there will be a major *oversupply* of EPs – for the first time ever - by the year 2030. This prediction coupled with the recent relative paucity of EP employment opportunity due to the impact of the pandemic, threatens the stability of the emergency medicine (EM) workforce, the capacity to provide our patients with access to care, and the ability to successfully recruit future EPs.

As President-elect, I will prioritize this existential challenge in a manner that optimizes ACEPs real-time relevance to all EPs. My efforts as a second-term Board member align with our strategy to (1) acknowledge the problem and rightful alarm, (2) inform by highlighting the complexities and differentiating fact from myth, (3) address head-on by sharing an action-based, multi-pronged strategy tied to an aggressive timeline, and (4) engage others to join these efforts in a unified way, which promotes swift progress. Consistent and transparent communication about our efforts and progress made is imperative. We must also highlight Chapter efforts, engage stakeholders in collaborations, and constantly seek feedback from our members.

Finally, we would be wise to acknowledge that a prediction is just that; several unknowns remain. For example, how will Covid-19 impact attrition? How might the role of workforce geographic distribution evolve? How will demand for EM services change? How will the proliferation of nurse practitioner (NP) and physician assistant (PA) workforce be impacted? The answers to these and other salient questions will undoubtedly impact the future of our workforce and must be considered now.

Scope of Practice – ACEP believes that emergency care should be EP-led and opposes the independent practice of NPs and PAs. As President-elect, I will lead efforts to attain and embrace data-driven solutions to combat scope of practice threats. We must be intentional about marketing our value and emphasizing why EP-led care offers distinct advantage as the gold standard. In doing so, ACEP's Clinical Emergency Data Registry (CEDR) data (>50 million ED visits from ~30,000 EPs, NPs, and PAs) would be an excellent tool to utilize in answering key questions and illustrating our comparative value. Further, as we pursue the implementation of ED Accreditation standards, we must determine and enforce best practices for quality-promoting staffing models relative to scopes of practice amongst the ED care team.

We must also build upon past and current efforts. Outstanding strides have been made, for example, through the work of ACEPs Advanced Practice Provider Task Force, statements on the importance of title transparency in clinical settings, and our partnership with the American Medical Association (AMA) to dispel the myth that increased NP/PA scope of practice improves access to care.

College Sustainability - My candidate platform includes the creation and optimization of infrastructure that fosters longevity for EP livelihoods and the financial stability of the College. ACEP is well positioned to achieve this goal by building upon its investment in quality and data.

The delivery of high-quality care will continue to be required, measured, and tied to reimbursement. ACEPs CEDR is a member benefit that promotes quality, while fostering EP compensation through federal quality reporting. The registry allows EPs to avoid financial penalties ($300 million in avoided penalties to date) and reap lucrative bonuses (up to $2,000 per EP for 2020).

CEDR is poised to evolve far beyond its current registry function, however. Imagine, for example, if ACEP had a digital platform by which to lead robust EM-focused research, real-time disease surveillance, and ethical data commercialization opportunities through unique EM use cases. Such would minimize the College's current reliance on member dues and meetings income (both total ~40% of revenue), while expanding our digital footprint in healthcare.

As President-elect, I will build upon my experience as Treasurer of the College during the pandemic, one of the toughest financial periods in the history of ACEP. I led our finance team in making tough but necessary decisions, encouraged the implementation of zero-based budgeting, and helped spearhead strategy-focused practices. These efforts contributed to the passage of a 2021/2022 budget that mitigated damage from the 2020 pandemic, resulting in a significantly reduced deficit.

Question #2: **Given the challenges facing emergency physicians, how will you lead the transformation of our specialty to continue making use of our unique skill sets and expertise in alternate care delivery models?**

As our specialty transforms, I would lead by first recognizing that the original premises upon which emergency medicine were built must be revisited and revised in order to ensure our bright future. This approach would employ innovative vision that motivates and inspires us to contemplate and address key questions. For example, how could technology make what we do obsolete? How can technology help us work smarter? What disruptive innovation is just over the horizon? How do we capitalize on our unique vantage point as a centralized hub of undifferentiated patients to impact care coordination and longitudinal outcomes? How can EM be a part of the solution to end fragmented and inequitable care? What funding model would best complement this evolution of practice? Just as the anesthesiologists created a new niche for themselves in pain management and the surgeons created acute care surgery in response to trauma surgery needs, we too must re-imagine how, where, and to whom we deliver care.

Ultimately, innovative ideas alone are not enough; we must embrace the process of translating those ideas into concrete efforts and meaningful change in perpetuity. In doing so, we must first increase awareness about the wealth of opportunity through our EDs and partner with entities with shared interest in order to attain resources and share risk. Second, efforts should be policy-based plans that integrate the community and other health resources. Third, we must embrace the fact that only about 10% of preventable death is a result of the medical care that we provide in the clinical setting, and thus, boldly re-design our practice and physical space to meet changing demands. Providing care through telehealth irrespective of location is just the beginning. Imagine the delivery of concierge medicine, for example, through the use of modalities such as augmented intelligence. These and other innovations must become routine, and eventually, the standard. Finally, in order to successfully implement this growth, we must create formal training opportunities that address gaps in the essential skill sets that are necessary to evolve. .

Question #3: **How do you advance the planned initiatives of the College in the face of volatile legislative, regulatory, and public health threats?**

Effective health policy and public health advocacy is largely dependent upon anticipating barriers, next steps, and political influence. ACEP is well equipped to advance its initiatives despite threats, in part due to its stellar and very well-connected Washington, DC legislative and regulatory office staff. Its multiple formal and informal relationships with numerous agencies and organizations ranging from the Centers for Disease Control and Prevention (CDC) to the National Quality Forum (NQF) also bode well for high impact networking and collaboration. Additionally, the likelihood of achieving success through planned initiatives increases significantly when developed in a comprehensive manner that includes multiple objectives, tactics, and a detailed timeline; this fosters flexibility and the ability to seamlessly pivot in response to a changing trajectory.

The key to maintaining and expanding advantage for the College is to remain vigilant and deliberate about investing in and nurturing strong relationships with legislative, regulatory, and public health bodies, as well as other medical societies. This will allow for the discovery and magnification of shared incentives and provide the opportunity to remain abreast of shifting priorities in real time. Doing so will ensure that ACEP is rarely caught off guard or unprepared to respond to and manage competing interests, while advancing our mission despite forces out of our control.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DATA SHEET

Aisha T. Terry MD, MPH, FACEP

Contact Information

3001 26th Street, NE, Washington, DC 20018
Phone: 443-801-8459
E-Mail: aterry@acep.org

Current and Past Professional Position(s)

2018-present Associate Professor, Department of Emergency Medicine
Senior Advisor, Emergency Medicine Health Policy Fellowship
George Washington University School of Medicine

2018-present Associate Professor, Department of Health Policy
Milken Institute of Public Health, George Washington University

2012-2018 Assistant Professor, Department of Emergency Medicine
Director, Emergency Medicine Health Policy Fellowship
George Washington University School of Medicine

2013-2018 Assistant Professor, Department of Health Policy
Milken Institute of Public Health, George Washington University

2007-2011 Assistant Professor, Department of Emergency Medicine
University of Maryland School of Medicine

Education (include internships and residency information)

1999 Duke University
Durham, North Carolina
Bachelor of Science (BS) in Biology, Chemistry and Spanish Minor

POST GRADUATE EDUCATION AND MEDICAL TRAINING:

2003-2006 University of Maryland Medical System, Department of Emergency Medicine
Emergency Medicine Residency Program

2003 University of North Carolina School of Medicine
Chapel Hill, North Carolina
Doctor of Medicine (MD)

2011 Columbia University Mailman School of Public Health
New York, New York
Executive Master of Public Health (MPH), Health Policy and Management Focus

Specialty Board Certifications(e.g., ABEM, AOBEM, AAP, etc.) and dates certified and recertified)

2008 Board Certified (ABEM) in Emergency Medicine; re-certified 2018
2011 Washington, DC, medical license (active)

Professional Societies

2001 - present Society for Academic Emergency Medicine (SAEM)
2003 - 2011 Maryland American College of Emergency Physicians (MD ACEP)
2002 – present American College of Emergency Physicians (ACEP)
2003 – present Emergency Medicine Residents' Association (EMRA)
2008 – present American Medical Association (AMA)
2012 – present District of Columbia College of Emergency Medicine
2013 – present Medical Society of the District of Columbia
2015 – present National Medical Association (NMA)

National ACEP Activities – List your most significant accomplishments

American College of Emergency Physicians (ACEP)

2004-2006 Emergency Medicine Practice Management and Health Policy Section member
2005-present 911 Legislative Network member
2005-2017 Public Health and Injury Prevention Committee member
--Disparities in Health Care Subcommittee, chair (2009-2012)
--Healthy People 2020 Subcommittee, member (2009-2011)
-- Sobering Centers Subcommittee, chair (2012-2014)
2007-present Young Physicians Section, member
2008-2009 Associate Membership Task Force, appointed Chair
2016-2018 Diversity and Inclusion Task Force, appointed Chair
2017-2018 Diversity in Leadership Task Force, appointed member
2017-2020 Board of Directors, elected member
- ACEP Quality and Patient Safety Committee, Board liaison
- ACEP CEDR Committee, Board liaison
- ACEP Quality Improvement and Patient Safety Section, Board liaison
- ACEP Research Section, Board liaison
- ACEP Diversity, Inclusion, and Health Equity Section, Board liaison
- ACEP Undersea and Hyperbaric Medicine Section, Board liaison
- ACEP Trauma and Injury Prevention Section, Board liaison
- ACEP Nominating Committee (Council Committee), member

2017-2019 ACEP 2nd Journal Editor-in-Chief Search Committee Task Force, member
2020-2023 Board of Directors, elected member (2nd term)
- ACEP Secretary/Treasurer
- ACEP Quality and Patient Safety Committee, Board liaison
- ACEP CEDR Committee, Board liaison
- ACEP Quality Improvement and Patient Safety Section, Board liaison

American College of Emergency Physicians

2008 Hero in Emergency Medicine Award
2009 ACEP Council Teamwork Award
2018 ACEP Council Diversity Champion Award
2021 ACEP John G. Wiegenstein Leadership Award **(nominee)**

ACEP Chapter Activities – List your most significant accomplishments

District of Columbia Chapter of the College of Emergency Medicine

2013-2015 Board of Directors member, President and Councilor
2015-2016 Board of Directors member, Immediate Past President and Councilor
2016-present Board of Directors member, Councilor through 2017

The Maryland State Medical Society, MedChi

2003-2011

Maryland American College of Emergency Physicians (ACEP)

2005-2006 Public Relations Committee member
2005-2012 Public Policy Committee member
2007-2012 Board of Directors member

Practice Profile

Total hours devoted to emergency medicine practice per year: **1200** Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.

Direct Patient Care **60** % Research **5** % Teaching **25** % Administration **10** %

Other: _____ ____%

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

Academics, multi-specialty physician group

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.)

Health Policy Fellowship, Senior Advisor

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**

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DISCLOSURE STATEMENT

Aisha T. Terry MD, MPH, FACEP

1. Employment – *List current employers with addresses, position held and type of organization.*

Employer: Medical Faculty Associates

Address: 2120 L Street, NW

Washington, DC 20018

Position Held: Associate Professor of Emergency Medicine and Health Policy, Attending Physician

Type of Organization: Multi-specialty physician group

2. Board of Directors Positions Held – *List all organizations and addresses for which you have served as a board member – including ACEP chapter Board of Directors. Include type of organization and duration of term on the board.*

Organization: American College of Emergency Physicians

Address: 4950 W. Royal Lane

Irving, TX 75063-2524

Type of Organization: 501c6

Duration on the Board: 2017-present

Organization: Emergency Medicine Foundation (EMF)

Address: 4950 W. Royal Lane

Irving, TX 75063-2524

Type of Organization: Non-profit

Duration on the Board: 2007-08

Organization: National Emergency Medicine Political Action Committee (NEMPAC)

Address: 4950 W. Royal Lane

Irving, TX 75063-2524

Type of Organization: Non-profit

Duration on the Board: 1 year

Organization: Legal Clinics for the Disabled (LCD)

Address: 1513 Race Street

Philadelphia, PA 19102

Type of Organization: Non- profit

Duration on the Board: 3 years

Organization: Minority Women in Science Foundation

Address: P.O. Box 90134

Washington, DC 20090

Type of Organization: 501c3 Non-profit Organization

Duration on the Board: 2006-Present

Organization: Stop the Spread empowered by Impact Assets

Address: info@stopthespread.org

Type of Organization: Non- profit

Duration on the Board: 1 year

Organization: District of Columbia Chapter of the American College of Emergency Physicians

Address: 4950 W. Royal Lane

Irving, Texas 75063-2524

Type of Organization: State Chapter Specialty Organization

Duration on the Board: 2013-2017

Organization: Maryland Chapter of the American College of Emergency Physicians

Address: 4950 W. Royal Lane

Irving, Texas 75063-2524

Type of Organization: State Chapter Specialty Organization

Duration on the Board: 2005-2012

Organization: Emergency Medicine Residents' Association (EMRA)

Address: 4950 W. Royal Lane

Irving, Texas 75063-2524

Type of Organization: Emergency Medicine Residents' Specialty Organization

Duration on the Board: 2005-2008

Organization: Emergency Medicine Foundation (EMF)

Address: 4950 W. Royal Lane

Irving, Texas 75063-2524

Type of Organization: Emergency Medicine Research Foundation

Duration on the Board: 2007-2008

I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

☒ NONE
☐ If YES, Please Describe:

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) a an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☒ NONE
☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☒ NONE
☐ If YES, Please Describe:

5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE
☐ If YES, Please Describe:

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO
☐ If YES, Please Describe:

I certify that the above is true and accurate to the best of my knowledge:

Aisha Terry Date 07.09.2021

Thursday, August 19, 2021

Gary R. Katz, MD, MBA, FACEP
Chair
Nominating Committee
P.O. Box 619911
Dallas, TX 75261-9911

Dear Dr. Katz,

As President of the District of Columbia Chapter, it is my pleasure to write to you on behalf of our three hundred and thirty emergency medicine physician members, to proudly endorse **Aisha T. Terry, MD, MPH, FACEP** for President-Elect of the American College of Emergency Physicians.

Dr. Terry's aptitude for planning, organization, and management has played an integral part in the Chapter's innovation and success. She has served in varying capacities in the Chapter, including as President, Councillor and BOD member. From 2013-2016, during her term as the Chapter President for the District of Columbia, the Chapter's activity flourished, membership increased by 50%, and revenue doubled.

In 2004, Dr. Terry started as a member of the College's Emergency Medicine Practice Management and Health Policy Section and the Public Health and Injury Prevention Committee. She was elected President of the Emergency Medicine Residents' Association (EMRA) and served on its Board of Directors from 2005-2008.

Dr. Terry continued her dedication and contributions to the College as a member of the Board of Trustees of the Emergency Medicine Foundation (EMF), while continuing her service on the Public Health and Injury Prevention Committee. She chaired the subcommittee on Disparities in Health Care as well as the subcommittee on Sobering Centers. In 2008, Dr. Terry was appointed chair of the College's Associate Membership Task Force. As a Board member, Dr. Terry has served or is currently serving as Board liaison to eight of the College's committees/sections. Her management and decision-making skills are evident by her election as the College's Secretary/Treasurer in 2020.

In 2016, Dr. Terry was appointed chair of the College's first Diversity and Inclusion Task Force. As chair Dr. Terry was innovative and created an Unconscious Bias Online Course, "Unconscious Bias: Protect Yourself and Your Patients". This course is available for CME to any member of the

DC ACEP CHAPTER
c/o National ACEP
4950 West Royal Lane
Irving, Texas 75063-2524
972-550-0911
855-261-4285
972-767-0056 (FAX)
www.dcacep.org

American College of Emergency Physicians and continues to serve as resource for many.

Many are inspired by Dr. Terry's contribution in the advancement of diversity in the College. She implemented several recommendations made by the College's Diversity and Inclusion Task Force by spearheading the creation of the Diversity, Inclusion and Health Equity (DIHE) Section. While serving as Board liaison to the DIHE section, several resolutions were proposed and adopted by the College's Council. Her leadership and expertise in policy making ensured the success of the DIHE section's resolutions. Her outstanding leadership was recognized by the Council in 2018 as she was named the inaugural recipient of the ACEP Council Diversity Champion Award.

Dr. Terry's leadership and expertise in the practice of emergency medicine is further demonstrated by her significant contributions (13 chapters as first or second author) to the College's COVID-19 Field guide online textbook.

Dr. Terry is well known for her expertise on quality measurement in emergency medicine. She has been a champion for ACEP's clinical data registry, CEDR (Clinical Emergency Data Registry). Dr. Terry serves as the Board liaison to ACEP's robust quality portfolio, which encompasses a significant percentage of ACEP's budget and requires the work of 12% of the College's staff. She serves as Board liaison to ACEP's national committees CEDR, Quality & Patient Safety (QPSC), and the Quality Improvement & Patient Safety (QIPS) Section.

The DC Chapter is fortunate to have such a dedicated advocate within our Chapter to represent emergency medicine. We hope you vote to elect Dr. Terry as President-Elect of the American College of Emergency Physicians.

Sincerely,

Leah E. Steckler, MD
President
District of Columbia ACEP Chapter

Aisha T. Terry MD, MPH, FACEP

Dear fellow colleagues and friends of the ACEP Council,

We are in the midst of contending with arguably the most challenging era of our professional lives; as the ravages of the pandemic rage on and we grapple with the impact of unprecedented internal and external forces, our ability to successfully cope and, in fact, thrive despite extraordinary odds, is beyond critical. Yet, here we are, doing just that – coping and thriving; here we are, *still* bravely serving on the front lines with steadfast conviction. Sincerely, I thank you for your grit, talent, and for the honor of serving alongside you for over 18 years and representing you on the Board for the past two terms.

I believe I am the right leader to shepherd ACEP during these challenging times. We need a spokesperson who is measured yet visionary, and able to represent and motivate all emergency physicians (EPs) around action that creates real change. Having a diverse clinical and professional background, I am confident that I will represent all EPs in exemplary fashion.

A Track Record of Leading Execution and Meaningful Change

As EMRA President from 2005 to 2008, revenue surpassed the $1M mark in part due to my leading efforts to broaden the reach of the publication, *EM Resident,* and the EMRA Job Fair, both of which continue to thrive.

As President of the District of Columbia Chapter of ACEP in 2012, I led the Board in revitalizing the organization by focusing on enhanced member value and fiscal stewardship. Membership increased by 50% and revenue doubled. Since 2018, I have served as lead Board liaison to ACEP's Quality Portfolio which fosters member value (e.g. $300M in avoided penalties for EPs) and College sustainability (~15% of revenue). My Washington, DC location has afforded me easy access to federal meetings about quality and otherwise, to ensure that our voice is heard as decisions about our practice are made.

As ACEP Treasurer, I led during the year of Covid-19 - arguably the most challenging financial period in the history of the College. 2021/2022 budget passed with greatly mitigated deficit.

The Vision for the Future

As President-elect, I will bring us together by highlighting what we all believe - that the emergency physician is an invaluable asset to the American health care system, deserving of stable livelihoods and wellness as we serve our nation's most vulnerable.

Key Objectives

1. Re-affirm the value of the EP and re-define the specialty of emergency medicine (EM) to secure the future of our practice
    - Champion early-career EP
    - Promote Board-certified EP-led care
    - Establish EM as essential public service with non-volume-based funding model
    - Prioritize wellness by improving workplace environment (e.g. staffing, autonomy, leadership)
    - Position EM as health equity leader

2. Optimize College's communications platform
    - Prioritize improved communication with members, more effective social media presence
    - Re-structure national ACEPs relationship with Chapters to foster bi-directional engagement and Chapter-to-Chapter information-sharing and collaboration
    - Communicate value of EPs to public

3. Ensure the longevity of our healthy livelihoods and the financial security of the College
    - Invest in quality to ensure that EPs earn bonuses and avoid penalties through quality reporting
    - Use data to create new streams of income for the College to alleviate reliance on member dues and meetings for revenue

As we find ourselves at an inflection point in our history, we must question status quo and be led by thoughtful execution. I see tremendous opportunity right before us and invite you to join me, as together we stand for our value. With humility, I ask for your support and vote for ACEP President-elect.

Sincerely yours in service,

Aisha Terry MD, MPH, FACEP

THE RIGHT LEADER FOR THESE CHALLENGING TIMES

- Track record of vision coupled with execution and action
- 16+ years of ACEP service
- Health policy and public health leader; skilled at finding commonality, bridging gaps, and building consensus
- ACEP Treasurer during unprecedented financial uncertainty of Covid era
- As DC ACEP President, membership increased by 50% and revenue doubled
- As EMRA President, revenue hit $1 Million mark, *EM Resident* publication was revolutionized, Job Fair reached new heights

AISHA TERRY
MD, MPH, FACEP

PRESIDENT-ELECT CANDIDATE

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

THE VISION and ACTION PLAN

- Re-affirm the value of the Emergency Physician and re-define our specialty to prepare us for a bright future
- Optimize ACEP's communications platform to promote relevance to members and improve Chapter connection
- Ensure the longevity of our healthy livelihoods & the financial stability of the College

@AishaTerryMD AishaTerryMD,MPH @aisha.tterry

- Associate Professor of EM & Health Policy
- Health Policy Fellowship Senior Advisor
- Full-time clinician; 15+ years of experience in academics, military ED's, & rural practice
- NEMPAC Board of Trustees
- EMF Board of Trustees

AISHA TERRY
MD, MPH, FACEP

PRESIDENT-ELECT CANDIDATE

"Dr. Terry's measured statements [were] refreshing, insightful, and balanced.The issues that Dr. Terry covered can be emotional and political tinderboxes, and [she] handled them with professionalism and aplomb. For me, [her] participation and contributions alone were worth the trip."
- 2021 LAC participant comment

"Dr. Terry dedicates a significant part of her career to the innovation and growth of medical education and is recognized as an accomplished educator and researcher.Dr. Terry's contribution to the specialty of emergency medicine extends to many areas of medicine and the world. [A prolific] author and grant awardee, Dr. Terry boldly advocates for and promotes the role of research within emergency medicine and the College."
- Excerpt from 2021 John G. Wiegenstein Leadership Award nomination letter

THE DIFFERENCE

- Applauded spokesperson; 25+ invited ACEP media contributions in 2020 alone
- 15+ years of mentoring and inspiring future health policy physician leaders
- Based out of Washington, DC - the epicenter of advocacy and headquarters for ACEP legislative and regulatory affairs
- Uniquely equipped with extensive ACEP quality portfolio knowledge
- Diversity and inclusion champion

District of Columbia
American College of Emergency Physicians

Curriculum Vitae

Aisha T. Terry (formerly Liferidge), MD, MPH
Associate Professor of Emergency Medicine and Health Policy
Health Policy Fellowship, Senior Advisor
Attending Physician
George Washington University School of Medicine and Health Sciences
American College of Emergency Physicians, Board Member and Secretary/Treasurer

DATE: May 2021

PERSONAL DATA:

3001 26th Street, NE
Washington, DC 20018
443-801-8459
aisha.t.terry@gmail.com

EDUCATION:

1999	Duke University Durham, North Carolina Bachelor of Science (BS) in Biology, Chemistry and Spanish Minor
2003	University of North Carolina School of Medicine Chapel Hill, North Carolina Doctor of Medicine (MD)
2011	Columbia University Mailman School of Public Health New York, New York Executive Master of Public Health (MPH), Health Policy and Management Focus

POST GRADUATE EDUCATION AND MEDICAL TRAINING:

2003-2006	University of Maryland Medical System, Department of Emergency Medicine Emergency Medicine Residency Program

COLLABORATIVE RESEARCH:

2001-2002 **Ability of laypersons to administer the Cincinnati Prehospital Stroke Scale (CPSS) Study**, University of North Carolina (Co-Investigator)
Preceptor: Jane H. Brice, MD, Department of Emergency Medicine
Description: Randomized validation study that sought to determine if the CPSS can be used by laypersons to help dispatchers recognize stroke prior to patient contact. Participants' ability to administer and interpret the results of the CPSS was evaluated. Data analysis revealed that the subjects' administration and interpretation were accurate, (statistically significant) implying that laypersons are able to use the CPSS appropriately.

2004-2006 **Rapid Assessment of Transient Ischemic Attack Etiologies (RATE) Clinical Trial**

University of Maryland Medical System, (Research Assistant)
Preceptor: Marian LaMonte, MD, Department of Neurology
Description: Chart review of TIA (transient ischemic attack) patients evaluated and treated in an Emergency Department observation unit, aimed to determine TIA/stroke risk factors and to evaluate the feasibility of instituting an algorithm of comprehensively and appropriately evaluating TIA patients within 24 hours.

2008-2012 **Neurological Emergencies Treatment Trials (NETT) Consortium**, National Institute of Neurological Disorders and Stroke (NIH NINDS); Multi-center; Multiple Trials through 2012.
-ALIAS Phase III Trial, "Albumin in Acute Ischemic Stroke"
- RAMPART, " Rapid Anticonvulsant Medications Prior to Arrival Trial"
- *POINT, "Platelet-Oriented Inhibition in New TIA"*
- *PROTECT, "Progesterone for Traumatic Brain Injury"*

2012-2013 **Triage of Low Acuity Emergency Department Patients to a Primary Care Clinic and Patient-Centered Medical Home: A Health Services Utilization and Cost Effectiveness Analysis**, George Washington University, Department of Emergency Medicine (Principal Investigator) *Description: Conducted at the Washington, DC Veterans Affairs Medical Center; retrospective pre and post intervention analysis to determine the impact of an ED-based triage protocol on patient health services utilization patterns and its cost.*

2013-2014 **Teaching Health Policy: Developing a Portable E-learning Tool for Medical Student Education,** George Washington University, Department of Emergency Medicine (Principal Investigator), *Description: Conducted at George Washington University School of Medicine; pilot crossover study that compared the effectiveness of an online and in-person curriculum. 6 lecture topics were included in both the online and in-person formats. The effectiveness of each teaching format in promoting knowledge retention was evaluated through tests administered before and after completion of each topic module. Results suggests that an online curriculum to teach medical students health policy may be as effective as an in-person curriculum.*

2015-2017 **Teaching Health Policy to Residents Physicians: A National Survey and Curricula Recommendations,** George Washington University, Department of Emergency Medicine (Principal Investigator), Description: *Seeks to (1) understand the culture, attitudes, and interests in resident health policy education guiding graduate medical education policymakers and director through a series of qualitative interviews, (2) describe the national landscape and extent of resident health policy education across multiple specialties utilizing a cross sectional survey of residency program directors and designated institutional officials, and (3) develop recommendations for a tailored interactive toolkit for effective resident health policy education based on the feedback received.*

2020 **The Medical Student Experience in the Era of Covid-19: Reflections on the Transformation of**

Medical Education, George Washington University, Department of Emergency Medicine (Principal Investigator), Description: *A virtual focus group of medical students was conducted on April 30, 2020. Each student was asked to broadly and candidly reflect on their personal experiences relative to the COVID-19 pandemic, and to specifically expound upon how their personal growth and medical education has been impacted. Conclusion: Key concepts to consider include prioritizing routine virtual delivery of content through innovative technology, encouraging increased student autonomy and self-directed learning through less prescriptive schedules, and emphasizing reflection training and sharing to improve self-awareness and professional development.*

PROFESSIONAL REGISTRATIONS, LICENSES, AND CERTIFICATIONS:

2008 Board Certified (ABEM) in Emergency Medicine; re-certified 2018
2006 Maryland, medical license
2011 Washington, DC, medical license (active)

EMPLOYMENT:

Academic Appointments:

2018-present Associate Professor, Department of Emergency Medicine
Senior Advisor, Emergency Medicine Health Policy Fellowship
George Washington University School of Medicine

2018-present Associate Professor, Department of Health Policy
Milken Institute of Public Health, George Washington University

2012-2018 Assistant Professor, Department of Emergency Medicine
Director, Emergency Medicine Health Policy Fellowship
George Washington University School of Medicine

2013-2018 Assistant Professor, Department of Health Policy
Milken Institute of Public Health, George Washington University

2007-2011 Assistant Professor, Department of Emergency Medicine
University of Maryland School of Medicine

Other Employment:

1998-1999 Research Assistant, Duke University Department of OB/GYN
Preceptor: Dr. Harold Schomberg
Description: Performed tissue cultures, DNA preparation, western blotting, PCR related to the biochemical properties of various proteins involved in Reproductive Biology.

2006-2007 Attending Physician, Department of Emergency Medicine
Maryland Emergency Medicine Network
Washington County Hospital Emergency Medicine Physicians

SOCIETIES:

2001 - present Society for Academic Emergency Medicine (SAEM)
2003 - 2011 Maryland American College of Emergency Physicians (MD ACEP)

2002 – present American College of Emergency Physicians (ACEP)
2003 – present Emergency Medicine Residents' Association (EMRA)
2008 – present American Medical Association (AMA)
2012 – present District of Columbia College of Emergency Medicine
2013 – present Medical Society of the District of Columbia
2015 – present National Medical Association (NMA)

HONORS/AWARDS:

Duke University
1996 Dean's List *with distinction*
1997 National Dean's List
1997 Dean's List
1998 Dean's List

University of North Carolina at Chapel Hill School of Medicine
1999-2003 North Carolina Board of Governors Academic Scholarship
Four-year scholarship funding full tuition, fees, and annual stipend; based of merit and interest in practicing medicine in North Carolina
1999-2003 Edward-Hobgood Distinguished Scholarship, four-year scholarship based on scholastic achievement, character, and service
1999 Honors in Medical Embryology
2000 Honors in Humanities and Social Science
2001 Honors in Endocrinology
2001 Honors in Dermatology
2001 Honors in Reproductive Biology
2002 Society for Academic Emergency Medicine (SAEM), Southeastern Regional Conference, Best Student Presentation
2002 Seventh Annual Emergency Medicine Research Forum, Dept. of EM, UNC, Chapel Hill, Best Student Oral Presentation
2002 Society for Academic Emergency Medicine (SAEM), National Conference, Best Student Paper Semi-finalist, May 2002
2005 American College of Emergency Physicians Leadership and Advocacy Conference, Chair's Challenge Scholar
2005 American College of Emergency Physicians/Emergency Medicine Residents' Association Health Policy Mini-Fellowship, Washington, DC

University of Maryland Medical Center, Department of Emergency Medicine
2006 Mission Statement Award, recognizes leadership and excellence in academics during residency

American College of Emergency Physicians
2008 Hero in Emergency Medicine Award
2009 ACEP Council Teamwork Award
2018 ACEP Council Diversity Champion Award
2021 ACEP John G. Wiegenstein Leadership Award **(nominee)**

Emergency Medicine Residents' Association
2019 EMRA 45 Under 45

ADMINISTRATIVE DUTIES AND UNIVERSITY ACTIVITIES:

National Service:

American College of Emergency Physicians (ACEP)

2004-2006 Emergency Medicine Practice Management and Health Policy Section member
2005-present 911 Legislative Network member
2005-2017 Public Health and Injury Prevention Committee member
--Disparities in Health Care Subcommittee, chair (2009-2012)
--Healthy People 2020 Subcommittee, member (2009-2011)
-- Sobering Centers Subcommittee, chair (2012-2014)
2007-present Young Physicians Section, member
2008-2009 Associate Membership Task Force, appointed Chair
2016-2018 Diversity and Inclusion Task Force, appointed Chair
2017-2018 Diversity in Leadership Task Force, appointed member
2017-2020 Board of Directors, elected member
- ACEP Quality and Patient Safety Committee, Board liaison
- ACEP CEDR Committee, Board liaison
- ACEP Quality Improvement and Patient Safety Section, Board liaison
- ACEP Research Section, Board liaison
- ACEP Diversity, Inclusion, and Health Equity Section, Board liaison
- ACEP Undersea and Hyperbaric Medicine Section, Board liaison
- ACEP Trauma and Injury Prevention Section, Board liaison
- ACEP Nominating Committee (Council Committee), member

2017-2019 ACEP 2nd Journal Editor-in-Chief Search Committee Task Force, member
2020-2023 Board of Directors, elected member (2nd term)
- ACEP Secretary/Treasurer
- ACEP Quality and Patient Safety Committee, Board liaison
- ACEP CEDR Committee, Board liaison
- ACEP Quality Improvement and Patient Safety Section, Board liaison

Emergency Medicine Residents' Association (EMRA) Board of Directors, Presidential cabinet
2005-2006 President-elect
2006-2007 President
2007-2008 Immediate Past-president

Emergency Medicine Foundation (EMF)
2006-2007 Board of Trustees member
2007 EMF Strategic Plan/Planned Giving Task Force member
2020-present Board of Trustees member

American Academy of Neurology
2009-2015 Practice Parameters Guidelines on the Treatment of First Seizure, subcommittee member

Stop the Spread empowered by Impact Assets – non-profit that seeks to harness the power of the private sector and philanthropic resources to impact the health of the nation.
2020-present Advisory Board member, appointed

State Service:

District of Columbia Chapter of the College of Emergency Medicine

2013-2015 Board of Directors member, President and Councilor
2015-2016 Board of Directors member, Immediate Past President and Councilor
2016-present Board of Directors member, Councilor through 2017

The Maryland State Medical Society, MedChi
2003-2011

Maryland American College of Emergency Physicians (ACEP)
2005-2006 Public Relations Committee member
2005-2012 Public Policy Committee member
2007-2012 Board of Directors member

Maryland Stroke Alliance
2009-2012 Executive Committee member

Local Service:

Baltimore City Medical Society (BCMS)
2004-2011 Community outreach programs conductor
2005-2006 Membership Committee member

Departmental:

George Washington University Department of Emergency Medicine
2012 –2018 Health Policy Fellowship, Director, provide didactic teaching, foster professional development, and facilitate office placement with Congressional office, government agency, or think tank for aspiring emergency physicians with public health and health policy interests.

2018-2019 Health Policy Fellowship, Co-Director, provide didactic teaching, foster professional development, and facilitate office placement with Congressional office, government agency, or think tank for aspiring emergency physicians with public health and health policy interests.

2019-present Health Policy Fellowship, Senior Advisor, provide mentorship, networking opportunities, and professional development to health policy fellows; participate in didactic teaching; facilitate office placement with Congressional office, government agency, and/or think tanks.

University:

University of Maryland School of Medicine/University of Maryland Medical System
2004-2006 University of Maryland Medical System
Medical Policy Sub-Committee member
2004-2006 Black House Officers Association
2007-2011 Introduction to Clinical Medicine II Instruction, Instruct second-year medical students in physical examination skills
2007-2011 Departmental liaison for the Departments of Emergency Medicine and Neurology

George Washington University School of Medicine
2014-present Clinical Skills and Reasoning Instructor (CSR) in *Practice of Medicine* Course; instruct first and

second-year medical students in history-taking and physical examination skills.

2015-present Professional Development (PD) Mentor in *Practice of Medicine* Course; teach professionalism skills to first-year medical students through small group sessions focused personal reflection and team-building exercises.

2015-present Learning Community Leader; lead faculty development exercises for faculty members teaching professional development to first year students.

2016-2018 Clinical Skills and Reasoning (CSR) Curriculum Theme, Co-director; responsible for the development, dissemination, and implementation of all CSR weekly faculty and student sessions for the School of Medicine, as well as faculty and student evaluation of materials application and remediation exercises.

2018-present Clinical Public Health Mentor, develop and teach curriculum which exposes first and second year medical students to systems-based learning.

2020-2021 Professional Development Coaching Task Force, Co-chair; Appointed by Deans to lead school wide effort to design, implement, and create evaluation around professional development coaching program for the school of medicine.

Other Service:

Duke University

1996-1997 North Carolina Rural Health Coalition
1997 Organization for Tropical Studies Study Abroad Program in Costa Rica
1998 Duke University Black Professional Health Organization
1998-1999 Spanish Community Center of Durham volunteer

University of North Carolina School of Medicine

1999-2003 Student National Medical Association
1999-2003 Spanish-Speakers Assisting Latinos Student Association (SALSA)
1999-2001 Student Health Action Coalition (SHAC)
2000-2001 Community Service Co-chair
2000-2001 SALSA Co-leader
2000-2001 Laboratory Technician
2000 Medical Education Development (MED) Program, Teacher's Assistant in Microbiology and Biochemistry
2000-2001 UNC School of Medicine Soup Kitchen Coordinator, Coordinated UNC medical students as cooks and servers each month, averaged 4 hours of service each month
2000-2001 Prevention in ACTion (PACT), 2000-2001, Vice President, coordinated community outreach targeting health promotion in local adolescent girls
2001-2003 Emergency Medicine Residents' Association (EMRA), Medical Student Liaison

TEACHING AND EDUCATIONAL ACHIEVEMENTS:

2007-2011 Emergency Medicine Residency Clinical Pearls Author, Create and distribute weekly clinical instruction pertaining to neurological emergencies to medical students and emergency medicine residents and attendings, distribution of > 2000

2007-2011 Introduction to Clinical Medicine II Instruction, Instruct second-year medical students in physical examination skills (University of Maryland School of Medicine)

2007-present Academic lecturer and bedside instructor to ~ 15 classes of emergency medicine residents (150+), off-service surgical and medical residents, and medical students, focus on and expertise in neurological emergencies and stroke and public health/health policy (University of Maryland Medical System, George Washington University Medical Center)

2009-2010 American College of Emergency Physicians Teaching Fellowship; intensive course for junior faculty that taught the fundamentals of teaching and evaluation, curriculum design and implementation, and skill in balancing an academic career with competing interests.

2012-2019 Implementation of Executive Coaching curriculum for all George Washington University Department of Emergency Medicine fellows

2012-2019 Implementation, management, and evaluation of health policy journal club independent study coursework for George Washington University Department of Emergency Medicine health policy fellows enrolled at the George Washington University School of Public Health

2014-present Clinical Skills and Reasoning (CSR) Instructor, George Washington University School of Medicine and Health Sciences. instruct first, second, third and fourth year medical students in history taking and physical examination skills

2015-present Clinical Skills and Reasoning (CSR) Group Leader, conduct first and second year medical student professional development and faculty development sessions.

2015-present Professional Development (PD) Mentor; teach professionalism skills to first-year medical students through seminar-style courses, reflection exercises, and team-building.

2015-present CSR/PD Learning Community Leader; lead faculty development exercises for faculty members teaching professional development to first year students.

2015-May-Jun Guest lecturer, 11 emergency medicine residents (PGY1), 12 hours of lecturing Including multiple Neurology lectures; Madurai, India

2015-June Guest lecturer, 20+ emergency medicine residents (PGY1-3), 12 hours of lecturing including written and oral Board review; Mumbai, India

2015-Nov Guest lecturer, 20+ emergency medicine residents (PGY1-3), 12 hours of lecturing including written and oral Board review; Bubaneswar, India

2016-present Clinical Skills and Reasoning (CSR) Theme Curriculum, Co-director; responsible for the development, dissemination, and implementation of all CSR weekly faculty and student sessions for the School of Medicine, as well as faculty and student evaluation of materials application and remediation exercises

2016-Dec Guest lecturer, 20+ emergency medicine residents (PGY1-3), 12 hours of lecturing including written and oral Board review; Delhi, India

2017-Mar Guest lecturer, 20+ emergency medicine residents (PGY1-3), 12 hours of lecturing including written and oral Board review; Mumbai, India

2018-present Clinical Public Health Mentor, develop and teach curriculum which exposes first and second year medical students to systems-based learning.

GRANTS AWARDED:

6/1/07-5/31/09 (Co-PI 5%) PI: M. Wozniak
"ALIAS Phase III Trial in Albumin in Acute Ischemic Stroke"
ALIAS Trial through NETT Consortium
University of Michigan Fixed Price Per Patient Clinical Trial Contract

8/1/07-7/31/09 (Co-Investigator 12.5%) PI: T. Ting
"RAMPART Rapid Anticonvulsant Medications Prior to Arrival Trial"
RAMPART Trial through NETT Consortium
University of Michigan Fixed Price Per Patient Clinical Trial Contract

9/30/07 - 8/31/2012 (Co-Investigator 25%) PI: B. Stern
"Neurological Emergencies Treatment Trials (NETT) Network Clinical Site Hubs (U10)"
National Institute of Neurological Disorders and Stroke (NIH NINDS)

Cooperative Agreement
Total Costs: $1,262,597.00

5/15/09 – 8/15/09 (PI, Mentor 10%)
Intramural Grant funding portion University of Maryland School of Medicine Summer Research Internship for two medical students
Total Grant: $4,000.00

10/01/12 – 10/01/13 (PI 35%)
"Triage of Low Acuity Emergency Department Patients to a Primary Care Clinic and Patient-Centered Medical Home: A Health Services Utilization and Cost Effectiveness Analysis"
Clinical and Translational Sciences Institute-Children's National (CTSI -CN) pilot grant.
Total Grant: $ 39, 000.00

07/01/2013 – 07/01/2014 (PI 18%)
"Teaching Health Policy: Developing a Portable E-learning Tool for Medical Student Education"
George Washington University Medical Education Research Grant
Total Grant: $ 14, 900.00

Grant Writing Experience:

12/2009 "The Feasibility of using Perfusion-weighted Brain MRI over Non-contrast CT to Emergently Diagnose Acute Ischemic Stroke: An Analysis of Accuracy, Cost Effectiveness, and Safety."
Emergency Medicine Foundation sponsored
Proposed award amount: $50,000
Hours devoted: 60+

12/2010 – 02/2011 "Targeted Legislation and Regionalization Improves Stroke Patient Outcomes" Emergency Medicine Foundation (EMF), EMD and Genentech sponsored
Proposed award amount: $100,000
Hours devoted: 150+

05/2012 – 09/2012 "Triage of Low Acuity Emergency Department Patients to a Primary Care Clinic and Patient-Centered Medical Home: A Health Services Utilization and Cost Effectiveness Analysis"
Hours devoted: 200+

01/2015 "Teaching Health Policy to Resident Physicians: A National Survey and Curricula Recommendations"
Hours devoted: 100+

PUBLICATIONS:

Book Chapters:

1. **Liferidge AT**, et al. GEMSoft Emergency Medicine Electronic Textbook. Neurology Section. In press, July 2011.

2. **Liferidge AT**, Dark J. *EM Clinics*. Dangerous Fever in the Emergency Department. Fever and Neurological Conditions. November 2013.
3. **Liferidge, A**. Book Chapter "Caveats to Sisterhood: Internal Gender Bias," *Diversity and Inclusion in Quality Patient Care: Case Compendium.* In Development. Anticipated publication 2018.
4. **Terry, A.T.** "Special Populations: The Elderly." ACEP COVID-19 Field Guide (online book). April 2020.
5. **Terry, A.T.** "Special Populations: Pediatrics." ACEP COVID-19 Field Guide (online book). April 2020.
6. **Terry, A.T.** "Special Populations: Pregnancy." ACEP COVID-19 Field Guide (online book). April 2020.
7. Salvo, M. **Terry, A.T.** "Special Populations: Dialysis Patients." ACEP COVID-19 Field Guide (online book). April 2020.
8. Ferebee, M. **Terry, A.T.** "Special Populations: Psychiatric Patients." ACEP COVID-19 Field Guide (online book). April 2020.
9. Hoffer, M. **Terry, A.T.** "Special Populations: Racial and Ethnic Minority Groups" ACEP COVID-19 Field Guide (online book). April 2020.
10. Lange, J. **Terry, A.T.** "Special Populations: Law Enforcement." ACEP COVID-19 Field Guide (online book). April 2020.
11. Brooks, J. **Terry, A.T.** "Special Populations: Health Care Workers." ACEP COVID-19 Field Guide (online book). April 2020.
12. Popovo, M. **Terry, A.T.** "Special Populations: The Homeless." ACEP COVID-19 Field Guide (online book). April 2020.
13. Dreyer, N. **Terry, A.T.** "Special Populations: The Incarcerated" ACEP COVID-19 Field Guide (online book). April 2020.
14. Payette, C. **Terry, A.T.** "Special Populations: The Immunocompromised." ACEP COVID-19 Field Guide (online book). April 2020.
15. Schulman, C. **Terry, A.T.** "Special Populations: Immigrants." ACEP COVID-19 Field Guide (online book). April 2020.
16. **Terry, A.T.** Book Chapter "Women Leadership in Emergency Medicine Leadership. Political and National Organized Medicine Leadership." *Strauss and Mayer's Emergency Medicine Management*. Second Edition. 2020.
17. **Terry, A.T.** Book Chapter "Women Leadership in Emergency Medicine Leadership. Women of Color." *Strauss and Mayer's Emergency Medicine Management*. Second Edition. 2020.

Peer-reviewed Journal Articles:

1. **Liferidge AT**, Brice JH, Overby B, Evenson KR. The Ability of Laypersons to Utilize the Cincinnati Prehospital Stroke Scale. *Prehospital Emergency Care*, October 2004, 8(4): 384-7.
2. **Liferidge, AT**, Kuo D. Stroke Mimics, *Critical Decisions in Emergency Medicine*, February 2006 edition.
3. Ali Farzad, M.D.; Bethany Radin, D.O.; Jason S Oh, M.D.; Heidi M Teague, M.D.; Brian D Euerle, M.D.; J.V. Nable, M.D.; **Aisha T Liferidge**, M.D.; Andrew T Windsor, M.D.; Michael D Witting, M.D. Emergency Diagnosis of Subarachnoid Hemorrhage: An Evidence-Based Debate. *J Emerg Med*. January 2013.
4. Guideline Development Editor, Allan Krumholz, Samuel Wiebe, Gary Gronseth, David Gloss, Ana M. Sanchez, Arif A. Kabir, **Aisha Liferidge**, Justin Paul Martello, Andres M. Kanner, Shlomo Shinnar, Jennifer L. Hopp, and Jacqueline French. Evidence-based Guideline: Management of an Unprovoked First Seizure in Adults: Report of the Guideline Development Subcommittee of the American Academy of Neurology and the American Epilepsy Society. *Neurology and Epilepsy Currents*. April 2015.
5. Otis Warren, Shannon Smith-Bernardin, Katherine Jamieson, Nikolas Zaller, **Aisha Liferidge**.

Identification and Practice Patterns of Sobering Centers in the United States. *Journal of Healthcare for the Poor and Underserved*, Volume 27, Number 4, November 2016, pp 1843-1857.

6. Nathan Seth Trueger, Kao-Ping Chua, Aamir Hussain, **Aisha T. Liferidge**, Stephen R. Pitts, Jesse M. Pines. Incorporating Alternative Care Site Characteristics into Estimates of Substitutable ED Visits. *Medical Care*. July 2017. Volume 55, Number 7: 693-697.
7. David Marcozzi, **Aisha Liferidge**, Brendan Carr. Trends in the Contribution of Emergency Departments to the Provision of Hospital-associated Health Care in the USA. *International Journal of Health Services*. October 17, 2017. 0(0): 1-22.
8. Elizabeth A. Samuels, Dowin Boatright, Leon D. Sanchez, Sheryl L. Heron, **Aisha T. Liferidge**, Taneisha Wilson, Ava Pierce, Alden Landry, Lisa Moreno-Walton, Jeffrey Druck, Joel Moll, Bernard L. Lopez. Clinical Vignettes Inadequate to Assess Impact of Implicit Bias: Concerning Limitations of a Systemic Review. *Academic Emergency Medicine*. November 2017. Volume 24, Issue 12: 1531-2.
9. Janice Blanchard MD PhD, Tenagne Haile-Mariam MD, Natasha Powell MD, MPH, **Aisha Terry MD, MPH**, Malika Fair MD, MPH, Marcee' Wilder MD, MPH, Damali Nakitende MD, Jared Lucas MD, Griffin Davis MD, MPH, MBA, Yolanda Haywood MD. "For Us, COVID-19 is Personal." *Academic Emergency Medicine.* 17 May 2020.
10. Marisa K Dowling, **Aisha T Terry**, Natalie L Kirilichin, Jennifer S Lee, Janice C Blanchard. United States Congressional COVID-19 Legislation: Recent Laws and Future Topics. *Western Journal of Emergency Medicine*. 2020 Aug 17;21(5):1037-1041.
11. Venkatesh, A; Janke, A; Li, X; Rothenberg, C; Goyal, P; **Terry, A***; Lin, M.* Emergency Department Utilization for Emergency Conditions During COVID-19. *Annals of Emergency Medicine*. January 2021.

Publications currently being developed:

1. **Liferidge AT**, McCarthy M, Ding R, Blanchard J, Li S, Seton P. Triage of Low Acuity Emergency Department Patients to a Primary Care Clinic and Medical Home: A Utilization and Cost Effectiveness Analysis.
2. **Liferidge AT**, Ryles A, Aziz M, Brown S, Trueger N, Burke G, Pourmand A, Blanchard J, Davis S. Teaching Health Policy: Developing a Portable E-learning Tool for Medical Student Education.
3. **Terry A.T.** "The Medical Student Experience in the Era of COVID-19: Reflections on the Transformation of Medical Education."

Abstracts and/or Proceedings:

1. **Liferidge AT**, Brice JH, Overby B, Evenson KR. The Ability of Laypersons to Utilize the Cincinnati Prehospital Stroke Scale. *Academic Emergency Medicine,* May 2002, 9(5): 497, (Abstract).
2. **Liferidge AT.** "Cost Effetiveness Analysis of Triage of Non-emergent Emergency Department Patients a Medical Home," 2012 International Forum on Quality and Safety in Health Care; Paris, France. April 2012. ***(International)***
4. **Liferidge AT**. "Triage of Low Acuity Patients from the Emergency Department to Primary Care and Medical Home: A Utilization and Cost Analysis." National Medical Association Annual Meeting, Honolulu, Hawaii, July 2014.
5. Ryles A, Aziz M, Brown S, Trueger S, Burke G, Pourmand A, Davis S, **Liferidge AT**, Blanchard J."Teaching Health Policy: Developing a Portable E-learning Tool for Medical Student Education." Society of Academic Emergency Medicine, Mid-Atlantic Regional Annual Meeting, Washington, DC, February 2015.
6. **Liferidge AT**. "Triage of Low Acuity Patients from the Emergency Department to Primary Care

And Medical Home: A Utilization & Cost Analysis." ACEP15 Scientific Assembly, Boston, MA, Oct 2015.

COURSE DEVELOPMENT:

1. **Liferidge, A.** *Health Policy for Medical Students* - Portable Electronic-Learning Modules; product of grant-funded research; 2014.
2. **Liferidge, A.** *Clinical Skills and Reasoning and Professional Development Course*, George Washington University School of Medicine and Health Sciences, Washington, DC, 2017-2018.
3. **Liferidge, A.** Unconscious Bias Online Course, *"Unconscious Bias: Protect Yourself and Your Patients,"* American College of Emergency Physicians, CME-eligible, 2017.
4. **Liferidge, A.** Developed idea around and led efforts to implement an **Executive Coaching Curriculum** through *Executive Advantage, LLC* for all George Washington University Department of Emergency Medicine fellows. 2012 to 2014.
5. **Terry, A.** Developed Professional Development Coaching Program for the George Washington University School of Medicine and Health Sciences. 2020-2021.

PRESENTATIONS:

Invited and Grand Rounds:

International:

1. **Liferidge AT**. 4-week lecture series on the fundamentals of emergency medicine. Bali International Medical Center (BIMC), Bali, Indonesia, April 2006.
2. **Liferidge AT**. Trauma training program; biannual 1-week lecture series on designing and implementing trauma systems; Hunan Provincial Peoples Hospital. Changshan, Hunan, China. March 2019 to 2021.

National:

1. **Liferidge, AT**, Stone, R. "Natural History of Illness: The Perils of Non-transport, Recognizing Stroke." EMS Care Annual Meeting, May 2005.
3. **Liferidge AT**. "What You Need Know about HIV Emergencies." National Medical Association Annual Meeting, Las Vegas, Nevada July 2009.
4. **Liferidge AT**. "What's the Point of Point-of-Care HIV Testing in the Emergency Department." National Medical Association Annual Meeting, Las Vegas, Nevada, July 2009.
5. **Liferidge AT**. "Brain Attack 101: Maintaining Your Stroke of Genius." National Medical Association Annual Meeting, Orlando, Florida, August 2010.
6. **Liferidge AT**, George Washington University Department of Emergency Medicine Health Policy Fellowship. "Sustained Growth Rate (SGR) Journal Club and Workshop." ACEP Leadership and Advocacy Conference, EMRA session. Washington, DC. May 2013.
7. **Liferidge AT.** "VIP Networking Event: "Code Black" Movie and Panel Discussion." ENGAGE Conference on Innovation in Patient Engagement, Presented by MedCityNews. Hyatt Bethesda, Bethesda MD, September 2014.
8. **Liferidge AT.** ""Who has Time to Coordinate?: Sensible Strategies for Reforming our Delivery System and Ending Fragmented Care." American College of Emergency Medicine, Leadership and Advocacy Conference, Washington, DC, May 2015.

9. **Liferidge AT.** ACEP Leadership and Advocacy Conference 2016. EMRA/YPS Journal Club. "EM Reimbursement through the Lens of Alternative Payment Methods," Grand Hyatt, Washington, DC, May 2016.
10. **Liferidge AT.** ACEP Leadership and Advocacy Conference 2016. Leadership Day. Diversity Panel Discussant. Grand Hyatt, Washington, DC, May 2016.
11. **Liferidge AT.** American Public Health Association Annual Conference 2016. Racial Inequity in Health Care and Public Health: A Discussion and Call to Action." Denver, CO, October 2016.
12. **Liferidge AT.** American College of Emergency Physicians Leadership and Advocacy Conference, Implicit Bias in Leaders Panel Discussion, invited panelist, Washington, DC, March 2017.
13. **Liferidge AT.** Latino Medical Student Association Health Policy Summit. Keynote Address. Washington, DC. October 2017.
14. **Liferidge AT**. Thinking Good – A Digital Media Community. "Empowering Future Breakthroughs: A Conversation with Dr. Aisha Liferidge." Invited Podcast Interview, February 28, 2018. http://thinkinggood.org/suite-talk/dr-aisha-liferidge
    - *Discusses career development*
    - *Discusses the work of the Minority Women in Science Foundation*
    - *Discusses leadership through the American College of Emergency Physicians from the context of its Diversity and Inclusion initiative and unconscious bias education*
15. **Liferidge AT.** National Hispanic Medical Association, Annual Meeting, "Leadership Development for Young Professionals in Non-traditional Roles," Panel Discussant, Gaylord Resort and Convention Center, Washington, DC, March 2018.
16. **Liferidge AT.** "Health Policy Perspectives and Predictions." Recorded: April 13, 2018. Host: Kate Woods, Esq. White and Williams, LLP. Release date: June 2018.
17. **Liferidge AT.** "Cardiovascular Health Disparities and Policy-based Action Plan." University of Illinois at Chicago. Grand Rounds Speaker. Chicago, Illinois. April 19, 2018.
18. **Liferidge AT.** "Why Diversity in Emergency Medicine Matters." Chicago Minority Medical Student Emergency Medicine (CMMSEM) Program Fundraiser, keynote address speaker. Chicago, Illinois. April 19, 2018.
19. **Liferidge AT.** "Glass or Ceiling: Ensuring that Women Lead" Panel Discussion Moderator. ACEP Leadership and Advocacy Conference. Washington, DC. May 2018.
20. **Liferidge AT.** "Opioid Panel 1: Putting Prevention into Practice" LAC Solutions Forum. Panel Discussion Moderator. ACEP Leadership and Advocacy Conference. Washington, DC. May 2018.
21. **Liferidge AT.** "Trailblaze." FIX18 (Feminine Idea Exchange) Conference. New York, New York. October 2018.
22. **Liferidge AT.** "Successful Team Dynamics: Champion Diversity and Inclusion." EMRA Leadership Academy. Virtual speaker. January 16, 2019.
23. **Liferidge AT.** Panelist. "Listen to Us! How Racial and Gender Bias Undermine Health." Families USA, 2019 Health Action Conference. Washington, DC. January 25, 2019.
24. **Lifeirdge AT.** "Real Change through Advocacy: A Cure for Moral Injury." ACEP BalancED Conference. Ojai, California. February 19-22, 2019.
25. **Liferidge AT.** "Drug Shortages Solutions Forum." Panelist. National Academies of the Sciences. Washington, DC. September 2018.
26. **Liferidge AT.** "Chapter Leadership: Making your Leadership Bullpen Ready for the Next Call." ACEP Leadership and Advocacy Conference. Washington, DC. May 2019.
27. **Liferidge AT.** "Health Equity in Emergency Medicine." Chicago Minority Medical Student in Emergency Medicine Program. Virtual Presenter. Chicago, IL. July 2019.
28. **Terry A.T.** Goyal P. Malcolm B. "MACRA and MIPS Reporting Complexities for 2020: Strategies for Success." ACEP Reimbursement and Coding Conference. Austin, Texas. January 2020.
29. **Terry A.T.** Goyal P. Malcolm B. "How CEDR Allows you to Meet MIPS Reporting Requirements for 2020." ACEP Reimbursement and Coding Conference. Austin, Texas. January 2020.

30. **Terry A.T.** Goyal P. "MACRA and MIPS Reporting Complexities for 2020: Strategies for Success." ACEP Reimbursement and Coding Conference (virtual). January 2021.
31. **Terry A.T.** Malcolm B. "How CEDR Allows you to Meet MIPS Reporting Requirements for 2020." ACEP Reimbursement and Coding Conference (virtual). January 2021.
32. **Terry A.T.** "Emergency Department Workforce: The Future of the Department's Most Valuable and Expensive Resource." ACEP Reimbursement and Coding Conference (virtual). January 2021.

State/Regional:

1. **Liferidge, AT**. "On Being a Doctor: The three "D's" of Success." Annual Technology Symposium, Maryland Health and Family Services, June 2005.
2. **Liferidge, AT**. "EMRA Update 2007," Pennsylvania ACEP Scientific Assembly, Philadelphia, Pennsylvania, April 2007.
3. **Liferidge, AT**. "EMRA Update 2007," Emergency Medicine Residents' Association of Michigan (EMRAM) Resident Research Symposium and Dinner, Lansing, Michigan, April 2007.
4. **Liferidge, AT**. "The Fascinating World of Emergency Medicine," Mount San Antonio College Annual Health Conference, Walnut, California, May 2007.
5. **Liferidge, AT**. "EMRA Update 2007," Ohio ACEP Scientific Assembly, Sandusky, Ohio, July 2007.
6. **Liferidge, AT**. "EMRA Update 2007," New York ACEP Scientific Assembly, Bolton Landing, New York, July 2007.
7. **Liferidge, AT**. "EMRA Update 2007," Florida CEP Annual Meeting, Naples, Florida, August 2007.
8. **Liferidge AT**. "Acute Stroke Management in the Emergency Department." Maryland Stroke Alliance Annual Meeting, November 2008.
9. **Liferidge AT.** "An Update in the Emergent Management of the Inconspicuous Assailant (TIA)," Maryland Stroke Alliance Annual Meeting, Maryland, November 2010.
10. **Liferidge AT.** UT Southwestern Medical Center, Grand Rounds, "*Tricks of the Trade for Managing HIV-related Emergencies.*" Dallas, Texas, April 2015.
11. **Liferidge AT.** UT Southwestern Medical Center, Grand Rounds, "*E-Tools for Learning Health Policy.*" Dallas, Texas, April 2015.
12. **Liferidge AT.** Community Day 2015, "Home Grown Leadership." Goldsboro, NC, Apr. 2015.
13. **Liferidge AT,** Fair M**.** "Health Policy Update 2015." Carolinas Medical Center, Grand Rounds, Charlotte, NC, September 2015.
14. **Liferidge AT.** "Health Policy Update 2017: Why You Need to Know." University of Maryland Medical System, Department of Emergency Medicine, Alumni Grand Rounds, Baltimore, Maryland, May 2017.
15. **Liferidge AT.** "National ACEP Update and Advocacy" ACEP Iowa Chapter Annual Meeting. Cedar Ridge, Iowa. June 28, 2018.
16. **Liferidge AT.** "National ACEP Update"; "Unconscious Bias in Clinical Practice." ACEP Pennsylvania Chapter Annual Meeting. King of Prussia, PA. April 2019.
17. **Liferidge AT.** "National ACEP Update"; "Health Equity in Emergency Medicine." ACEP Illinois Chapter Annual Meeting. Chicago, IL. April 2019.
18. **Liferidge AT.** "National ACEP Update"; "Unconscious Bias in Clinical Practice." ACEP Coastal Emergency Medicine Conference (North Carolina, South Carolina, and Georgia Chapters) Annual Meeting. Kiawah Island, SC. June 2019.
19. **Liferidge AT.** "National ACEP Update"; "Unconscious Bias in Clinical Practice." ACEP Ohio Chapter Annual Meeting. Columbus, OH. August 2019.
20. **Terry A.T.** "Health Equity in Emergency Medicine." Virginia ACEP Annual Conference Keynote Speaker. February 2020.

21. **Terry A.T.** "Wellness and Minimizing Burnout in Emergency Medicine." Rhode Island ACEP Annual Conference. June 2020.
22. **Terry A.T.** "Tricks for Achieving a Diverse Physician Workforce and Inclusive Workplace" Washington ACEP Leadership Conference. November 2020.
23. **Terry A.T.** "Health Disparities and Inequities: Next Steps and Solutions." Yale University School of Medicine, Department of Emergency Medicine. Grand Rounds. November 2020.
24. **Terry A.T.** "Tricks for Achieving a Diverse Physician Workforce and Inclusive Workplace" Wisconsin ACEP Annual Conference. April 8, 2021.
25. **Terry A.T.** "Tricks for Achieving a Diverse Physician Workforce and Inclusive Workplace" Massachusetts ACEP Annual Conference. May 5, 2021.
26. **Terry A.T.** "National ACEP Update"; "Unconscious Bias in Clinical Practice." Missouri ACEP Annual Conference. May 27, 2021.

Local/Institutional:

1. **Liferidge, AT**. "Stress Dose Steroids in the Anesthesia Patient." University of Maryland Medical System, Shock Trauma Anesthesia, April 2005.
2. **Liferidge, AT**. "Preoperative Preparation in the Emergency Department." University of Maryland, Emergency Medicine, Junior Case Conference, May 2005.
3. **Liferidge, AT**. "Leadership and Patient Advocacy in Emergency Medicine." University of Maryland Emergency Medicine Grand Rounds, September 2005.
4. **Liferidge AT**. "Current Concepts in Stroke Diagnosis and Management." University of Maryland Emergency Medicine Grand Rounds, January 2006.
5. **Liferidge AT**. "Opportunities Through Organized Medicine." University of Maryland Emergency Medicine Grand Rounds, June 2006.
6. **Liferidge AT**. "Current Concepts in Stroke Diagnosis and Management." Georgetown University Department of Emergency Medicine Grand Rounds, December 2008.
7. **Liferidge AT.** "Day on the Hill Wrap-up for Medical Students." George Washington University School of Medicine. Washington, DC, September 2012.
8. **Liferidge AT.** "The Georgetown University Emergency Medicine Interest Group Symposium: Health Policy Workshop/American Academy of Emergency Medicine (AAEM)." Georgetown University School of Medicine. Washington, DC, October 2012.
9. **Liferidge AT.** "The Georgetown University Emergency Medicine Interest Group Symposium: Health Policy Workshop/American Academy of Emergency Medicine." Georgetown University School of Medicine. Washington, DC, October 2013.
10. **Liferidge AT.** "Leadership Panel Discussion," guest panelist, Melrose Hotel, Washington, DC, November 2013.
11. **Liferidge AT.** George Washington University Resident Fellowship in Health Policy, Career Leadership Panel, Panelist, Washington, DC, March 2015.
12. **Liferidge AT.** George Washington University Department of Emergency Medicine, Annual Capitol Hill Day, "ACEP Update." Washington, DC. April 11, 2018.
13. **Liferidge AT.** National Christian Academy, Career Day. "A Day in the Life of Dr. Aisha Liferidge." Fort Washington, Maryland. April 27, 2018.
14. **Liferidge AT.** "Career Development and Health Policy." George Washington University. September 2018.
15. **Terry A.T.** "Health Equity in Emergency Medicine." Alteon Health. Sibley Hospital Department of Emergency Medicine Virtual Grand Rounds. Washington, DC. May 2020.

<u>Research</u>:

1. **Liferidge, AT**, Brice, JH, Overby, B, and Evenson, KR. The Ability of Laypersons to Utilize the Cincinnati Prehospital Stroke Scale. University of North Carolina Annual Emergency Medicine Research Forum, April 2002.
2. **Liferidge, AT**, Brice, JH, Overby, B, and Evenson, KR. The Ability of Laypersons to Utilize the Cincinnati Prehospital Stroke Scale. Society for Academic Medicine (SAEM) Southeastern Regional Conference, April 2002.
3. **Liferidge, AT**, Brice, JH, Overby, B, and Evenson, KR. The Ability of Laypersons to Utilize the Cincinnati Prehospital Stroke Scale. Society for Academic Emergency Medicine (SAEM) National Conference, May 2002.
4. **Liferidge, AT**. The Ability of Laypersons to Utilize the Cincinnati Prehospital Stroke Scale. The University of Maryland Emergency Medicine Residency Research Forum, June 2005.
5. **Liferidge AT**. "Defining and Objectively Measuring Quality for an Inner City Academic Emergency Department." Society for Academic Emergency Medicine Mid-Atlantic Conference, Georgetown University School of Medicine, Washington, DC, February 2013.
6. **Liferidge AT.** "Triaging Non-emergent Emergency Department Patients to a Medical Home through a Federally Qualified Health Center." Society for Academic Emergency Medicine Mid-Atlantic Conference, Georgetown University School of Medicine, Washington, DC, Feb. 2013.
7. **Liferidge AT.** "Triaging Non-emergent Emergency Department Patients to a Patient Centered Medical Home (PCMH) through a Federally Qualified Health Center (FQHC): A Cost Effectiveness Analysis." Society of Academic Emergency Medicine, Western Regional Annual Meeting. Long Beach, California. March 23, 2013.
8. **Liferidge AT.** "Triaging Non-emergent Emergency Department Patients to a Patient Centered Medical Home (PCMH) through a Federally Qualified Health Center (FQHC): A Cost Effectiveness Analysis." National Medical Association Annual Meeting, Toronto, Canada, July 2013. ***(International)***
9. **Liferidge AT**. "Triage of Low Acuity Patients from the Emergency Department to Primary Care and Medical Home: A Utilization and Cost Analysis." National Medical Association Annual Meeting, Honolulu, Hawaii, July 2014.
10. Ryles A, Aziz M, Brown S, Trueger S, Burke G, Pourmand A, Davis S, **Liferidge AT**, Blanchard J. "Teaching Health Policy: Developing a Portable E-learning Tool for Medical Student Education." Society of Academic Emergency Medicine, Mid-Atlantic Regional Annual Meeting, Washington, DC, February 2015.
11. **Liferidge AT.** "Metabolizing to Freedom: Sobering Centers and Policy Solutions for the Chronic Inebriate." National Medical Association Annual Meeting, Detroit, MI, August 2015.
12. **Terry AT, et al. The Medical Student Experience in the Era of Covid-19: Reflections on the Transformation of Medical Education,** George Washington University, Department of Emergency Medicine (Principal Investigator), Description: *A virtual focus group of medical students was conducted on April 30, 2020. Each student was asked to broadly and candidly reflect on their personal experiences relative to the COVID-19 pandemic, and to specifically expound upon how their personal growth and medical education has been impacted.*

<u>Proferred Communication</u>:

1. LaMonte, Marian; Kuo, Dick; Barhout, Mona; **Liferidge, AT**; Yarbrough. Rapid Assessment of Transient Ischemic Attack Etiologies (RATE), ACEP Scientific Assembly, New Orleans, La, October 2006.

WEBINARS/PODCASTS:

1. "COVID-19 Educational Discussion." Webinar. Nationally broadcasted. **A. Terry** served as expert clinical informant, interviewed by Star Jones. Sponsored by *Power Rising*. https://www.facebook.com/IAmPowerRising/videos/?ref=page_internal. March 25, 2020.

2. "The Epidemiology of COVID-19: The Impact Upon Youth, Adults, and Black America." Webinar. Nationally broadcasted series. Guest panelist. **A. Terry** interviewed by Art Norman. Co-panelist Congresswoman Robin Kelly. Powered by *100 Black Men of Chicago*. http://facebook.com/100BMC. May 7, 2020.

3. "Two Truths and a Lie." Podcast. Nationally available. An in depth discussion about the pathophysiology of the novel coronavirus and its impact. **A. Terry** interviewed by Victor Carraway. National Association of Black Accountants (NABA). August 11, 2020.

4. "Preparing for the Next Pandemic: Disparities and Vulnerable Populations." Webinar. **A. Terry** interviewed by Gail D'Onofrio. Guest expert panelist. Sponsored by the American College of Emergency Physicians (ACEP). https://www.acep.org/corona/COVID-19-alert/covid-19-articles/preparing-for-the-next-pandemic/. August 31, 2020.

5. "A Discussion on COVID-19 Health Policy." Podcast. Nationally available. **A. Terry** interviewed by Andrew Meltzer. Co-guest Dr. Marisa Dowling, senior health policy fellow. *Urgent Matters*. https://smhs.gwu.edu/urgentmatters/content/discussion-covid-19-health-policy-dr-dowling-and-dr-terry. https://twitter.com/Urgent_Matters/status/1318245780273188865. October 2020.

6. "Racial Injustice and Inequities: Where Do We Go from Here?" Webinar for the American College of Emergency Physicians' (ACEP) Annual Conference (ACEP20). **A. Terry** interviewed reknown historian and best selling author, Ibram X. Kendi. Co-interviewer, Dr. Mark Rosenberg, ACEP President. October 27, 2020.

7. "COVID-19 and Stroke Overview." Podcast. Nationally available. **A. Terry** interviewed by Ryan Stanton. *Frontline* with Ryan Stanton. https://podcasts.apple.com/nz/podcast/acep-frontline-emergency-medicine/id1063793120. November 3, 2020.

8. "Women on the Frontlines: Stronger Together." Webinar. Nationally available. A. Terry (panelist). https://youtu.be/ZdGbSTaXk6k. The Nassau County Medical Society of New York. March 31, 2021.

INVITED MEDIA CONTRIBUTIONS:

Television:
COVID-19 and the impact of the pandemic. Physician expert guest panelist. Nationally broadcasted. **A. Terry** interviewed by Mark Albert, national investigative correspondent. *Hearst TV Broadcast*. Local station: WBAL-TV, NBC affiliate. Pt1: bit.ly/2UoYdb9 (start at 12 min); Pt2: bit.ly/2WPFkzW. March 27, 2020.

Radio:
COVID-19's impact on physical and mental health, particularly in communities of color. Physician expert guest interviewee. Nationally syndicated radio broadcast. *iHeart Radio* "Chicago Speaks." **A. Terry** interviewed by Darryl Dennard. https://www.spreaker.com/user/9809268/chicago-speaks-may-17-2020. https://www.youtube.com/watch?v=Z8CSq_RdY9M&feature=youtu.be. May 17, 2020.

Print:

1. "When Everything Changes: On the Frontlines of COVID-19." **A. Terry** interviewed by Stacy Weiner. *American Association of Medical Colleges (AAMC).* https://www.aamc.org/news-insights/when-everything-changes-front-lines-covid-19. March 26, 2020.

2. "Coronavirus Pandemic Takes Toll of ER Dcotors' Health and Families." **A. Terry** interviewed by Sarah McMammon. *NPR.* https://www.npr.org/2020/03/28/822228196/coronavirus-pandemic-takes-a-toll-on-er-doctors-health-and-families. March 28, 2020.

3. "Death is Our Greeter: Doctors, Nurses Struggle with Mental Health as Coronavirus Cases" **A. Terry** interviewed by Rick Jervis. *USA Today*. https://www.usatoday.com/story/news/nation/2020/05/03/coronavirus-death-count-has-doctors-struggling-mental-health/3063081001/. May 5, 2020.

4. "Protests May Add COVID-19 Cases and Compound Racial Disparities." **A. Terry** interviewed by Emily Kopp. *Congressional Quarterly. Roll Call*. Policy Section. https://www.rollcall.com/2020/06/02/protests-may-add-covid-19-cases-and-compound-racial-disparities/. June 2, 2020.

5. "To Battle Racism, Experts Say Make Health Equity a Central Principle." **A. Terry** interviewed by Steven Johnson. *Modern Healthcare*. https://www.chartis.com/resources/files/resources/MH_To-battle-racism-experts-say-make-health-equity-a-central-principle.pdf. June 6, 2020.

6. "Emergency Physicians: Pandemic Compounds Stress of Difficult Job." A. Terry interviewed by David Hodgberg. Washington Examiner. https://www.washingtonexaminer.com/news/emergency-physicians-pandemic-compounds-stress-of-difficult-job. August 13, 2020.

7. "The Coronavirus is Creating a Mental Health Crisis for Health Care Workers." A. Terry interviewed by Jeffrey Young. Huffington Post. https://www.huffpost.com/entry/health-care-workers-covid-mental-health_n_5f625a6ac5b6c6317cfed815. September 21, 2020.

SERVICE TO THE COMMUNITY:

2006-present Minority Women in Science Foundation (MWSF), 501c3 not-for- profit, Founder and CEO
Provides mentorship, tangible resources, networking opportunities, and career-long support to minority women with interest in science careers.

- *Perform key note address speeches and talks which promote awareness and motivation at local, state, and national level*
- *Provided 13 scholarships to aspiring youth in 2013 totaling approximately $8,000*
- *Provided block grant to Sister Mentors though EduSeed funding SAT preparatory courses for 10 high school juniors in 2015 totaling approximately $7,000.*
- *Provided 10 academic and merit based scholarships to 10 rising college freshmen totaling approximately $25,000 in 2016.*
- *Renewed approximately $10,000 in academic scholarships to previous beneficiaries based on maintenance of GPA criteria in 2017.*
- *Annual scholarships granted.*
- *Regular and frequent presentations given for applicable groups.*

American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

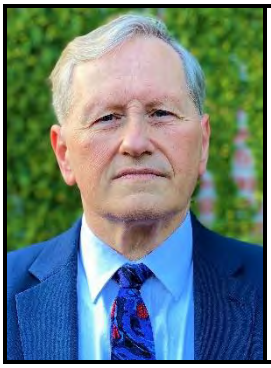
Board of Directors Candidates

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2021 Board of Directors Candidates

L. Anthony Cirillo, MD, FACEP

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer
- CV



William B. Felegi, DO, FACEP

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer
- CV

John T. Finnell, II, MD, MSc, FACEP

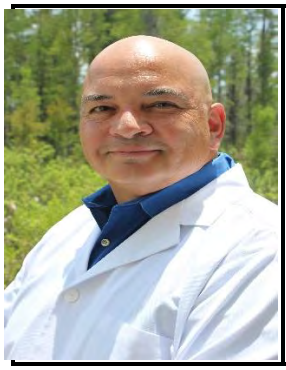
- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer
- CV

Rami R. Khoury, MD, FACEP

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer
- CV

Heidi C. Knowles, MS, MD, FACEP

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer
- CV



Michael Lozano, Jr., MD, MSHI, FACEP

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer
- CV

Henry Z. Pitzele, MD, FACEP

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer
- CV

Joseph R. Twanmoh, MD, MBA, FACEP

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer
- CV

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2021 BOARD OF DIRECTORS CANDIDATE WRITTEN QUESTIONS

L. Anthony (Tony) Cirillo, MD, FACEP

Question #1: **How do you build confidence that the College prioritizes the interests of our members and our specialty?**

The building of confidence in any relationship is based upon how we listen to, respect, and act both toward each other, and in support of each other. In my 30 years of ACEP membership, I have had the opportunity to work with and represent so many great emergency physicians. From my early days as an eager young resident serving on the EMRA Board of Director to my service now on the ACEP Board of Directors, and in the course of each and every committee, task force, and Board meeting I have never forgotten that I serve the interests of all ACEP members and the specialty of emergency medicine. ACEP is recognized within the house of medicine and with policy makers in the healthcare arena as THE voice of emergency medicine. The College is respected in this role because we always focus on doing the right thing for our patients and our members. Focusing on the needs of our members and patients is the core of everything we do in ACEP, and we must never lose this foundation.

For this question, I believe one can substitute the word "trust" for "confidence". I believe that trust in a relationship is built on two things: communication and action. As the College has matured, we have become a multi-generational organization. This maturation has led to some amazing moments, such as a mom or dad emergency physician literally passing the baton of care during shift sign out to a daughter or son. ACEP's maturation also creates challenges for effective communication with our members. Creating a sense of connection and family is a critical role of ACEP that emphasizes our uniqueness as a specialty. As some in emergency medicine and the healthcare arena are trying to tear us apart, the College, and by that, I mean each member, has been a source of pride and strength for me. But effective communication with a multi-generational group of emergency physicians requires that the College enhance our communication strategies. ACEP's connection to each and every member, regardless of generation is vital to our future.

Question #2: **Now that you have risen to a high level of leadership within ACEP, how do you transition from accomplishing tasks as an individual to guiding others and leading strategically?**

One of the hallmarks of every successful organization is that its leaders focus intently on the empowerment of the next generation of leaders. There's a great quote by Marlene Caroselli that states, "*True leaders have so much power that they are willing to give it away. Power is not a fixed quantifiable sum; instead, it is a limitless abstraction that grows as it is shared".* During my career in ACEP, I have been the beneficiary of that sharing. My first ACEP Scientific Assembly (which hopefully brings some good karma) was 30 years ago, in 1991, in BOSTON! At the very first EMRA annual meeting I attended there, I was welcomed and encouraged to get more involved. I felt that I had found my "tribe" and have never looked back--believing that service in ACEP would be my path for engagement in organized medicine. As part of my service on the EMRA Board, serving as the ACEP Representative, to my service now on the ACEP Board, I have had the opportunity to have power shared with me by many. Now I focus on sharing back with the next generation of emergency physician leaders.

In the practice of sharing power, I have come to appreciate that opportunities to be a "leader" aren't just about being the chair of a committee, a task force, or even serving on the Board of Directors. Those opportunities are scarce and always time limited. But there are no limits to the moments that we create to actively listen and share our experiences and perspectives with one another. This type of sharing of power and empathetic listening affords us the opportunity to focus not on individual goals, but on the goals of others, and on that of the greater good of the organization. It makes us all better leaders and better people by demonstrating that we are willing to invest in understanding the needs of others through open-minded and respectful discourse.

Over the past three years, I am proud of the work that the ACEP Board has undertaken and the manner in which we have done so. Open, transparent, and thoughtful discussions focusing on the strategic issues that matter most to our members is how we position the College to remain the leading organization representing emergency physicians. I am enthusiastic about the opportunity to continue, and accelerate, this work on behalf of our members.

Question #3: **What areas of improvement do you see that are needed within the College and what are your proposed solutions?**

Identifying the areas of improvement needed within the College requires that we first acknowledge ACEP's success in the arenas of advocacy, clinical education, and overall representation of emergency physicians and the specialty of emergency medicine. Much has been accomplished, but we have much work to do. I believe improvements are most needed in three areas: communication, relationship building, and emergency physician career support.

As the world of technology continues to accelerate, the speed and complexity of communication has evolved as well. The College needs to invest resources to stay engaged with our diverse membership and to improve the breadth and depth of our external and internal communication capabilities. The College is fortunate to have members extending from the "Post War" generation (yes, post WWII) to Gen Z'ers. This variety of experience is a great strength of the College, but it also demands a communication strategy that meets our members where they are today, and to have a communication approach that is adaptable to future technological advances. The communication strategies we develop need to allow for mobile, real-time, and transparent engagement and interaction with our members.

Next, I believe it essential that we reconnect with our members, our chapters, and our residencies in emergency medicine. Especially during COVID-19, we have all felt isolated and distant from each other and from the inherent support that being a part of the ACEP family brings. While all of us are part of the national ACEP family, relationships, just like politics, are local. We need to develop stronger ties and relationships with Chapters and EM residency programs. This requires a commitment to devoting time to listening and speaking on a regular basis, not just during once-a-year gatherings. The College will need to commit financial and personnel resources to this effort, supported by the continued outreach by our volunteer leaders. We need to build on the strength of the local relationships that occur in Chapters and residencies to reconnect with every emergency physician.

The third area of improvement I view as vital is practice support for the emergency physician. Given the realities of the external pressures from the healthcare practice environment in this country, we must provide improved career education and support for all emergency physicians. The College needs to continue to develop and strengthen policies and programs that support the goal of every emergency physician having the opportunity to enjoy a long, rewarding, and successful career in emergency medicine. We must create resources to provide emergency physicians the tools for success in every practice model. Further, we must expand the realm of emergency medicine practice opportunities based upon each emergency physician's particular interests and passions at all stages of their career.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DATA SHEET

L. Anthony (Tony) Cirillo, MD, FACEP

Contact Information

91 Woodridge Drive
Saunderstown, RI 02874
Phone: 401-465-0806
E-Mail: lacirillo@acep.org

Current and Past Professional Position(s)

Staff Emergency Department Physician, AdventHealth Dade City and Palm Harbor Emergency Departments
Director of Government Affairs, US Acute Care Solutions
Chief, Center for Emergency Preparedness & Response, Department of Health, State of Rhode Island
Medical Director, Pequot Emergency Department, Groton, CT
Site Quality Director, US Acute Care Solutions (multiple sites)
Physician-in-Chief, Department of Emergency Medicine, Memorial Hospital of RI
Instructor, Albany Medical Center, Department of Emergency Medicine

Education (include internships and residency information)

UMASS Medical Center, Worcester, MA
Residency in Emergency Medicine (1991-94) / Chief Resident 1993-94

George Washington University Hospital, Washington, DC
Preliminary Year, Internal Medicine (1990-91)

University of Vermont College of Medicine (M.D.) May 1990

Certifications

ABEM (1995, 2005, 2015)

Professional Societies

ACEP – RI Chapter (primary), FL Chapter (secondary)
RI Medical Society
EMRA – Alumni Member

National ACEP Activities – List your most significant accomplishments

Current
Board of Directors, Member
ACEP*Now* Editorial Board
ACEP/EDPMA Surprise Medical Billing Implementation Task Force, Steering Committee
ACEP/EMRA Health Policy Mentor Program

Past

Chair, Federal Government Affairs Committee

Chair, State Legislative & Regulatory Committee

Chair, Membership Committee

Member, NEMPAC Board of Trustees

Member, Residency Engagement Task Force

Member, Alternative Payment Model (APM) Task Force, Workgroup Chair

Member, Single Payer Task Force

Member, Communications Plan Task Force

Member, Core Curriculum Task Force

Member, Section Grant Task Force

Member, Board Nominating Committee

Member, Council Steering Committee

Member, Council Tellers & Credentials Committee

ACEP Chapter Activities – List your most significant accomplishments

RI Chapter Member, 1997-Present

RI Chapter President, 1998-1999

RI Councilor/Alternate Councilor 1998-2018

Practice Profile

Total hours devoted to emergency medicine practice per year: **2000** Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.

Direct Patient Care **30** % Research **0** % Teaching **0** % Administration **70** %

Other: _____ %

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

For the past 17 years I have been employed by Emergency Medicine Physicians (EMP) and now its successor company US Acute Care Solutions (USACS), which is a national emergency medicine group that is currently 98% physician owned with 2% ownership by one partner healthcare system. I have practiced clinically every year since my completion of EM residency training in 1994 and continue to provide direct patient care as a staff emergency department physician an average of 48 hours per month. During my time at EMP/USACS I have worked at a variety of clinical sites in many states, providing bedside ED care in a variety of clinical settings. Since joining EMP/USACS I have served as the Director of Government Affairs, coordinating our advocacy federal and state efforts, and educating physicians on the importance of advocacy to improve our healthcare system. In addition to my clinical responsibilities, I have also previously served in both a Medical Director capacity for one of our freestanding hospital affiliated emergency departments and as a Site Quality Director overseeing quality improvement activities at three of our emergency department sites.

Expert Witness Experience

If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony.

Defense Expert 0 Cases **Plaintiff Expert 1 Case (none since 2016)**

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DISCLOSURE STATEMENT

L. Anthony (Tony) Cirillo, MD, FACEP

1. Employment – *List current employers with addresses, position held and type of organization.*

Employer: US Acute Care Solutions, LLC

Address: 4535 Dressler Road, NW

Canton, OH 44718

Positions Held: Director of Government Affairs
Staff Emergency Department Physician

Type of Organization: Emergency Medicine Group Practice

2. Board of Directors Positions Held – *List organizations and addresses for which you have served as a board member. Include type of organization and duration of term on the board.*

Organization: Emergency Medicine Residents Association (EMRA)

Address: 4950 W. Royal Lane

Irving, TX 75063

Type of Organization: Not-for-profit organization representing Emergency Medicine Residents and Medical Students with a career interest in Emergency Medicine

Duration on the Board: 1992-1994

Organization: RI Chapter of the American College of Emergency Physicians

Address: 405 Promenade Street

Providence, RI 02908

Type of Organization: State Chapter of ACEP

Duration on the Board: 1997-2018

Organization: US Acute Care Solutions Political Action Committee (USACS PAC)

Address: 4535 Dressler Road, NW

Canton, OH 44718

Type of Organization: Company affiliated federally qualified political action committee

Duration on the Board: 2013 – Present (Chair of the Board)

Organization: RI Chapter – American Heart Association

Address: 1 State Street, Suite 200

Providence, RI 02908

Type of Organization: Not-for-profit chapter of the American Heart Association

Duration on the Board: 1998-99

Organization: The Safer Institute

Address: 12 Bassett Street

Providence, RI 02903

Type of Organization: Company providing digital personnel security and data services

Duration on the Board: October 2011 - Present

I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

√ NONE

☐ If YES, Please Describe:

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

√ NONE

☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

√ NONE

☐ If YES, Please Describe:

5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

√ NONE

☐ If YES, Please Describe:

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

√ NO

☐ If YES, Please Describe:

I certify that the above is true and accurate to the best of my knowledge:

L. Anthony Cirillo, MD, FACEP Date July 4, 2021

August 19, 2021

Dear Councillors,

On behalf of the Rhode Island Chapter of the American College of Emergency Physicians, it is my privilege and honor to provide this Letter of Endorsement in support of ***L. Anthony (Tony) Cirillo, MD, FACEP***, who is running as an incumbent for the ACEP Board of Directors. Dr. Cirillo exemplifies the qualities and qualifications that ACEP desires for the Board of Directors, a true advocate, driven to serve and advance emergency medicine as a specialty.

My first encounter with Dr. Cirillo was at one of our annual chapter meetings, just after I had been elected a new councilor. After the meeting, Dr. Cirillo, approached me and asked why I was interested in ACEP Council. I replied, "I want to be more involved." He looked at me and told me, "You're in the right place." In that moment, I felt welcomed with a sense of comradery and purpose. That was the first time I had experienced his natural guidance and mentorship, but I have since come to rely on Dr. Cirillo as trusted and invaluable counsel, even more so I began my role as President of RI ACEP this summer.

Dr. Cirillo is an expert in Health Care policy, having received the 2018 ACEP Collin C. Rorrie, Jr. Health Care Policy Award. He has continued to explore and champion health care policy topics as they relate to our specialty while serving on ACEP's Single Payer and Alternative Payment Method Task Force and chairing ACEP's Federal and Government Affairs and State Legislative and Regulatory Committees. He not only drives the issues, but also engages all of the players to ensure that emergency medicine emerges in a better position than where it started; he is a true champion, steadfast in the belief that any topics related to acute injuries and illness are the domain of our specialty and worth pursuing.

We in Rhode Island have especially come to rely on his expertise in Out-of-Network/Balanced Billing. Dr. Cirillo identified this issue early on and subsequently drove and shaped the conversation, additionally informing National ACEP policy. He has tirelessly worked to pass legislation in the state of Rhode Island while working with the Rhode Island Medical Society and engaging leadership in other medical specialties. When the COVID-19 Relief bill and Medicare Physician Fee Schedule were approaching finality, Dr. Cirillo was instrumental in communicating with members on how and when to effectively reach out to their legislators, even providing education and summaries so all could understand the many nuanced ways that the looming changes could affect our varied practices.

Rhode Island ACEP
405 Promenade Street, Suite A
Providence, RI 02908
TEL (401) 331-3207
FAX (401)751-8050
WWW.RIACEP.ORG
email mBIALEK@rimed.org

And though Dr. Cirillo's success and knowledge in health policy is widely known, those who have crossed paths with him know his boundless passion for mentorship and care for personal relationships. Whether medical students or Senators, Dr. Cirillo drive to engage others in doing the right thing is obvious. From being a mentor in ACEP/EMRA's Mentorship Program to volunteering to shepherd medical students and residents at the ACEP Leadership and Advocacy Conference, he is there to encourage others to likewise navigate the proceedings and understand the issues.

The long and varied career of Dr. Cirillo made him a natural candidate for ACEP's Board of Directors three years ago and even more so for another term. His expertise in health policy and passion for mentorship are invaluable to ACEP and emergency medicine as a whole. He is exactly who we need at the table, driving the conversation, leading emergency medicine into the future. On behalf of RI ACEP, I whole-heartedly endorse Dr. Cirillo for ACEP Board of Directors.

Sincerely,

Nadine T. Himelfarb, MD, FACEP
President, Rhode Island Chapter of the American College of Emergency Physicians

Rhode Island ACEP
405 Promenade Street, Suite A
Providence, RI 02908
TEL (401) 331-3207
FAX (401)751-8050
WWW.RIACEP.ORG
email mBIALEK@rimed.org

L. Anthony Cirillo, MD, FACEP

Dear Councillors and ACEP Colleagues,

Thank you for your service to the Council, the College and the specialty of Emergency Medicine. For my 30 years of membership in ACEP, it has been my great privilege to work directly with many of you on behalf of our emergency physician colleagues, our patients, and our specialty. Over the past three years, I have been even more honored to represent and serve you as a member of the ACEP Board of Directors. At this time, I respectfully ask for your vote to provide me the opportunity to continue that service for a second term on the Board.

The healthcare landscape is evolving at an incredible pace, which has only been accelerated due to COVID-19. With the inevitable evolution, and revolution of healthcare there will be important opportunities for us to imagine and create a new future for emergency medicine. The unique training and diverse skills of emergency physicians will position us to define new paradigms of practice for emergency medicine.

Defining OUR Future

The COVID-19 pandemic has been incredibly difficult for emergency physicians. As hard as our jobs were before, COVID took our daily challenges to the brink. Each of us has experienced physical, emotional, mental, and financial stress while responding to the nation's call for us to, once again, serve as the safety net for the entire healthcare system. COVID exposed just how frail the EM world is, with dramatic decreases in ED volume accelerating workforce issues that were on the horizon. For all of the hardship that COVID created, it also provided a clear view to the world of the inherent strength, dedication, and resolve of emergency physicians.

Continued advances in the use of technology in healthcare will require us to think outside the box and develop systems of "bringing your brain" to patients inside and outside of the brick and mortar of traditional EDs. While telehealth and technology will be valuable tools, there are many more opportunities for expanding the realm of emergency medicine. By taking ownership of more aspects of the care we provide, and the patients we provide that care to, we open a broader path for emergency physicians to follow their individual passions and to have a long, successful, and rewarding career.

Advocacy for the Specialty

ACEP remains the leading voice advocating for emergency physician members and our specialty. Emergency medicine's role as the safety net of the U.S. healthcare system must be continually championed to healthcare policymakers. We care for patients who seek our services because they are injured, ill, or afraid, and we turn no one away. Emergency departments provide care to patients when the rest of society and the healthcare system can't, or won't. Emergency physicians can take pride in the role we play in the healthcare system and society, and policymakers need to acknowledge and respect the invaluable role we play.

Focusing on the Needs of Emergency Physicians

Every day, there will be new issues and challenges facing the specialty of emergency medicine. As ACEP addresses these issues, our guiding primary principle must be to support emergency physicians. ACEP must prioritize those issues that enhance our ability to care for patients AND make it easier and less frustrating to provide that care. Ensuring that emergency physicians remain the recognized specialists and leaders in the evaluation and management of acute illness and injury must be our top priority. I am fully prepared, and enthusiastically committed to help lead our specialty in this endeavor.

L. Anthony Cirillo, MD, FACEP - Candidate for Re-election to the ACEP Board of Directors

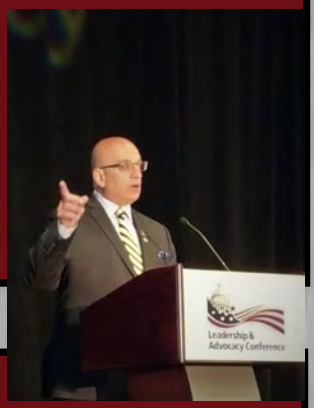
TONY CIRILLO, MD, FACEP

Candidate for Re-Election to the ACEP Board of Directors

Endorsed by the Rhode Island Chapter

ACEP Leadership

- Member, National Board Of Directors
- Councilor / Alternate Councilor, 25 Years
- Federal Government Affairs Committee, Chair
- State Legislative & Regulatory Affairs Committee, Chair
- Membership Committee, Chair
- Residency Engagement Task Force
- Alternative Payment Method Task Force, Workgroup Chair
- Healthcare Financing/Single Payer Task Force
- ACEP*Now* Editorial Advisory Board
- Council Steering / Tellers & Credentials Committees
- Board Nominating Committee
- Past President, RI Chapter



Advocacy for Emergency Physicians

- 2018 Recipient of the ACEP Rorrie Health Policy Award
- Emergency Medicine Policy Institute, Board of Governors
- ACEP / EDPMA Surprise Medical Billing Implementation Task Force
- NEMPAC Board of Trustees, Past Member
- EMRA / ACEP Health Policy Mentor

Active Clinical Practice

- Clinically Practicing 48 hours/month at 2 community hospital sites
- 27 years of clinical experience and emergency department leadership roles in academic, rural, community and free-standing emergency settings

Dear Fellow Councillors and ACEP Colleagues,

Thank you for your service to the Council, the College, and the specialty of Emergency Medicine. For my 30 years ofmembership in ACEP, it has been my great privilege to work directly with many of you on behalf of our emergency physician colleagues, our patients, and our specialty. Over the past three years, I have been even more honored to represent and serve you as a member of the ACEP Board of Directors. At this time, I respectfully ask for your vote to provide me the opportunity to continue that service for a second term on the Board.

The healthcare landscape is evolving at an incredible pace. Changes in clinical practice, technology, and the healthcare delivery system, all of which accelerated due to COVID-19, guarantee that the future practice of emergency medicine will be markedly different than it is today. While these changes present challenges, they also create important opportunities for us to imagine and create a new future for emergency medicine. The unique training and diverse skills of emergency physicians position us well to lead an evolution in the paradigm of an emergency medicine career. Working together with each of you, today's ACEP Board is charged with creating that future for emergency medicine .

Defining OUR Future

The COVID-19 pandemic has been incredibly difficult for emergency physicians. As hard as our jobs were before, COVID took our daily challenges to the brink. Each of us has experienced physical, emotional, mental, and financial stress while responding to the nation's call for us to, once again, serve as the safety net for the entire healthcare system. COVID exposed just how frail the EM world is, with dramatic decreases in ED volume accelerating workforce issues that were on the horizon. For all of the hardship that COVID created, it also provided a clear view to the world of the inherent strength, dedication, and resolve of emergency physicians.

Finally unfettered by government regulations, telehealth now allows patients to be evaluated where they are, not just in the ED. This technology and the concept of "bringing your brain" to the patient expands the scope of emergency practice, provides greater career opportunities, and allows for the remote care of patients outside of the bricks and mortar of our EDs. While telehealth and technology will be valuable tools, there are many more opportunities for expanding the realm of emergency medicine. By taking ownership of more aspects of the care we provide, and the patients we provide that care to, we open a broader path for emergency physicians to follow their individual passions and to have a long, successful, and rewarding career.

Advocacy for the Specialty

In the rapidly evolving healthcare system environment, ACEP remains the leading voice advocating for emergency physician members and our specialty. Emergency medicine's role as the safety net of the U.S. healthcare system must be broadcast incessantly to policymakers and healthcare leaders. We care for patients who seek our services because they are injured, ill, or afraid, and we turn no one away. Emergency departments are the epitome of health equity in our nation for it is we who provide care to patients when the rest of society and the healthcare system can't, or won't. Emergency physicians can take pride in the role we play in the healthcare system and society, and policymakers need to acknowledge and respect the invaluable role we play.

Focusing on the Needs of Emergency Physicians

Every day, there will be new issues and challenges facing the specialty of emergency medicine. As ACEP addresses these issues, our guiding primary principle must be to support emergency physicians. ACEP must prioritize those issues that enhance our ability to care for patients AND make it easier and less frustrating to provide that care. Ensuring that emergency physicians remain the recognized specialists and leaders in the evaluation and management of acute illness and injury must be our top priority. I am fully prepared, and enthusiastically committed to help lead our specialty in this endeavor.

L. Anthony Cirillo, MD, FACEP

Candidate for Re-election to the ACEP Board of Directors

CONFIDENTIAL CURRICULUM VITAE

L. ANTHONY CIRILLO, MD, FACEP
Saunderstown, Rhode Island 02874
401-465-0806

PROFILE

Practicing Emergency Physician leader with 25-plus years' experience in transformational leadership roles within a variety of hospital, healthcare, and public health organizations.

- Experienced physician executive leading transformational changes in healthcare delivery through professional advocacy.
- Successful in leading organizations to embrace change through strong relationship-building skills, subject matter expertise, ability to present data clearly, and skill in engaging support through collaboration and partnership with public, private, and governmental entities.
- Strong leadership with excellent interpersonal and communication skills focusing on creation and execution of a vision for organizational improvement.

EMPLOYMENT

2004-Present US Acute Care Solutions, LLC, Canton, Ohio

Emergency Physician Clinical Practice 2004-Present
Providing clinical emergency medical services for company specializing in the staffing of hospital-based emergency departments with board-certified emergency medicine physicians.

Clinical Practice Sites

- 2004 – 2008 Roger Williams Medical Center, Providence, RI
- 2004 – 2006 St. Joseph's Medical Center, Syracuse, NY
- 2007 – 2009 St. Francis Medical Center, Tulsa, OK
- 2008 – 2019 Lawrence & Memorial Hospital, New London, CT
- 2009 – 2019 Pequot Health Center, Emergency Department, Groton, CT
- 2014 – 2019 Westerly Hospital, Westerly, RI
- 2019-Present AdventHealth Dade City Hospital, Dade City, FL

Medical Directors / Site Quality Director 2011-17

- Provided physician medical leadership for free-standing Emergency Department within hospital integrated healthcare delivery system.
- Participated in hospital preparation for successful Joint Commission surveys.
- Managed all quality functions for Emergency Department sites at Lawrence & Memorial Main Campus and Pequot Health Center freestanding Emergency Department.
- Performed new provider audits, radiology and laboratory discrepancy audits as well as monthly audits of high-risk clinical conditions.
- Coordinated reporting of all CMS required audits.
- Developed hospital based OPPE metrics and reporting tool for Emergency Dept. providers.

EMP Medical Group Board of Director 2010-14

- Elected member of 11-person board serving to represent the more than one thousand (1000) physicians and mid-level providers employed by EMP.
- Served as Chair of Nominations & Elections sub-committee of the Board with responsibility for oversight and management of annual search, nomination, and election process for members

of the Board of Directors.

- Developed policies and procedures for election process in accordance with the legal operating agreement for the medical group.

Director of Government Affairs **2006-Present**

- Executing position with responsibility for coordinating all company-wide activities related to health care legislation and regulation affecting the practice of emergency medicine at the federal and state level.
- Developing and implementing strategies for successful advocacy with legislators and regulators in the health policy arena on innovations related to delivery of acute care medical services.
- Working cooperatively with national, state, and local health care organizations to improve the practice environment and healthcare financing models of the practice of emergency medicine and acute care services.

2020-Present **Senior Medical Advisor - Consultant**
Graphene Composites – USA

- Serving as consultative medical advisor to innovation company creating public health and physical safety solutions utilizing graphene-based nanotechnologies.
- Providing public health and clinical medical expertise in development of viricidal and bactericidal products to reduce spread of infectious agents via airborne and direct contact routes.

2006-2008 **Chief, Center for Emergency Preparedness & Response**
Rhode Island Department of Health

- Managed the public health emergency preparedness operational unit within the Department of Health with direct supervisory authority for development and coordination of all emergency preparedness and response activities related to all-hazards public health emergency management.
- Served as Principal Investigator for CDC Public Health Emergency Preparedness and ASPR (Assistant Secretary for Preparedness & Response – USHHS) Hospital Preparedness Program grants.
- Represented the State of Rhode Island as the Director of Public Health Preparedness within the Association of State and Territorial Health Officials (ASTHO) organization.
- Served as statewide System Director for the Emergency System for Advanced Registration for Volunteer Health Professionals (ESAR-VHP) supplemental grant program sponsored by ASPR with responsibility for development of an integrated system for identification and pre-registration of healthcare professionals with an interest in responding to a public health emergency.
- Supervised all Pandemic Flu preparedness activities, including direction of federal grant programs for statewide preparation for pandemic influenza.
- Functioned as the principal coordinator of New England regional public health preparedness efforts with goal of developing a collaborative planning, preparedness, and response process related to pandemic influenza and other public health emergencies.

2003-2006 **Medical Director, Hospital Bioterrorism Preparedness Program**
Rhode Island Department of Health

- Provided medical direction (part-time) as a consultant for the Rhode Island Department of Health in support of the development of a comprehensive strategy of public health emergency preparedness.
- Provided content expertise and focused input on operational issues of public health emergency preparedness for hospitals and other healthcare partners.

1997-2003 **Physician-in-Chief, Department of Emergency Medicine**
Memorial Hospital of Rhode Island, Pawtucket, Rhode Island

- Provided supervisory oversight and administrative direction of clinical emergency services provided in the Emergency Department. Represented the Emergency Department internally in a matrixed health care organization on interdisciplinary committees and working groups and in day-to-day operational affairs.
- Represented the Emergency Department and institution to various external private and public organizations on issues related to emergency care and access to care.
- Identified opportunities for and implemented programs to improve quality of patient care and increase efficiency in the delivery of health care services.
- Provided direct clinical patient emergency care services.
- Coordinated the training of health care professional students on clinical rotations in the Emergency Department.

1997-2003 **Medical Director, Barrington Urgent Care Center**
Barrington, Rhode Island

- Provided medical direction and oversight to Memorial Hospital owned free standing facility provided urgent care services to the East Bay communities of Rhode Island.

1994-1997 **Director, Emergency Department**
Hillcrest Hospital, Pittsfield, Massachusetts

1994-1997 **Attending Physician, Instructor**
Department of Emergency Medicine
Albany Medical Center, Albany, New York

EDUCATION

Sep 1996-May 1990 **Doctor of Medicine**
University of Vermont College of Medicine, Burlington, Vermont

Sep 1980-May 1984 **Bachelor of Arts, *cum laude***
Baruch College, City University of New York, New York, New York
Psi Chi, National Psychology Honor Society

Sep 1978-Dec 1979 John Jay College of Criminal Justice, City University of New York, New York

Jul 1978-Sep 1978 United States Military Academy, West Point, New York

POSTGRADUATE TRAINING

Jul 1991-Jun 1994 **Residency in Emergency Medicine**
University of Massachusetts Medical Center, Worcester, Massachusetts

- Flight Physician UMASS Life Flight
- Chief Resident

Jun 1990-Jun 1991 **Preliminary Internship in Internal Medicine**
George Washington University Hospital, Washington D.C.

PROFESSIONAL LICENSURE

2018-Present	State of Florida
1997-Present	State of Rhode Island
Inactive	Connecticut, Oklahoma, Massachusetts, New York

PROFESSIONAL MEMBERSHIPS

American College of Emergency Physicians 1990-Present

- 2018-Present National Board of Directors
  - Committee Liaison Appointments
    - Reimbursement
    - Coding & Nomenclature
  - Section Liaison Appointments
    - Medical Directors
    - Emergency Medicine Practice Management & Health Policy
    - Observation
- 2019-Present Residency Program Engagement Task Force
- 2015- Present Alternative Payment Method Task Force Workgroup Chair
- 2017-2019 Single Payer Task Force
- 2015- 2017 Quality Clinical Data Registry Committee Subcommittee Chair
- 2002-2008, 2011-2018 Federal Government Affairs Committee Chair 2014-Present
- 2006-2013 State Legislative Affairs Committee Chair 2010-2012
- 2003-2005 Council Tellers and Credentials Committee
- 1997-Present Rhode Island Chapter President 1998-1999
- 1999-2001, 2015-16, National Nominating Committee
- 1995-1997 Section Grant Task Force Chair 1995-1997
- 1994-1997 Membership Committee Chair 1995-1997
- 1995-1996 Communications Plan Task Force
- 1994-1995 Core Curriculum Task Force
- 1992-1994 Council Steering Committee
- 1995-2000 Young Physicians Section Chair 1997-1998
- 1991-1995 Health Policy Section
- 1994-1997 New York Chapter Councilor 1996
- 1990-1994 Massachusetts Chapter

Emergency Department Practice Management Association 2015-Present

- 2017-2019 ACEP/EDPMA Joint Task Force
- 2018-Present Board of Directors
- 2018-Present EDPMA PAC, Chairman
- 2018-Present State Regulatory Committee
- 2018-Present Federal Health Policy Committee

Rhode Island Medical Society 1997- 2010, 2015-

2000-2008 **Rhode Island Medical Political Action Committee - Chairman**

- Coordinated lobbying and political activity efforts for statewide physician organization.
- Collaborated with medical society staff to develop and implement strategies for increasing effectiveness of physician communication with legislators and state general officers.
- Provided testimony to various legislative committees and administrative departments on health care related legislation and initiatives.

1997-2008 **Rhode Island Medical Society Council**

- Representative to governing and policy making body of the Rhode Island Medical Society comprised of representatives from county and specialty medical societies.
- Served as voting member as Chair of the Rhode Island Medical Political Action Committee and previously represented RI Chapter - American College of Emergency Physicians.

Society for Academic Emergency Medicine 1999-2004

Emergency Medicine Residents Association 1990-Present

- 1992-1994 Board of Directors, Representative to ACEP
- 2010-Present Alumni Member

American Association for Psychiatric Emergencies 2019-Present

American Medical Association 1997-2010

American College of Physician Executives 2006-2010

FEDERAL CONGRESSIONAL TESTIMONY

- United States House of Representatives Homeland Security Committee, Subcommittee on Emerging Threats, Cybersecurity, and Science and Technology. "Beyond the Checklist: Addressing Shortfalls in National Pandemic Influenza Preparedness." September 25, 2007.

STATE LEGISLATIVE TESTIMONY

- State of Texas, House Insurance Committee. Testimony on Out-of-Network/Balance Billing legislation, March 2019
- State of Ohio, Senate Insurance Committee. Testimony on HB 388/SB 184 Out-of-Network/Balance Billing legislation, November 2019

INVITED NATIONAL SPEAKING

- Brookings Institute, Washington, DC. Panel Discussion on Out-of-Network/Balance Billing. March 2019

HOSPITAL COMMITTEE SERVICE

Memorial Hospital of Rhode Island

09/01-08/03 Department of Health Hospital Preparedness Planning Committee - Representative

- Represented Memorial Hospital at organizational and planning group sponsored by the Rhode Island Department of Health and Hospital Association of Rhode Island (HARI) focusing on issues of statewide coordination of Emergency Management and Preparedness.
- Interacted with representatives of various health care institutions and agencies including Rhode Island Emergency Management Agency and the Rhode Island Department of Health.

05/97-08/03 Hospital Association of Rhode Island (HARI) - Representative EMS Committee

- Represented Memorial Hospital at HARI sponsored working group of physician, nursing, emergency department administrative leadership and representatives of the public and private sector Emergency Medical Services communities.
- Focused on prospectively identifying common issues to all hospital institutions providing emergency care and making formal recommendations to HARI governing board regarding improvements in emergency medical care.
- Specific issues addressed including hospital emergency department diversion and mandatory equipment exchange.

05/97-08/03 Hospital Committee Participation

- Performance Improvement Committee
- Graduate Medical Education Committee
- Internal Medicine Residency Review Committee
- Emergency Management Committee Co-Chair 2001-2003
- Patient Care Committee

Hillcrest Hospital

01/95-04/97 Hospital Committee Participation

- Emergency Department Committee — Chair 1995-1997
- Medical Staff Executive Committee
- CPR Committee — Chair 1995-1997

AWARDS / RECOGNITIONS

- 2018 ACEP - Colin H. Rorrie, Jr. Award for Excellence in Health Policy
- 2000, 2002 Voted a "Top Doc" in Emergency Medicine by RI Monthly Magazine
- 1999 "Lifesaver of the Year Award" - American Heart Association Rhode Island Chapter
- 1995 Diplomate, American Board of Emergency Medicine, recertified 2005, 2015
- 1996 Fellow, American College of Emergency Physicians

ACADEMIC APPOINTMENTS

- **2003-Present** Clinical Associate Professor, University of Rhode Island, College of Nursing
- **2007-2010** Clinical Assistant Professor, Brown Medical School, Department of Community Health
- **2004-2006** Clinical Assistant Professor, SUNY Syracuse Medical School, Department of Emer Medicine
- **1997-2005** Clinical Assistant Professor, Brown Medical School, Division of Emergency Medicine
- **1994-1997** Instructor, Albany Medical College, Department of Emergency Medicine

TRAINING / CERTIFICATIONS

- Emergency Response to Domestic Biological Incidents
- WMD Awareness for First Responders
- Emergency Medical Service Operations and Planning for WMD
- Hospital Emergency Incident Command System (HEICS) Trainer
- Incident Command System (ICS) Level 100, 200, 300, 400, 401
- National Response Plan – IS 700
- National Incident Management Systems – IS 800 / IS-800B
- National Disaster Medical System Response Team Training Program
- Emergency Manager: An Orientation to the Position – FEMA Emergency Management Institute
- Hospital Emergency Management for WMD Incident

LECTURES / GRAND ROUNDS PRESENTATIONS / MEDIA

- "That's Crazy Talk": Improving the Care of Patients with Mental Illness in the Emergency Department
  - ACEP Colin Rorrie, Jr Health Policy Lecture – ACEP19 Conference
- Surprise Medical Billing: Finding Solutions
- Healthcare Spending in our "Senior" Years
- Effective Healthcare Advocacy for Physicians
- Pandemic Influenza Preparedness
- Hospital Incident Command Systems (HICS)
- Introduction to Biological Terrorism
- Introduction to Chemical Terrorism
- Wound Management
- Intravenous Fluid Resuscitation
- Automated External Defibrillation and Public Access Defibrillation
- Politics and Medicine

- Patient Protection and Affordable Care Act
- Drugs of Abuse and Cardiac Toxicity
- Approach to the Emergency Department Patient with Chest Pain
- Automated External Defibrillators – Channel 10 WJAR – NBC
- Aortic Dissection – Channel 10 WJAR – NBC

PUBLICATIONS

ACEP *Now – Official Newsletter of ACEP*

- May 2019 – ACEP 2018 Leadership & Advocacy Conference Highlights
- May 2018 – ACEP 2018 Leadership & Advocacy Conference Highlights
- June 2017 - ACEP 2018 Leadership & Advocacy Conference Highlights
- February 2017 – "Not My America"
- June 2016 – ACEP 2016 Legislative Advocacy Conference Highlights
- February 2016 - What Will 2016 Presidential Election Mean for Health Care in the U.S.?
- June 2015 – ACEP Legislative Advocacy Conference & Leadership Summit Highlights
- January 2014 – ACA Roundtable

Emergency Physicians Monthly (EP Monthly)

- March 2010 – Healthcare Reform – A First Look
- September 2008 – The Health Care Divide

Books and Book Chapters

- Strauss R, Mayer, T. Emergency Department Management, Second Edition. 2019. Chapter written by Cirillo LA: Chapter 13B: The Mechanics of Advocacy.
- Aghababian R. Emergency Management of Cardiovascular Diseases, First Edition. 1994. Chapter written by Cirillo, LA: Commonly Used Cardiac Medications.

PROFESSIONAL SERVICE

- 2013-Present ACEP *Now*, Editorial Advisory Board, Official Newsmagazine of ACEP
- 2013-Present Emergency Medicine Action Fund (EMAF), Board of Governors Chair, 2020
- 2017-Present EDPMA / ACEP Balance Billing/OON Joint Task Force
- 2010-2013 Emergency Physicians Monthly (EP Monthly), Editorial Advisory Board
- 2009-2010 American Professional Education Services
  - School of Paramedicine Advisory Board / Medical Director
- 1999-2008 Primary Care Physicians Advisory Council - Rhode Island Department of Health
- 2007-2008 Department of Homeland Security, Federal Emergency Management Agency
  - Region I - Regional Advisory Council
- 2003-2008 Trauma Systems Advisory Committee – Rhode Island Department of Health
- 1997-2003 Lincoln Rescue Service, EMS Medical Director
- 1997-2003 Pawtucket Fire Department, EMS Medical Director
- 1994-1997 Malta Ambulance Corp, Volunteer Medical Director
- 1995-1997 Clifton Park Ambulance Corp, Medical Director

PUBLIC / COMMUNITY SERVICE

- 2008-2019 Boy Scouts of America
  - Staff Medical Physician 2010 National Jamboree – July 2010
  - Jamboree Troop 128, Narragansett Council, Committee Chair
  - Troop 152, North Kingstown, RI, Assistant Scoutmaster
- 2008 Candidate, RI General Assembly, District 33

- 2008-2102 North Kingstown Flag Football League Volunteer Referee
- 2007-2010 Karate Instruction Assistance Initiative (KIAI) Board of Directors
- 2005-2010 YMCA of Greater Providence Board of Directors
- 2002-2015 Rhode Island Disaster Medical Assistance Team/NDMS Medical Officer
- 2001-2007 Regional Center for Poison Control (MA & RI) Advisory Committee Member
- 1998-2005 Coalition for Public Safety Defibrillation Medical Director
- 1998-2002 North Kingstown School Committee Vice- Chair 1998-2000
- 1998-2010 North Kingstown Republican Town Committee Member
- 1998-1999 American Heart Association, RI Affiliate Board of Directors

NATIONAL SECURITY CLEARANCE

- SECRET LEVEL – United States Department of Homeland Security (Inactive)

REFERENCES (contact info available upon request)

The Honorable Representative James Langevin
Member of Congress

The Honorable Representative Raul Ruiz, MD
Member of Congress

Steven Stack, MD, FACEP
Past President
American Medical Association

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2021 BOARD OF DIRECTORS CANDIDATE WRITTEN QUESTIONS

William B. Felegi, DO, FACEP

Question #1: **How do you build confidence that the College prioritizes the interests of our members and our specialty?**

- **We must all recognize and accept the notion that ACEP does not have unlimited resources.** Action plans have a cost whether financial (salaries, legal fees, etc.), physical resources, staff and members time, etc.
- **Priorities are established based on the needs of our patients, members, residents, and society.** This is what I call the proactive needs. Most people would agree that this is the essential basis of why we are emergency physicians. It's what makes our specialty unique. It's about fair balanced billing, maintaining integrity of prudent layperson, fair Medicaid and Medicare reimbursement, protecting EMTALA, etc.
- The second group is what I call the reactive needs – issues which arise, sometimes unexpectedly, as a part of another's agenda. Whether it's the government, elected officials, national mega contract management or private equity groups, hospitals, other physician groups, or providers. Examples include COVID and the lack of personal protection, PA's wanting to change their name to physician associates, etc. Not something we anticipated, but issues that rise to the forefront because it's the news of the day.
- Unfortunately, the latter priorities often do not allow us to plan accordingly. This is compounded by special interest groups that have more than adequate financial resources and political influence. ACEP's leadership responsibilities call for us to have a better understanding of issues that outside interests (and members) may have so that we can subvert or divert in a more proactive way. We can do better.
- **Accurate messaging is key for our membership to understand the Colleges priorities.** ACEP recently announced an anticipated surplus of residency trained emergency physicians. One of many examples of reducing residents was to extend EM residencies by one year. The messaging was off track, and some interpreted as, "Let's punish current and future residents for the shortage by increasing their length of training and further placing them in deeper debt without a guaranteed job." Where I know that this was not the intent, it was the message that future and new residents heard and disseminated on social media to create further concern and panic. Unintended consequences of messaging are so often overlooked in the big scheme.
- **We must clarify some of what I refer to as bipolar behavior in our messaging and priorities.** On one hand, we aspire to have board certified emergency physicians working in every emergency department in this country. On the other hand, some want to ensure that all free-standing emergency departments are staffed similarly. Yet, critical access hospitals are not mandated by Medicare to have the same requirements. In fact, there is no requirement to have a physician physically present on site 24/7. Many critical access and rural hospitals have tried to increase the quality of care delivered to patients by hiring PAs that have additional training in emergency medicine, but some training programs have been ostracized for calling them "residency programs." If our goal is to have a EM physician lead team in every ED, then we need to work on ways to make this happen. Do we really know why residents do not want to practice in critical and rural hospitals? Do we need to re-adjust training for residents to practice in rural areas? We have made many assumptions in the past, but are they correct? Estimates of 42% of the population get its care in rural ED's yet these ED's only make up 17% of all ED visits. Do we abandon our efforts? We need to figure this out quickly or this goal will never be realized, and we will need to readjust our prioritizes.
- **ACEP needs to maintain its integrity.** A long time ago, I learned at an ACEP leadership event that integrity was **doing the right thing at the right time for the right reason.** We need to base our priorities, interests, and messaging on strengthening our integrity.

Question #2: **Now that you have risen to a high level of leadership within ACEP, how do you transition from accomplishing tasks as an individual to guiding others and leading strategically?**

- In my opinion, physicians who are successful leaders should be more focused on goal orientation rather than task oriented. There are many ways (hence tasks) that can be accomplished to achieve a goal, and yes, we deal with tasks in our everyday clinical work, but our everyday goal is not about each single patient encounter but rather what we have accomplished 24/7 in our department as a team. The practice of emergency medicine is performed by teamwork which is why emergency physicians succeed in leadership roles. Leadership is the ability of an individual or a group of individuals to influence and guide followers or other members of an organization.

- Countless books have been written as to what makes a great leader and strategic thinker. As I have repeatedly said, leadership is not about the individual but in his or her ability to guide others and to be able to project the big picture. Imperative is one's motivation and tone. Often, passion can be confused with anger, but passion is key in projecting clear messaging. Empathy and the ability to listen, synthesize and then reframe is vital in understanding others' opinions and more importantly in trying to understand the unintended consequences. And finally, inclusion is key to buy-in from membership.

Question #3: **What areas of improvement do you see that are needed within the College and what are your proposed solutions?**

- ACEP and its leadership must refocus priorities to meet the needs of our members and the patient's we serve. However, we need to concentrate on the messages that our members are conveying to leadership and **fully understand our membership's needs** for us to continue to provide excellent care for our patients. As an example, a few years ago, there was considerable interest and action taken which centered on "physician wellness." Training and emphasis focused on physicians' style of life, stress reduction, and improving one's 'lifestyle.' Physician wellness is not just about going to the gym or working out. Little was done to focus on **why** physicians needed improvement in wellness. For some, wellness did not mean how much time he or she had at home but rather what the work environment was like. Did our colleagues even have enough energy left after a shift to enjoy their free time, or were they sucked dry of all their vital juices day in and day out because of working conditions? Physician burnout is a reflection of physician job satisfaction — a vital exhaustion, characterized by loss of enthusiasm for work, depersonalization, lack of purpose, and a low sense of accomplishment. Let's be honest — the emergency department is not an easy place to work. But everyone in America is entitled to decent working conditions and to have what they need to perform their jobs well to optimize patient care. No one else in America has been given the privilege with dealing and caring for the sickest and most critical injured. Yet, we work in a dangerous environment.
- Healthcare has been focused on patient satisfaction and customer satisfaction. Many providers are compensated on patient satisfaction scores and performance measured by how many letters of complaints one receives as a physician. Yet, have we, as an organization really focused on physician satisfaction? Physician satisfaction is not necessarily receiving a free lunch or ice cream while at work, sponsored by the hospital, often at the busiest time of the shift when we can't get to the event anyway. It also is not necessarily measured by the total annual income or hourly rate. It is measured by how well physicians are treated at work, how well respected they are by staff, colleagues, patients, hospital administrators, and employers. ACEP has been advocates for developing policies for transparency when it deals with business situations like contractual relationships, compensation arrangements, and billing. However, we fail individual members when it comes to the everyday work environment. **Why haven't we advocated for an emergency physician "Bill of Rights?"**
- **The landscape for the practice of emergency medicine has evolved over the last 30 plus years** where the priority was to have properly trained emergency physicians replace "rent a doc" and establish a foot hold in emergency departments. Practices changed and many "democratic" EM groups successfully practiced. For many reasons, the corporatizing of medicine emerged and many of us now work as employees of hospitals, publicly traded national companies, or contract management groups owned by private equity. Our College is no longer our grandfather's College. The employee model has evolved and has changed the needs of many of our members. I have heard stories of hospitals terminating contract management groups and allowing physicians to work for the hospital but not offering vacations, sick time, or other benefits. Why do we tolerate such behavior at our members' expense? Physicians are replaced because they speak up about working conditions or quality of care. Years ago, I would have been first in line to lobby for fair balanced billing and out of network billing but when I worked for a national contract management group that was notorious for inflating its billing and out of network billing tactics, I was no longer credible on the hill. **The employee model has drastically changed the dynamics of the organization and our membership.**
- ACEP has the resources to be able to address these changes and ensure that our member's sustainability is just as important as our patients. We always do the right thing for our patients and we need to do the right things for our members and focus on emergency physicians and their immediate needs.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DATA SHEET

William B. Felegi, DO, FACEP

Contact Information

731 Red Lion Way
Bridgewater, New Jersey 08807-1668
Phone: 908-227-3484 (cell)
E-Mail: William.felegi@ahsys.org

Current and Past Professional Position(s)

- Medial Director Van Buren County Hospital Emergency Department
- Medical Director Van Buren County Hospital Ambulance
- EMS Medical Director Farmington Ambulance
- Medical Director, Atlantic Health, Morristown Medical Center, Travel MD, Corporate Health
- Life Member Bound Brook Rescue Squad, Inc.
- American Board of Emergency Medicine Senior Board Examiner (Approximately 24 exams)
- Iowa Osteopathic Medical Association Board of Directors
- State of New Jersey Gubernatorial Commission Appointments
  - Rationalizing Health Care Resources, Subcommittee Hospital/Physician Relations & Practice Efficiency Commission (Gubernatorial Appointment), 2007-2008
  - Health Care Access Commission (Gubernatorial Appointment), 2006-2008
  - Advisory Council for Basic & Intermediate Life Support (EMTFF), (Gubernatorial Appointment), 2002-present
  - State of New Jersey Influenza Pandemic Action Committee, 1999-2006
- Assistant Clinical Professor Emergency Medicine, Sidney Kimmel Medical College - Thomas Jefferson University, Philadelphia, Pennsylvania, 2015-2018
- Assistant Clinical Professor Emergency Medicine, Mount Sinai School of Medicine, New York, New York 2018-2015
- Department of Emergency Medicine, Hackettstown Medical Center, Hackettstown, NJ, 2016-2017
- Morristown Medical Center Advisory Board, 2014-2016
- Department of Emergency Medicine, Morristown Medical Center, Morristown, NJ
  - Chairman, 2015-1206
  - Interim Chairman, 2014-2015
  - Vice Chairman, 2001-2013
  - Attending & Faculty Member, Residency in Emergency Medicine, 2001-2016
  - Associate Attending & Faculty Member, Residency in Emergency Medicine, 1996-2001
  - Assistant Attending & Faculty Member, Residency in Emergency Medicine, 1994-1996
  - Clinical Medical Director Fast Care & Work Med, 1995-2016
  - Medical Review Officer, Work Med, 1995-2016
  - Associate Director Emergency Department 1995-2014
  - Chairman, Trauma Quality Improvement Committee, 2002-2003, 2004 -2005
  - Member, Atlantic Health Sepsis Initiative Committee, 2011-2016
  - Member, Quality & Patient Safety Committee, 1998-2016
  - Member, Department of Cardiovascular Medicine, STEMI Team Committee, 2007-2016
  - Member, Radiology Task Force, 2005-2006
  - Member, ED Peer Review Committee, 2005-2016

- Member, Clinical Resource Management Committee, 2001-2005
- Member, CPR Committee 1994-1998
- Chairman, ED/Radiology Performance Improvement Team, 1998-2003
- Chairman, ED Performance Improvement Committee, 1996-1998
- Member, Hospital Wide Performance Improvement Committee, 1995-2008
- Member, MI Critical Pathway Committee, 1995-2003
- Chairman, CPR Committee, 1994-1998
- ACLS Course Medical Director, 1994-1997
- Member, Trauma Quality Improvement Committee, 1994-2002, 2003-2
- Trauma Liaison, Dept. EM to Dept. Surgery, Section of Trauma for Level I Designation, 1994-2016
- Member, Trauma/Radiology CQI committee, 1994

- New Jersey Association of Osteopathic Physicians & Surgeons (NJAOPS) Board of Directors, 2014-2017

Education (include internships and residency information)

- Bachelor of Arts, Major: Psychology, Rutgers College of Rutgers University New Brunswick, New Jersey, 1979
- Internship, St. Michael's Medical Center Seton Hall University School of Graduate Medical Education Newark, New Jersey, July, 1989-90 (AOA approved rotational/transitional type)
- PGY 1 - Somerset Medical Center Residency in Family Practice Somerville, New Jersey, July, 1990-91
- PGY 1-3 - Morristown Memorial Hospital Residency in Emergency Medicine Morristown, New Jersey, July, 1991-94
- Chief Resident, Morristown Memorial Hospital Residency in Emergency Medicine Morristown, New Jersey, July, 1993-94
- American Osteopathic Association (AOA) Health Policy Fellowship, Ohio University College of Osteopathic **Medicine, Athens, Ohio, September 2012-2013**

Doctor of Osteopathic Medicine, University of New England College of Osteopathic Medicine Biddeford, Maine, May, 1989

Specialty Board Certifications(e.g., ABEM, AOBEM, AAP, etc.) and dates certified and recertified)

- American Board of Emergency Medicine (ABEM) - Continuously certified since initial certification 1995
- American Board of Osteopathic Emergency Medicine (AOBEM) 2020

Professional Societies

American College of Emergency Physicians (**ACEP**)

- New Jersey Chapter of ACEP
- Iowa Chapter ACEP

American College of Osteopathic Emergency Physicians (**ACOEP**)
American Medical Association (**AMA**)
American Osteopathic Association (**AOA**)
Iowa Osteopathic Medical Association (**IOMA**)
International Society of Travel Medicine (**ISTM**)
American Association for Physician Leadership (**AAPL**) formerly **ACPE**

National ACEP Activities – List your most significant accomplishments

- Member, Council Reference Committee B 2016 Council Meeting
- Board of Governors, Emergency Medicine Action Committee (EMAF), 2011-13

- Chairperson, Federal Governmental Affairs Committee (FGA), 2011-14
- Team Captain, 911 Legislative Network, 2007-present
- Member, Federal Governmental Affairs Committee (FGA), 2003-present
- 911 Legislative Network, 2003-present.
- Board of Directors National Emergency Medicine Political Action Committee (NEMPAC), 2003-2008
- Member, State Legislative/Regulatory Committee, 2006-present
- ACEP National Awards - During the last 16 years serving with national ACEP, my time has been devoted to becoming well versed in national and state political agendas and the art of political advocacy working with numerous groups and our members. Were we have achieved many wins and assisted other chapters, I have always felt that just because one is a leader, the credit goes to the group of individuals that you work with in the committees and subgroups since leadership and emergency medicine are a team effort. No one person can be credited with our success stories. That's why when your peers honor you with a prestigious award one does feel that in some way, they have made a significant accomplishment on behalf of the group.
    - ACEP 2009 911 Legislative Network Member of the Year
    - ACEP 2008 911 Legislative Network Member of the Yea

ACEP Chapter Activities – List your most significant accomplishments

NJ ACEP

- Immediate Past Present, 2006
- President, 2005-2006
- President-Elect, 2004-2005
- Secretary/Treasurer, 2003-2004
- Councilor or Alternate Councilor, 2003-present
- Treasurer, 2002-2003
- Board of Directors, 1999-2006
- Chairman, Political Action Committee, STATPAC, 2002-2013
- Government Affairs/STATPAC, 2001-2003
- Co-Chair, Government Affairs STATPAC, 2000-2001
- NJ ACEP State Awards - During the last 22 years serving with NJACEP, my time has been devoted to becoming well versed in the state political agendas and the art of political advocacy working with numerous groups and members including our state Political Action Committee - STATPAC. Whether it was collecting record breaking PAC donations or achieving exemption from ACLS for board certified emergency medicine physicians to perform procedural sedation, we have achieved many wins. I have always felt that just because one is a leader, the credit goes to the group of individuals that you work with in the committees and subgroups since leadership and emergency medicine is a team effort. No one person can be credited with our success stories. That's why when your peers honor you with prestigious awards one does feel that in some way, they have made a significant accomplishment on behalf of the group.
    - NJ ACEP Distinguished Service Award, 2009
    - NJ ACEP Good Government Award, 2003

Practice Profile

Total hours devoted to emergency medicine practice per year: **3500*** Total Hours/Year*includes paid on-call time

Individual % breakdown the following areas of practice. Total = 100%.

Direct Patient Care **80** % Research **0** % Teaching **5** % Administration **15** %

Other: _____ ____%

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

I practice full time rural emergency medicine for the last three years at a small independent 25 bed licensed critical access hospital in Southeast Iowa. The nearest tertiary care facility is 90 minutes away and the ED has four beds. I am a full-time salaried employee working for the hospital and the only residency trained, board certified emergency medicine physician who works in the Emergency Department in a 50 square mile county of 7,150 residents. The remainder of the time, the ED is staffed with either an AP or PA and either myself or another family medicine trained physician who is on call for back-up as needed. We also have the 24/7 availability of a telemedicine service staffed by board certified emergency physicians 24/7 provided by an independent third party paid for by the hospital.

The remainder of my career was spent at a level one trauma center, regional pediatric hospital, cardiac center and emergency medicine residency training program with 25 year's experience as a faculty member, attending, and various administrative rules including the Chairperson of the Department of Emergency Medicine. Originally a physician shareholder in an emergency medicine owned group at multiple hospitals in the tristate area in the Northeast, our company was sold to a large national contract management group which was then purchased by a multi-specialty private equity firm.

Provide specific title(s) or position(s) within your group, hospital, department, system (e.g., Medical Director, Regional Director, Director of Quality, Vice President, Chief of Staff, etc.)

Van Buren County Hospital, Keosauqua, Iowa
Emergency Department Medical Director
Medical Staff Secretary, 2019-2020
Quality & Patient Safety Committee, 2018-present
Pharmacy & Therapeutics Committee, 2018-present
Trauma Committee, 2018-present
Utilization Review Committee, 2018-present

Expert Witness Experience

If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony. Expert witness testimony is defined as oral or written evidence given by an expert witness under oath, at trial, or in an affidavit or deposition.

Defense Expert 0 Cases **Plaintiff Expert 0 Cases**

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DISCLOSURE STATEMENT

William B. Felegi, DO, FACEP

1. Employment – *List current employers with addresses, position held and type of organization.*

Employer: Van Buren County Hospital
Address: 304 Franklin Street
Keosauqua, Iowa 52565
Position Held: Emergency Department and Ambulance Medical Director
Type of Organization: Critical Access Hospital

Employer: Atlantic Health (as an independent contractor)
Address: 101 Madison Avenue, Suite 202
Morristown, New Jersey 07960
Position Held: Medical Director, Travel MD®, Corporate Health
Type of Organization: Non-Profit Hospital System

Employer: Envision Physician Services formerly EmCare's Partners Group, formerly Emergency Medical Associates
Address: 3 Century Drive
Parsippany, New Jersey 07054
Position Held: Per diem contract employee with privileges at Hackettstown & Morristown Medical Centers, NJ. No income generated for the last 3 years
Type of Organization: Private equity owned physician management organization

2. Board of Directors Positions Held – *List all organizations and addresses for which you have served as a board member – including ACEP chapter Board of Directors. Include type of organization and duration of term on the board.*

Organization: Iowa Osteopathic Medical Association
Address: 6919 Vista Drive
West Des Moines, Iowa 50266
Type of Organization: State organized medical society
Duration on the Board: 2011-current

Organization: New Jersey Association of Physicians & Surgeons (NJAOPS)

Address: 666 Plainsboro Road, Suite 356

Plainsboro, New Jersey 08536

Type of Organization: State organized medical society

Duration on the Board: 2014-2017

Organization: Morristown Medical Center Advisory Board

Address: 100 Madison Avenue

Morristown, New Jersey 07960

Type of Organization: Non-Profit Hospital

Duration on the Board: 2014-2016

Organization: Board of Governors Emergency Medicine Action Committee (EMAF)

Address: 1125 Executive Circle

Irving, Texas 75038-2522

Type of Organization: Nationally organized group to financially support advocacy efforts for ACEP

Duration on the Board: 2011-2013

Organization: Board of Directors National Emergency Medical Political Action Committee (NEMPAC)

Address: 2121 K Street, Suite 325

Washington, DC 20037

Type of Organization: Physician National Political Action Committee

Duration on the Board: 2003-2008

Organization: NJACEP Board of Directors

Address: c/o 201 East Main Street

Lexington, Kentucky 40507

Type of Organization: State organized medical society

Duration on the Board: 1999-2006

I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

☒ NONE

☐ If YES, Please Describe:

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) a an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☒ NONE
☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☒ NONE
☐ If YES, Please Describe:

5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE
☐ If YES, Please Describe:

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO
☐ If YES, Please Describe:

I certify that the above is true and accurate to the best of my knowledge:

William B. Felegi, DO, FACEP Date 7/9/2021

NEW JERSEY CHAPTER
AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

August 20, 2021

Dear Councillors:

The New Jersey Chapter of the American College of Emergency Physicians (NJ-ACEP) would like to provide our support to William B. Felegi, D.O., FACEP for the national ACEP Board of Directors. Our chapter enthusiastically endorses Bill's candidacy. His presence on the Board will immensely benefit our college for years to come.

Bill's career spans over 30 years ranging from attending the first state run EMT class as a volunteer rescue squad member at the age of 16, to Chairman and Assistant Clinical Professor of Emergency Medicine at a tertiary care center and trauma center with the oldest emergency medicine residency in NJ.

Bill began his relationship with the NJ Chapter as a resident when he attended our board meetings. He was involved in the chapter as a board member for two terms and then in the leaderships tract holding all leadership offices including **Chapter President**. He decided not to re-run for the board to allow younger physicians the opportunity to participate in the chapter mentoring future leaders. He has served either as Councilor or Alternate for 18 years.

He has been an ACEP member since 1991 and has embraced service to ACEP with passion and determination over the last 3 decades. For over 15 years he has served on two important national committees - State Regulatory & Legislative Affairs and the Federal Government Affairs Committee where he served as the Chairman for 3 years. He has helped guide not only ACEP's positions on important issues but also many members with similar interests.

Bill has been a fixture at ACEP's annual Leadership & Legislative Conference for over 25 years mentoring young or inexperienced physicians when lobbying with our annual hill visits. For his continued national efforts, he was **twice awarded ACEP's prestigious 911 Member of the Year**.

In NJ, Bill is credited with protecting emergency physicians when he championed a campaign to lobby against regulations that mandated all physicians who provided procedural sedation to have ACLS training well before ABEM publicly supported the "no merit badges" for board certified emergency physicians. In NJ, even anesthesiologists must take ACLS. Due to his perseverance, emergency physicians are the only specialty exempt from the regulation.

Another accomplishment was his championship to lobby for the contemporaneous reading of CT's for suspected stroke patients with a radiology attending and radiology resident. Prior readings were only offered by residents at hospitals with a radiology residency and often lead to re-reads the following day when an attending was available. Stroke care was compromised. He engaged in a successful grass roots letter writing campaign to the Commissioner of Health to accomplish the change in the regulations.

Bill was the chairman of our PAC, NJ STATPAC, and under his leadership, was able to collect a record amount donated per election cycle. Our chapter also has recognized his accomplishments with our **NJ ACEP "Distinguished Service" Award and our "Good Government" Award.**

Bill's strongest qualities are his highly collaborate management style, a desire and willingness to engage physicians and to improve working environment, and a passion for our specialty. Perhaps one of his greatest attributes are his **humor, honesty and integrity**. His greatest asset is his ability to participate in a discussion of a critical issue with a group, synthesize the discussion, summarize the important elements, and then offer a broad review of the pro's and con's. It is not uncommon for a group to change their decision based on his synopsis of **unintended consequences** which are often overlooked.

Our proud chapter stands behind Dr. Felegi as he seeks to advance emergency medicine through our vital organization.

Sincerely,

Jenice Baker
Jenice Baker, M.D., FACEP
NJ-ACEP President

William B. Felegi, DO, FACEP

My Fellow Councillors:

ACEP has remained resilient since its inception in 1968. The grandfathers of EM saw a need for our specialty and the house of medicine recognized EM. We have learned to be creative not only in the practice of our specialty but in addressing serious issues of care that our society and our government have neglected or choose to ignore.

ED's in America have always acted as the "canary in the coal mine" for our societal issues. We have witnessed the plight of the homeless, opiate misuse, poverty, inequities in medical care, uninsured, hospital and ED overcrowding, and most recently COVID-19.

We persevere for now... The definition of "persevere" is to "continue in a course of action even in the face of difficulty or with little or no prospect of success." Sounds to me like the latter part of this statement is what we face every day in our line of work. Our tasks have become more complex and complicated. Many have become employed physicians either working for a hospital, hospital system, or contract management group. Many have not been treated fairly by our employers. Democratic physician run companies are becoming sparse.

ACEP must focus on the individual physician. We need to have a "Physician Bill of Rights" for adequate and safe working conditions. If hospitals and managed contract groups cannot treat physicians fairly despite our dedication to our patients, then we need a better organized approach to focus on these inequities. Decades ago, unions were established because employees were mistreated. If a viable alternative is available, many will leave the College unless ACEP becomes more active in fighting for physician rights and a safe workplace

We can no longer always try to do the right thing because of political consequences. Once such example was our support for an emergency physician running for Congress who went on national television spouting that there was no need to wear masks to protect against COVID. **By choosing the easy way out, we may avoid conflicts with others but create conflicts within. Integrity is doing the right thing at the right time for the right reason. We need to maintain integrity.**

In rural America there are huge health care disparities. Where it is ideal to have a residency trained emergency physician in every ED, it may not be practical. ACEP needs to continue to advocate for EM physician lead teams and to **aggressively question the training of any advanced practitioner who works in any ED.** We can start with a rural ED accreditation program similar to the American College of Surgeons trauma center certification. Many rural hospitals are not accredited by the Joint Commission and CMS has no desire to police the care in rural America. We need to advocate for our profession and all our patients.

Paramount is ACEP's solutions for anticipated workforce issues. It is sad that residents may not have a job of their choice and their families have to be uprooted to move across the country. We know that the majority of residents attend a program where they want to practice or choose to practice in bigger cities or suburban areas. **We will continue to have a mismatch in the concentration of EM physicians regardless of a predicted surplus of physicians. We need to explore the reasons behind residents' choices to practice and work on viable solutions.**

Finally, **messaging to our members is overriding.** We need to seriously consider our messaging and the unintended consequences to our members. **Foremost are our actions in responding to our members' issues.**

I look forward to further discussion with you. **Stay Safe!**

William B. Felegi, DO, FACEP
Board of Directors Candidate

Clinical Practice
- Residency trained Board Certified Attending & Faculty Member EM Residency 25 years in NJ
- Past Chairman, EM tertiary care hospital, trauma center & pediatric hospital in NJ
- Currently at Rural Critical Access Hospital in Iowa as ED & Ambulance Service Medical Director
- Travel MD Medical Director

State Leadership
- NJACEP Past Board Member
- Past President NJ ACEP
- Councilor or Alternate 18 years
- Past Chairman NJACEP STATPAC
- Past Chairman NJACEP Government Affairs
- Board Member Iowa Osteopathic Medical Society

National Activities & Leadership
- Past Chairman FGA
- Member FGA & State Legislative/Regulatory Committees
- Past Board of Governors EMAF
- Past Board of Directors member NEMPAC
- ABEM Board Examiner – 24 Exams

Awards
- 911 ACEP 911 Legislative Network Member of the Year 2008 & 2009
- NJACEP Distinguished Service Award
- NJACEP Good Government Award
- 5 Faculty Teaching awards

Work Experience
- Morristown Medical Center, NJ – Envision Physician Services formerly– EmCare's Partners group formerly Emergency Medicine Associates of NJ (Prior 24 years)
- Van Buren County Hospital, Iowa – current for the last 3 years

About Me
- Extensive experience with regulatory and federal issues germane to EM
- Health Care Policy Fellowship
- No longer on the payrole of a CMG
- Exclusive fulltime rural ED work

Strengths

- Integrity – doing the right thing at the right time for the right reason
- Collaboration
- Consensus building
- Examining unintended consequences

Reasons for Seeking Election

- I have watched emergency medicine grow over the last 25 years. Our specialty has had its growing pains and has fought many battles on behalf of the profession and our patients. But we have not adequately protected our members. We always do what's right for our patients. We devise ingenious work arounds so that we continue to provide excellent emergency care in environments that at times are not very supportive of what we do. However, you are the most important patient and we cannot neglect that fact the physicians who are employed providers are entitled to basic employment rights and safe working conditions just like any other employee.

- With so many physicians employed by either a hospital or managed contract group the membership of ACEP has changed to the employed physician model in the majority and we need to recognize that this has changed the landscape of our membership and priorities.

- Disparity exists in rural America and care models in emergency medicine must adapt to the rural environment. Once size does not fit all. Where I spent the majority of my career in an academic program, I now practice full time in a small rural critical access hospital and the only board-certified emergency physician in a county of 9,000.

Significant Issues & ACEP Mission

- ACEP needs to develop an EM **physician's "Bill of Rights" that encompasses a fai**r and safe employment environment. We have rights spelled out for contracts and billing practices but not basic rights for fair working benefits and safety like many other employees. Unions were developed to protect workers who were being abused. ACEP needs to advocate for our physicians.

- We need to focus on physician satisfaction with the work environment just like we have focused on patient satisfaction. We too need to be satisfied with our jobs and workplace.

- Disparities in rural America need to be addressed. Many ED's are staffed by AP's and we need to question their training and advocate for physician lead teams with emergency physician oversight. AP training programs must be held accountable and a rural ED program of ACEP sponsored ED accreditation needs to be implemented.

- Work force issues are paramount and need viable and reasonable solutions. Regardless, we will continue to experience a mismatch in the concentration of EM physicians regardless of a predicted surplus of physicians. We need to explore the reasons behind residents choices to practice and work on viable solutions.

Curriculum Vitae

William B. Felegi, D.O., FACEP
731 Red Lion Way
Bridgewater, New Jersey 08807
908.227.3484 (Cell)
william.felegi@ahsys.org

RESIDENCIES

Chief Resident, Morristown Memorial Hospital Residency in Emergency Medicine Morristown, New Jersey, July, 1993-94

PGY 1-3 - Morristown Memorial Hospital Residency in Emergency Medicine Morristown, New Jersey, July, 1991-94

PGY 1 - Somerset Medical Center Residency in Family Practice Somerville, New Jersey, July, 1990-91

Internship, St. Michael's Medical Center Seton Hall University School of Graduate Medical Education Newark, New Jersey, July, 1989-90 (A.O.A. approved rotational/transitional type)

EDUCATION

American Osteopathic Association (AOA) Health Policy Fellowship, Ohio University College of Osteopathic Medicine, Athens, Ohio, September 2012-13

Emergency Medicine Foundation (EMF) & American College of Emergency Physicians (ACEP) Teaching Fellowship Program, Dallas, Texas, 2002

Doctor of Osteopathic Medicine, University of New England College of Osteopathic Medicine Biddeford, Maine, May, 1989

University of New England College of Osteopathic Medicine Dean's Summer **Research Fellowship**, 1986, "Gastric Laceration and Rupture As a Complication of Cardiopulmonary Resuscitation."

Bachelor of Arts, Major: Psychology, Rutgers College of Rutgers University New Brunswick, New Jersey, May, 1979

LICENSE & CERTIFICATION

State of New Jersey 10/26/90, No. 25MB05562100, Expiration: 6/30/2021

State of Iowa 2/13/2018, No. DO-05145, Expiration: 1/01/2022

NJ DEA Registration, No. FF7427188, Expiration: 9/30/2023

IA DEA Registration, No. BF2583690, Expiration: 9/30/2023

NJ CDS Registration, No. DO53599, Expiration: 10/31/2021

LICENSE & CERTIFICATION (con't.)

IA CSA Registration, No. 1307596. Expiration 9/30/2021

Diplomate National Board of Osteo. Medical Examiners, No. 18031, 7/1/1990

Diplomate American Board of Emergency Medicine, No. 23557, 12/31/2025

Diplomate Amer. Osteo. Board of Emergency Medicine, No. 4448, 12/31/2022

Fellow, American College of Emergency Physicians, 1997

Certificate in Travel Health™, International Society of Travel Medicine, 20011-present

Fundamental Critical Care Support Instructor, Society of Critical Care, 9/04

Civil Defense Radiological Monitor, United States Department of Defense

PROFESSIONAL ORGANIZATIONS

American College of Emergency Physicians (**ACEP**), No. 360717, 1991-present
New Jersey Chapter (**NJACEP**), 1991-present
Iowa Chapter (**Iowa ACEP**), 2018-present

American Medical Association, (**AMA**), 2011-present

American Association for Physician Leadership (**AAPL**) formerly **ACPE**, 2011-present

International Society of Travel Medicine (**ISTM**), 2003-present

American Osteopathic Association (**AOA**), No. 52018, 1989-present

American College of Osteopathic Family Practitioners (**ACOFP**), No. 52018, 1989-2016

Iowa Osteopathic Medical Association (**IOMA**), 2017-present

New Jersey Association of Osteopathic Physicians and Surgeons (**NJAOPS**), 1989-2017

Medical Society of New Jersey (**MSNJ**), 1990-2017

Morris County Medical Society, 2004-2017

Somerset County Medical Society, 1990-2004

Morris & Sussex County Society of Osteopathic Physicians, 2002-2017

Member Emergency Medical Associates Research Foundation, 1997-2017

Psi Sigma Alpha Society (National Osteopathic Scholastic Honorary Society), 1989-present

PROFESSIONAL ORGANIZATIONS (con't.)

Sigma Sigma Phi, Grand Chapter (National Honorary Osteopathic Fraternity), 1989-present

Life Member, University of New England College of Osteopathic Medicine Alumni Association, 1989-present

AWARDS

Morristown Memorial Hospital Residency in Emergency Medicine, **Most Valuable Contributor, 2009-10**

American College of Emergency Physicians – **2009 911 Legislative Network Member of the Year**

NJ ACEP **Distinguished Service Award**, 2009

American College of Emergency Physicians – **2008 911 Legislative Network Member of the Year**

Morristown Memorial Hospital Residency in Emergency Medicine, **Clinical Instructor of the Year, 2005-06**

Morristown Memorial Hospital Residency in Emergency Medicine**, Most Valued Contributor to the Residency Program, 2004-05**

NJ ACEP **Good Government Award**, 2003

Morristown Memorial Hospital Residency in Emergency Medicine, **Most Valued Contributor to the Residency Program, 2001-02**

Morristown Memorial Hospital Residency in Emergency Medicine, **Teacher of the Year, 2000-01**

Special Advisor, The Advisory Board, Clinical Initiatives Center, "The Clockwork ED - Expediting Diagnosis," 1999

Morristown Memorial Hospital Residency in Emergency Medicine, **Most Valuable Contributor, 1997-98**

Psi Sigma Alpha Society (National Osteopathic Scholastic Honorary Society)

Sigma Sigma Phi, Grand Chapter (National Honorary Osteopathic Fraternity)

Student Osteopathic Medical Association (SOMA) Scholarship, 1987

Howard G. Lapsley Memorial Scholarship, Muhlenberg Hospital, Plainfield, New Jersey, 1987

New Jersey State First Aid Council State Championship - First Aid Competition, Youth Group, 1976

Commendation from N. J. State First Aid Council 5th District - 5/19/91 for service to first aid & rescue squads

NATIONAL ACTIVITIES

American Board of Emergency Medicine (**ABEM**):
- Oral Board Examiner, 2002-2013 (4 Terms)
- Senior Oral Board Examiner, 2014–present (23 Exams)

American College of Emergency Physicians (**ACEP**):
- Board of Governors, Emergency Medicine Action Fund (**EMAF**), 2011-2013
- Chairman, Federal Governmental Affairs Committee (**FGA**), 2011-2014
- Team Captain, 911 Legislative Network, 2007-present
- Federal Governmental Affairs Committee (**FGA**), 2005-present
- 911 Legislative Network, 2003-present
- Board of Directors National Emergency Medicine Political Action Committee (**NEMPAC**), 2003-08.
- State Legislative/Regulatory Committee, 2006-present

STATE ACTIVITIES

American College of Emergency Physicians, New Jersey Chapter (**NJACEP**):
- Immediate Past President, 2006
- President, 2005-06
- President-Elect, 2004-05
- Secretary/Treasurer, 2003-04
- Councilor or Alternate Council, 2003-present
- Treasurer, 2002-03
- Board of Directors, 1999-2006
- Chairman, Political Action Committee, **STATPAC**, 2002-2013
- Government Affairs/STATPAC, 2001-2003
- Co-Chair, Government Affairs/STATPAC, 2000-01

New Jersey Association of Osteopathic Physicians and Surgeons (**NJAOPS**):
- Board of Directors, 2014-2018
- Government Affairs Committee, 2014-2018
- Grassroots Committee, 2014-2018

State of New Jersey Commission on Rationalizing Health Care Resources, Subcommittee Hospital/Physician Relations & Practice Efficiency Commission (Gubernatorial Appointment), 2007-08

State of New Jersey Health Care Access Commission (Gubernatorial Appointment), 2006-08

State of New Jersey Advisory Council for Basic & Intermediate Life Support (EMTTF), (Gubernatorial Appointment), 2002-present

State of New Jersey, Influenza Pandemic Action Committee, 1999-2006

EMPLOYMENT EXPERIENCE

Van Buren County Hospital, Keosauqua, Iowa, 2016-present

Envision Physician Services, formerly EmCare (EmCare's Partners Group-EPG), formerly Emergency Medical Associates (EMA), Parsippany, NJ – Employed Physician, 1994-present

EMPLOYMENT EXPERIENCE (con't.)

Current Base Hospital – Hackettstown Medical Center, Hackettstown NJ, 2016-present

Prior Base Hospital - Morristown Medical Center, Morristown, NJ, 1994-2016

Atlantic Health, Morristown Medical Center, Travel MD™, Corporate Health - Clinical Medical Director, 1995-present (Independent Contractor Status)

PROFESSIONAL EXPERIENCE

Emergency Department, Van Buren County Hospital (**VBCH**), Keosauqua, IA
- Emergency Department Director
- Medical Director VBCH Ambulance

Department of Emergency Medicine, Morristown Medical Center, Morristown, NJ:
- Chairman, Department of Emergency Medicine 2015-2016
- Interim Chairman, Department of Emergency Medicine 2014-2015
- Vice Chairman, Department of Emergency Medicine 2001-2013
- Attending & Faculty Member, Residency in Emergency Medicine, 2001-2016
- Associate Attending & Faculty Member, Residency in Emergency Medicine, 1996-2001
- Assistant Attending & Faculty Member, Residency in Emergency Medicine, 1994-96
- Clinical Medical Director Fast Care & Work Med, 1995-2016
- Medical Review Officer, Work Med, 1995-2016
- Associate Director Emergency Department, 1995-2014

Staff Physician - Your Doctor's Care, Somerville, NJ, 1994

Team Physician Sports Coverage Parsippany-Troy Hills High School, Parsippany, NJ 1993

Morristown Memorial Hospital Mt. Kimball Division Work Med - Occupational Medicine Clinic Morristown, NJ, 1993-94

HOSPITAL ACTIVITIES

Van Buren County Hospital, Keosauqua, IA
- Medical Staff Secretary, 2019-2020
- Member, Quality and Patient Safety Committee, 2018-present
- Member, P&T Committee, 2018-present
- Member, Trauma Committee, 2018-present

Morristown Medical Center, Morristown, NJ:
- Morristown Medical Center Advisory Board Member, 2014-2016
- Member, Atlantic Health Sepsis Initiative Committee, 2011-2016
- Member, Quality and Patient Safety Committee, 2008-2016
- Member, Department of Cardiovascular Medicine, STEMI Team Committee, 2007-2016
- Member, Radiology Task Force, 2005-06
- Member, ED Peer Review Committee, 2005-2016
- Member, Clinical Resource Management Committee, 2001-05
- Co-Chairman, Trauma Quality Improvement Committee, 2005-2016

HOSPITAL ACTIVITIES (con't.)

Chairman, Trauma Quality Improvement Committee, 2002-03, 04-05
Member, CPR Committee, 1999-2013
Chairman, ED/Radiology Performance Improvement Team, 1998-2003
Chairman, ED Performance Improvement Committee, 1996-98
Member, Hospital Wide Performance Improvement Committee, 1995-2008
Member, MI Critical Care Pathway Committee, 1995-2003
Chairman, CPR Committee, 1994-98
ACLS Course Medical Director, Advanced Cardiac Life Support American Heart Association, 1994-97
Member, Trauma Quality Improvement Committee, 1994-2002, 2003-2004
Trauma Liaison, Department of Emergency Medicine to Department of Surgery, Section of Trauma for Level I Trauma Center designation, 1994-2016
Member, Trauma/Radiology CQI Committee, 1994

ACADEMIC APPOINTMENTS

Assistant Clinical Professor Emergency Medicine, Sidney Kimmel Medical College – Thomas Jefferson University, Philadelphia, Pennsylvania, 2015-2018

Assistant Clinical Professor Emergency Medicine, Mount Sinai School of Medicine, New York, New York, 2008-2015

FUNDED RESEARCH

Program Title: Expanded Access IND Program to Provide Stamaril® Vaccine to Persons in the United States for Vaccination Against Yellow Fever
Program #: STA00011
Sponsor: Sanofi Pasteur
Sponsor's Primary Investigator: Dr. Riyadh Muhammad
Sub-Investigator: William B. Felegi, D.O.

PUBLICATIONS

Felegi WB, Silverman M, Allegra, J. (2003). Does **the distribution of written guidelines with accompanying educational information for appropriate use of meperidine change emergency department physicians' prescribing habits? Annals of Emergency Medicine** (abstract), 42, s101.

Felegi, W.B., Lavery, W.B., Oh, D., Tortella, B.J.: **Does Point-of-Care Testing in the Out-of-Hospital Setting Influence Patient Care?** (Abstract). Prehospital Emergency Care, 1(3): 179.

Lavery, R.L., Felegi, W.B., Oh, D., Tortella, B.J.: **Does Point-of-Care Testing in the Out-of-Hospital Setting Influence Patient Care?** (Abstract). Academic Emergency Medicine, 4(5): 436.

Felegi, W.B, Doolittle, R.L., Conston, A.S., Chandler, S.V.: **Gastric Trauma and Pulmonary Aspiration at Autopsy After Cardiopulmonary Resuscitation** (Abstract). Prehospital and Disaster Medicine, 1996, 11(3): 103.

Felegi, W.B, Doolittle, R.L., Conston, A.S., Chandler, S.V.: **Gastric Trauma and Pulmonary Aspiration at Autopsy After Cardiopulmonary Resuscitation** (Abstract). Academic Emergency Medicine, 1996, 3(5).

PRESENTATIONS (con't.)

Allegra, J.R., Brennan, J., Felegi, B., Fields, L., Grubiner, F, Kiss, G., Lavery, B., Pruzik, T.: **Use of Time-Temperature Indicators to Monitor the Storage Temperature of Medications in the Prehospital Setting** (Abstract). Annals of Emergency Medicine, 1996, 27(1): 147.

Felegi, W.B.: **The Silent Killers, Part II - Methane**. Emergency Medical Services, 1983, 12(3):62-64.

Felegi, W.B.: **The Silent Killers, Part I - Carbon Monoxide**. Emergency Medical Services, 1983, 12(2):54-59.

Nirmala, A., W. Felegi, J.M. Stern: ***In Utero*** **Alcohol Heightens Juvenile Reactivity**. Pharmacology, Biochemistry & Behavior, 1980, 13:531-535.

Arizona College of Osteopathic Medicine, Phoenix, AZ, **"Escape Fire"** – Panel Discussion with Questions and Answers by the 2012-13 AOA Health Policy Fellows, March 14, 2013

Givaudan Fragrances, Ridgedale Site, East Hanover, NJ, **"International Travel Medicine – Protect Your Health Before You Go,"** October 16, 2012

Schindler Elevator, Randolph, Morristown, NJ, **"'Hot' Tips for the Prevention and Treatment of Heat Emergencies,"** August 14, 2012

Schindler Elevator, Morristown, NJ, **"'Hot' Tips for the Prevention and Treatment of Heat Emergencies,"** June 28, 2012

Bi-Annual Overlook Family Medicine Reunion and Update, "Global Health and Medical Volunteerism" - Overlook Hospital, Summit, NJ, **"Don't Become a Patient: Preparation for International Travel,"** May 16, 2008

Grand Rounds/Visiting Professor Lecture Series, Department of Emergency Medicine, SUNY – Stony Brook, **"Emergency Medicine Billing & Reimbursement,"** June 5, 2007

American College of Emergency Physicians 2006 Leadership & Advocacy Conference, **"Leveraging the ACEP State Report Card to Advance Your State Advocacy Agenda"** with Panel Discussion, May 23, 2006

American College of Emergency Physicians 2006 Leadership & Advocacy Conference, **"Power-Packed Ideas to Empower Your State PAC"** with Panel Discussion, May 23, 2006

NJ Emergency Nurses' Association (ENA) Emergency care Conference, **"Illness in unexpected places – Travel Related Medicine in the ED,"** May 17, 2006

St. Joseph's Regional Medical Center Emergency Medicine Residency Governmental Affairs Conference Day**, "State Liability Issues and Update"** with Panel Discussion, August 11, 2004

2004 Bridgewater Township Middle School Career Day, **"Emergency Medicine & Osteopathic Medical Education."**

PRESENTATIONS (con't.)

2003 American College of Emergency Physicians Research Forum, Boston, Massachusetts, abstract poster presentation entitled: **"Does the Distribution of Written Guidelines with Accompanying Educational Information for Appropriate Use of Meperidine Change ED Physicians' Prescribing Habits?"**: W.B. Felegi, M.E. Silverman, J.R. Allegra Department of Emergency Medicine, Morristown Memorial Hospital, Morristown, New Jersey, October, 2003

2003 Atlantic Health System Annual Research Day abstract poster presentation entitled: **"Does the Distribution of Written Guidelines with Accompanying Educational Information for Appropriate Use of Meperidine Change ED Physicians' Prescribing Habits?"** W.B. Felegi, M.E. Silverman, J.R. Allegra Department of Emergency Medicine, Morristown Memorial Hospital, Morristown, New Jersey, June, 2003

2003 New Jersey Chapter of the American College of Emergency Physicians Scientific Assembly, Woodbridge, New Jersey abstract poster presentation entitled: **"Does the Distribution of Written Guidelines with Accompanying Educational Information for Appropriate Use of Meperidine Change ED Physicians' Prescribing Habits?"** W.B. Felegi, M.E. Silverman, J.R. Allegra Department of Emergency Medicine, Morristown Memorial Hospital, Morristown, New Jersey, May, 2003

2003 7th Annual New England Regional Society for Academic Emergency Medicine, Shrewsbury, Massachusetts, abstract poster presentation entitled: **"Does the Distribution of Written Guidelines with Accompanying Educational Information for Appropriate Use of Meperidine Change ED Physicians' Prescribing Habits?"** W.B. Felegi, M.E. Silverman, J.R. Allegra Department of Emergency Medicine, Morristown Memorial Hospital, Morristown, New Jersey, April, 2003

2003 6th Annual Mid-Atlantic Regional Society for Academic Emergency Medicine, Washington, DC, abstract poster presentation entitled: **"Does the Distribution of Written Guidelines with Accompanying Educational Information for Appropriate Use of Meperidine Change ED Physicians' Prescribing Habits?"** W.B. Felegi, M.E. Silverman, J.R. Allegra Department of Emergency Medicine, Morristown Memorial Hospital, Morristown, New Jersey, March, 2003

1999 Institute for Health Care Improvement 11th Annual National Forum on Quality Improvement & Health Care storyboard entitled **"Decreasing X-Ray Turnaround Time in the Emergency Department"**: W.B. Felegi, Department of Emergency Medicine, Morristown Memorial Hospital, December, 1999

1998 Institute for Healthcare Improvement, National Congress on Reducing Waits & Delays & Improving Patient Satisfaction in the Emergency Department, Orlando, Florida, oral lecture entitled, **"Reducing X-Ray Times in the Emergency Department,"** W.B. Felegi, Department of Emergency Medicine, Morristown Memorial Hospital, November, 1998

PRESENTATIONS (con't.)

1998 Morristown Memorial Hospital Annual Research Day Competition, abstract poster presentation entitled, **"Does Point-of-Care Testing in the Out-of-Hospital Setting Influence Patient Care?"**: R. Lavery, W.B. Felegi, D. Oh, B. Tortella, Department of Emergency Medicine, Morristown Memorial Hospital, Morristown; Department of Surgery, University of Medicine & Dentistry, Newark, New Jersey, June, 1998

1998 Emergency Medicine Clinical Pathological Conference (CPC) Region D (Central Region) Competition, Society of Academic Emergency Medicine, Chicago, Illinois, May, 1998

1997 National Association of Emergency Medical Services Physicians Mid-Year Meeting and Scientific Assembly, Incline Village, Nevada, abstract oral presentation entitled, **"Does Point-of-Care Testing in the Out-of-Hospital Setting Influence Patient Care?"**: R. Lavery, W.B. Felegi, D. Oh, B. Tortella, Department of Emergency Medicine, Morristown Memorial Hospital, Morristown; Department of Surgery, University of Medicine & Dentistry, Newark, New Jersey, July, 1997

1997 Annual Meeting Society for Academic Emergency Medicine, Washington, D.C., oral poster presentation entitled, **"Does Point-of-Care Testing in the Out-of-Hospital Setting Influence Patient Care?"**: R. Lavery, W.B. Felegi, D. Oh, B. Tortella, Department of Emergency Medicine, Morristown Memorial Hospital, Morristown; Department of Surgery, University of Medicine & Dentistry, Newark, New Jersey, May, 1997

1997 1st Annual New England Regional Society for Academic Emergency Medicine Conference & Brown University School of Medicine, Providence, Rhode Island, abstract poster presentation entitled, **"Does Point-of**

Care Testing in the Out-of-Hospital Setting Influence Patient Care?" R. Lavery, W.B. Felegi, D. Oh, B. Tortella, Department of Emergency Medicine, Morristown Memorial Hospital, Morristown; Department of Surgery, University of Medicine & Dentistry, Newark, New Jersey, April, 1997

1996 Special Guest Speaker for Emergency Medical Services Paramedics **'Gynecological, Obstetrical & Neonatal Emergencies"** - New Jersey State First Aid Council 68**th** Annual Convention, Educational Symposium & Trade Show, Lake Kiemesa, New York, October, 1996

1996 American College of Emergency Physicians Research Forum, Cincinnati Ohio, abstract presentation entitled **"Use of Time - Temperature Indicators to Monitor the Storage Temperature of Medications in the Prehospital Setting"**: J.R. Allegra, J. Brennan, B. Felegi, L. Fields, F. Grubiner, G. Kiss, B. Lavery, T. Pruzik; Department of Emergency Medicine, Morristown Memorial Hospital, Morristown, New Jersey; Lifeline Technologies, Inc.; and, University & Dentistry of New Jersey, February 1996

1996 Annual Meeting Society for Academic Emergency Medicine, Denver, CO, abstract poster presentation entitled, **"Gastric Trauma and Pulmonary Aspiration at Autopsy After Cardiopulmonary Resuscitation"**: W. B. Felegi, R.L. Doolittle, A.S. Conston, S.V. Chandler; Department of Emergency

PRESENTATIONS (con't.)

Medicine, Morristown Memorial Hospital, Morristown, New Jersey; Department of Pathology, Somerset Medical Center, Somerville, New Jersey, May 1996

1996 New Jersey Chapter of the American College of Emergency Physicians Scientific Assembly, Atlantic City, NJ, abstract poster presentation entitled, **"Gastric Trauma and Pulmonary Aspiration at Autopsy After Cardiopulmonary Resuscitation"**: W. B. Felegi, R.L. Doolittle, A.S. Conston, S.V. Chandler; Department of Emergency Medicine, Morristown Memorial Hospital, Morristown, New Jersey; Department of Pathology, Somerset Medical Center, Somerville, New Jersey, June 1996

1996 National Association of Emergency Medical Services Physicians Mid-Year Meeting and Scientific Assembly, San Diego, CA, abstract oral presentation entitled, **"Gastric Trauma and Pulmonary Aspiration at Autopsy After Cardiopulmonary Resuscitation"**: W. B. Felegi, R.L. Doolittle, A.S. Conston, S.V. Chandler; Department of Emergency Medicine, Morristown Memorial Hospital, Morristown, New Jersey; Department of Pathology, Somerset Medical Center, Somerville, New Jersey, July 1996

Special Guest Speaker for Emergency Medical Services Paramedics Gynecological, Obstetrical & Neonatal Emergencies" 1995 - New Jersey State First Aid Council 67th Annual Convention, Somerset, New Jersey

Special Guest Speaker for Emergency Medical Services Paramedic Personnel: Morris County Fire & Police Academy Emergency Medical Technician Core Lecturer EMT Basic & Refresher Courses, 1991- 1994

Introduction to Emergency Nursing Lecture Series of Morristown Memorial Hospital Guest Speaker, 1992

13th Annual Maine Biological and Medical Services Symposium poster presentation entitled **"Gastric Ruptures, Gastric Mucosal Lacerations, and Gastric Dilation Following Cardiopulmonary Resuscitation in the Prehospital Environment,"** June 1987

Special Guest Speaker for Emergency Medical Services Personnel and their response to the Crime Scene for:

1984 - St. Peter's Medical Center Area First Aid Council, New Brunswick, N.J.
1984 - Plainfield Rescue Squad, New Jersey
1984 - Essex County and the Cedar Grove Rescue Squad, New Jersey
1984 - New Jersey State First Aid Council 56th Annual Mid-Year Assembly, Cherry Hill, New Jersey
1983 - New Jersey State First Aid Council 55th Annual Convention, New York

COMMUNITY SERVICE

Medical Director, Farmington EMS, Farmington, IA, 2018-present

Life Member Bound Brook Rescue Squad, Inc., 1974-present

Delegate-at-Large to the 5th District of the New Jersey State First Aid Council, 1983-present

Community Member, Bridgewater Township Emergency Medical Services Committee, 2001-03

Vice-President 5th District of the New Jersey State First Aid Council, 1983-85

Democratic Male Committee Member, Bridgewater Township District 26, 2004-2008

Former ACLS (American Heart Association) Instructor 1994-2007

Former Instructor American Red Cross Standard & Advanced First Aid & Emergency Care (10 years)

Former Instructor American Heart Association C.P.R. (8 years)

Former Instructor NJ State First Aid Council Extrication (4 years)

Former member Somerset County's Citizen Advisory Task Force on Domestic Violence for Battered Spouses & Child Abuse (1 year)

Former member Bound Brook School District Citizen's Advisory Thoroughness & Efficiency Committee (2 years)

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2021 BOARD OF DIRECTORS CANDIDATE WRITTEN QUESTIONS

John T. Finnell, II, MD, MSc, FACEP

Question #1: **How do you build confidence that the College prioritizes the interests of our members and our specialty?**

I've recently learned of an expected death of a dear colleague, which reminds me of a poem called *The Dash* by Linda Ellis. The Dash represents the time we have and what we can accomplish and reflect upon how we spend *our Dash*. The actions we take, the progress we make, is all about *The Dash.*

Confidence in our College is built upon *our* actions and achievements – *The Dash*. It begins with the ACEP Council, our councilors, and the board of directors. What we accomplish at Council sets the stage for what we need to accomplish today, tomorrow, and the rest of the year. While our progress may feel incremental, significant changes can and do happen.

The College can and should do more to promote our achievements. Our members may not fully realize everything that ACEP is doing for our members and our specialty. As a brief summary:

Advocacy in 2018:

- Four emergency medicine-focused bills signed into law
- 30 Congressional letters of support or comment submitted
- Ten regulatory comment letters submitted
- 555 legislative visits conducted by ACEP members and staff
- More than 4,000 members in the ACEP 911 Legislative Grassroots Network respond to advocacy alerts when needed by ACEP by emailing their members of Congress on a particular issue of concern to emergency medicine. This network covers 95 percent of Congressional districts.
- 5,215 donors to NEMPAC, the 4th largest physician specialty PAC
- NEMPAC contributed $2.2 million to House and Senate candidates and party committees in 2018.

Notable Board items in 2021:

- Legislative & Regulatory Priorities for the First Session of the 117th Congress
- National Pandemic Readiness - Ethical Issues
- Definition of Democracy in EM Practice
- Safer Working Conditions for Emergency Care Workers
- Prudent Layperson Model State Legislation
- Artificial Intelligence in Emergency Medicine

As I reflect over the past two and half years, your board has considered over 400 items of business. The Council resolutions that you create and approve are the work products and achievements for the College. Think about it—over 400 items of business in close to three years. Our memories are short; the COVID-19 pandemic challenged all of us but allowed us to become stronger. We became stronger by working together to produce the ACEP COVID-19 Field Guide. This resource launched April 8th, 2020, and one month later had over 100k page views, over 150 agencies/websites/links to our site, and has been translated into Japanese, Chinese, Spanish, Hindi, and Urdu with over 230 pages of content – outstanding, and a great example how the College prioritizes the interest of members and specialty.

So, in the end, what matters most is not the beginning or the end but *our Dash. Our* achievements. How will we continue to lead and advance the specialty for all emergency physicians?

I'm proud to be an ACEP member and to serve you and the College.

Question #2: **Now that you have risen to a high level of leadership within ACEP, how do you transition from accomplishing tasks as an individual to guiding others and leading strategically?**

Strategic leadership requires the ability to anticipate, challenge, interpret, decide, align, and learn. I strive to be an adaptive strategic leader—both stubborn and flexible, persistent in the face of setbacks, and able to react strategically to environmental shifts. Given the limited space allotted, I'll touch on only be able to touch on a few of these.

Anticipate: Many systems are poor at detecting threats and opportunities on the periphery of their business—Kodak and Blockbuster come to mind. As your board member, I am wired to anticipate these changes. As an informatician and research scientist, I am trained to scan the environment for weak signals of change that will impact our practice.

If you recall, as part of my earlier message to the council, we need to be the leaders in Telehealth; we need to actively investigate and pursue alternative educational offerings and diversify our revenue streams. These three items recently came to light during the pandemic.

Challenge/Interpret/Align: I am a leader that is patient and comes with an open mind. I am the first board member to have an external advisory council. The advisory council comprises key chapter leaders and members, relating their positions on interests before the board. For me, it's a form of a mini-reference committee where all voices can be heard and opinions shared.

Lastly, **Learn.** I've been a learner all my life. I want to understand how things work and why they work. I enjoy constructively exploring options and outcomes to find the hidden lessons and best path forward.

Question #3: **What areas of improvement do you see that are needed within the College and what are your proposed solutions?**

There are several issues before the College that impact our members and specialty. The workforce taskforce report announced in April, and confirmed by others, for the first time, anticipates an oversupply of emergency physicians by 2030. A simplistic approach is to look at the supply and demand sides of the equation to better understand our options, and more importantly, our opportunities moving forward. This will take a village. There is no simple solution and will require all of our efforts to help address our workforce needs.

If we are recovering from the pandemic, we need to heal. Our friends and colleagues continue to endure the scars of our battle with COVID-19. I'm a runner. There is nothing like the high you get while training and preparing for an event. However, when the event is over, there's a slump, and we, as a College, need to ensure the health and well-being of our members for us to work and provide care. This is a medical problem, just like heart disease or diabetes, and needs to be addressed as such. The College should continue to lobby for changes in state reporting requirements that currently encourage us to bury our mental health concerns.

Lastly, the College is and should continue to explore how best to diversify our revenue streams. Most of the College income comes from member dues and educational offerings. While I don't have a crystal ball, it strikes me how we learn, how we educate must and will change. Virtual meetings last year expanded an industry of tools to work and learn remotely. How do we leverage these types of activities and tools to best benefit all of our members?

Jo

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DATA SHEET

John T. Finnell, II, MD, MSc, FACEP

Contact Information

505 South 5th St, Zionsville, IN. 46077
Phone: 317-454-1089
E-Mail: jtfinnell@acep.org

Current and Past Professional Position(s)

ACADEMIC

University of Minnesota	Assistant Professor of Emergency Medicine	1995-2002
Indiana University	Assistant Professor of Clinical Emergency Medicine	2002-2005
Regenstrief Institute	Investigator and Faculty Member Division of Biomedical Informatics	2005-Present
Indiana University	Associate Professor of Clinical Emergency Medicine	2005-2020
	Professor of Clinical Emergency Medicine	2020 - Present
Indiana University	Associate Professor of Informatics	2010-Present
Indiana University	Director of Health Informatics	2010-2013

NON-ACADEMIC

South County Physicians Medical Group, Selma, CA	Staff Physician	1995
Quantum Emergency Medical Associates, Selma, CA	Staff Physician	1994-1995
Ramsey Medical Center, St. Paul, MN	Attending Physician	1995-1997
Regions Hospital, St. Paul, MN	Attending Physician	1997-2002
Hudson Regional Medical Center, Hudson, WI	Attending Physician	2001-2002
Wishard Memorial Hospital, Indianapolis, IN	Attending Physician	2002-2013
Clarian Health Partners, Indianapolis, IN	Attending Physician	2002-2005
Eskenazi Health, Indianapolis, IN	Attending Physician	2013-Present

Education (include internships and residency information)

POSTDOCTORAL		
Regenstrief Institute, Inc.	NLM Medical Informatics Research Fellow	2002-2005
Indiana University	Clinical Investigator Training Enhancement Program M.S. in Health Services Research and Informatics	2002-2004
UCSF-Fresno	Emergency Medicine Residency	1991-1995
GRADUATE		
University of Vermont	MD	1987-1991
UNDERGRADUATE		
University of Vermont	BS	1983-1987

List Medical Degree (MD or DO) and Year Received Here
University of Vermont, MD 1991

Specialty Board Certifications(e.g., ABEM, AOBEM, AAP, etc.) and dates certified and recertified)

Diplomat, American Board of Emergency Medicine	1996-Present Last Recert 2015
Diplomat, American Board of Preventive Medicine in Clinical Informatics	2013-Present

Professional Societies

American Medical Student's Association	1987-1991
Emergency Medicine Resident's Association	1991-1996
American College of Emergency Physicians	1989-Present
Society of Academic Emergency Physicians	1995-Present
Council of Residency Directors	1995-2003
American Academy of Emergency Medicine	1999-Present
American Medical Informatics Association	2001-Present
American Medical Association	2014-Present
American College of Medical Informatics	2016-Present

National ACEP Activities – List your most significant accomplishments

American College of Emergency Physicians	Academic Affairs Committee	1999-2003
	Secretary Informatics Section	2002-2003
	Clinical Policies Committee	2004-2007

	Reference Committee Member	2010-2013
	State Leader 911 Network	2010-Present
	Tellers, Credentials Committee Member	2010-2013
	Indiana Counselor	2010-Present
	Council Steering Committee	2013-2015
	Education Committee	2014-Present
	Chairman Reference Committee	2014
	Nominated: ACEP Board of Directors	2016-2018
	Member, ACEP Board of Directors	2018-Present
	Board Liaison Academic Affairs Committee	2018 - Present
	Board Liaison Research Committee	2018 - Present
	Board Liaison Research Section	2018 - Present
	Board Liaison Ultrasound Section	2018 - Present

ACEP Chapter Activities – List your most significant accomplishments

American College of Emergency Physicians – Minnesota Chapter:	Legislative Affairs Committee	1996-2001
	Education Committee	1998-2002
	Editor, MN EPIC	1999-2002
	Counselor, MN Chapter	2000-2002
	Chair, Communications Committee	2001-2002
American College of Emergency Physicians – Indiana Chapter:	Board of Directors	2009-Present
	President INACEP	2013-2014
	Past-President INACEP	2014

Practice Profile

Total hours devoted to emergency medicine practice per year: **1152 hrs/year** Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.

Direct Patient Care **20** % Research **5** % Teaching **60** % Administration **15** %

Other: _____ ____%

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

Staff physician at Eskenazi Health. County, Level 1 trauma and burn center; and training site for IU's Emergency Medicine program.

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.)

CMIO

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 DISCLOSURE STATEMENT

John T. Finnell, II, MD, MSc, FACEP

1. Employment – *List current employers with addresses, position held and type of organization.*

Employer: Indiana University

Address: Bloomington, Indiana

Position Held: Attending Physician

Type of Organization: Not For Profit

2. Board of Directors Positions Held – *List all organizations and addresses for which you have served as a board member – including ACEP chapter Board of Directors. Include type of organization and duration of term on the board.*

Organization: American College of Emergency Physicians

Address: 4950 W. Royal Lane

Irving, TX 75063

Type of Organization: Professional Society

Duration on the Board: 2+ years

Organization: IN ACEP

Address: Indianapolis, IN

Type of Organization: IN ACEP Chapter

Duration on the Board: 15+ years

Organization: Outrun the Sun

Address: Indianapolis, IN

Type of Organization: Research for Melanoma

Duration on the Board: 3 years

I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

☒ NONE

☐ If YES, Please Describe:

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) a an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☒ NONE
☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☐ NONE
☒ If YES, Please Describe:
Starting as the Chief Medical Officer for VisualDx on 8/2/2021.

5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE
☐ If YES, Please Describe:

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO
☐ If YES, Please Describe:

I certify that the above is true and accurate to the best of my knowledge:

John T. Finnell Date July 8, 2021

INDIANA CHAPTER
American College of Emergency Physicians
PO Box 17136, Indianapolis, IN 46217
Phone: (317) 455-3335
Email: inacep@inacep.org

Section for Emergency Medicine Informatics
American College of Emergency Physicians
P.O. Box 619911
Dallas, TX 75261-9911

September 8, 2021

Councillors
ACEP 2021 Scientific Assembly
Boston, Massachusetts

Dear Councillors:

First, thank you for your service on the 2021 Council. This will no doubt be another year of challenges for the Council given the continued uncertainty of the pandemic. We cannot thank you enough for your time and dedication.

Next, the Indiana ACEP Chapter and the Section for Emergency Medicine Informatics write to you today to highly recommend John Thomas Finnell MD,FACEP as a candidatefor the national ACEP Board of Directors. As you will see from his Curriculum Vitae, Dr. Finnell has spent many years in leadership positions with the Indiana Chapter and has been involved with numerous national ACEP committees and functions including the Informatics Section.

As said before, but we must emphasize again, Dr. Finnell's energy and continued commitment to ACEP's interests are outstanding and his leadership skills are impeccable. He has formal training in BioMedical Informatics, is board certified in Clinical Informatics, is the program director for the first EM based Clinical Informatics program in the country and has represented Emergency Medicine Informaticists' interests in ACEP and many other organizations. This specific skill set will continue to help ACEP realize its informatics goals with CEDR and other data initiatives and broaden the college's growth in the modern healthcare landscape.

The Indiana ACEP Board of Directors and the Leadership of The Section for Emergency Medicine Informatics wholeheartedly supports John Thomas Finnell MD,FACEP for candidacy to thenational ACEP Board of Directors.

Sincerely,

Cynthia L. Kirchhofer
Executive Director, Indiana ACEP

Benjamin H. Slovis MD MA FACEP
Chair, Section for Emergency Medicine Informatics

Indiana ACEP Officers and Board of Directors 2021/2022

Tyler Johnson DO, FACEP
President

Daniel Elliott MD, FACEP
Vice President

Lindsay Zimmerman MD, FACEP
Secretary-Treasurer

Lauren Stanley MD, FACEP
Immediate Past President

Board Members:
Mary Blaha DO
Heather Clark MD,FACEP
Kyle English MD, FACEP
Daniel Garrison MD
Tricia Kreuter MD, FACEP
Neil Malhotra MD, FACEP
Justin Ritonya MD, FACEP
Nick Sansone DO, FACEP
Lindsay Zimmerman MD

Cynthia L. Kirchhofer
Executive Director

ACEP Section for Emergency Medicine Informatics Leadership

Carrie Baker DO, MS, FACEP
Chair – Elect

Nicholas Genes MD, PhD, FACEP
Immediate Past Chair

Indira Gowda MD
Secretary/Newsletter Editor

John T. Finnell, II, MD, MSc, FACEP

Dear Colleagues:

The past eighteen months have been the most challenging times of our personal and professional careers. I want to thank each of you for your service, your leadership, and your friendship. It is my great honor and privilege to work with you on behalf of our patients, physicians, and specialty. At this time, I respectfully ask for your vote to continue to represent you on the ACEP Board of Directors.

Our work is before us. Workforce, Private Equity, and the COVID-19 Pandemic are all re-shaping our future. Currently, we see nursing shortages in our departments. Our volumes are returning with increased acuity. Our collective patience with the pandemic is waning, leading to increased stress and behavioral health concerns within our profession.

Over the past three years, I have learned a tremendous amount about the board, the college, and the challenges of our chapters and practices across the country. While I have been a member of ACEP for over 30 years, I have acquired a unique set of skills that offers leadership, innovation, and advocacy.

What will emergency care look like in the next three, five, or ten years into the future?
Due to the pandemic, we've seen tremendous changes to how we practice emergency medicine. The healthcare landscape continues to evolve at an incredible pace. Differences in clinical medicine, technology, and the healthcare delivery system guarantee that the future practice of emergency medicine will be markedly different than it is today. While these changes present challenges to our specialty, they also offer incredible opportunities for us to build a future of patient-focused, technology-enhanced, high-quality emergency care.

Please entrust me with your vote and the opportunity to serve, work with, and represent you. I ask you for your vote to the ACEP Board of Directors so that I may continue to advocate for you and our specialty.

John T. (JT) Finnell, MD, MSc, FACEP
ACEP Board of Directors Candidate

WHO I AM:
University of Vermont: Undergraduate/Medical School
UCSF Fresno, California: Residency
Masters/Fellowship: Indiana University, Regenstrief Institute
Diplomate, ABEM
Diplomate, Clinical Informatics

MY GOALS AS A BOARD MEMBER:
Expanding the scope of Emergency Medicine
Advocate for Physician Wellness

NATIONAL/CHAPTER SERVICE:
American College of Emergency Physicians – National:

ACEP Board of Directors	2018-Present
Council Steering Committee	2013-2015
Chairman Reference Committee	2014
Education Committee	2014-Present
Indiana Counselor	2010-Present
Tellers, Credentials Committee Member	2010-2013
State Leader 911 Network	2010-Present
Reference Committee Member	2010-2013
Clinical Policies Committee – Informatics Liaison	2004-2007
Academic Affairs Committee	1999-2003

American College of Emergency Physicians – Indiana:

Past-President INACEP	2014
President INACEP	2013-2014
Board of Directors	2009-Present

PROVEN LEADERSHIP:
Department Chair Health Informatics, Indiana University
Fellowship Program Director, Clinical Informatics
Chief Medical Officer, VisualDx

CLINICAL PRACTICE:
30 years of clinical activity in a Level 1 Trauma Center, Urban Academic Environment

SERVICE:
American Board of Emergency Medicine
- Oral Board Examiner
- Item Writing Committee
- Senior Case Reviewer
- Case Development Panel

American Medical Informatics Association (AMIA)
- Board of Directors

LEADERSHIP – SERVICE - RESEARCH SCIENTIST

John T. Finnell, II
CURRICULUM VITAE

EDUCATION

POSTDOCTORAL

Regenstrief Institute, Inc.	NLM Medical Informatics Research Fellow	2002-2005
Indiana University	Clinical Investigator Training Enhancement Program M.S. in Health Services Research and Informatics	2002-2004
UCSF-Fresno	Emergency Medicine Residency	1991-1995

GRADUATE

University of Vermont	MD	1987-1991

UNDERGRADUATE

University of Vermont	BS	1983-1987

APPOINTMENTS

ACADEMIC

University of Minnesota	Assistant Professor of Emergency Medicine	1995-2002
Indiana University	Assistant Professor of Clinical Emergency Medicine	2002-2005
Regenstrief Institute	Investigator and Faculty Member Division of Biomedical Informatics	2005-Present
Indiana University	Associate Professor of Clinical Emergency Medicine	2005-Present

Indiana University	Associate Professor of Informatics	2010-Present
Indiana University	Director of Health Informatics	2010-2013

NON-ACADEMIC

South County Physicians Medical Group, Selma, CA	Staff Physician	1995
Quantum Emergency Medical Associates, Selma, CA	Staff Physician	1994-1995
Ramsey Medical Center, St. Paul, MN	Attending Physician	1995-1997
Regions Hospital, St. Paul, MN	Attending Physician	1997-2002
Hudson Regional Medical Center, Hudson, WI	Attending Physician	2001-2002
Wishard Memorial Hospital, Indianapolis, IN	Attending Physician	2002-2013
Clarian Health Partners, Indianapolis, IN	Attending Physician	2002-2005
Eskenazi Health, Indianapolis, IN	Attending Physician	2013-Present

LICENSURE AND CERTIFICATION

National Board of Medical Examiners	July 1, 1992
Instructor, Advanced Cardiac Life Support	1993-Present

Pediatric Advanced Life Support		1993-2002
Instructor, Advanced Trauma Life Support		1996-2002
CA Supervisor of Physician Assistants	# SA 21491	1993-1996
Drug Enforcement Administration	# BF3430749	1992-Present
California License	# G075367	1992-1999
Minnesota License	# 37974	1995-2002
Wisconsin License	# 40584-020	2000-2003
Indiana License	# 01056033A	2002-Present

SPECIALTY BOARD STATUS

Diplomat, American Board of Emergency Medicine	1996-Present
Diplomat, American Board of Preventive Medicine in Clinical Informatics	2013-Present

American Medical Student's Association	1987-1991
Emergency Medicine Resident's Association	1991-1996
American College of Emergency Physicians	1989-Present
Society of Academic Emergency Physicians	1995-Present
Council of Residency Directors	1995-2003
American Academy of Emergency Medicine	1999-Present
American Medical Informatics Association	2001-Present
American Medical Association	2014-Present
American College of Medical Informatics	2016-Present

PROFESSIONAL ORGANIZATION MEMBERSHIPS

PROFESSIONAL HONORS AND AWARDS

TEACHING

Physician Mentor of the Year Award	Indiana University	2018

SERVICE

Impact Award for Outstanding Service	Indiana University	2006

RESEARCH

Distinguished Paper Award	AMIA Annual Symposium	2007
Meritorious Award	Anthem Blue Cross	2007
Prestigious External Award Recognition	AMIA Annual Symposium	2008
Distinguished Paper Award	AMIA Annual Symposium	2011
21st Century Achievement Award	The Computer World Honors Program	2012
Outstanding Research Article in Bio-surveillance	International Society for Disease Surveillance Award	2012
Best Paper Award-Public Health Informatics	AMIA Annual Symposium	2012

OTHER

PATENTS

US Patent: 9,228,680: Conduit identification system

Partnership with IURTC and IU School of Mechanical Engineering

US Provisional Patent Application No. 61/610,689 May 2012

US Provisional Patent Application No. 61/622,641 May 2012

PROFESSIONAL DEVELOPMENT

EMF/ACEP Teaching Fellowship	ACEP, Dallas Tx	1998
Evidence Based Medicine	McMaster University	2001
LAMP	Indiana University	2008

TEACHING ASSIGNMENTS

Kelley School of Business

GRADUATE

#93ZE690	Senior Clerkship, Emergency Medicine	Clinical	Faculty	2002-Present

#93ZE720	Medical School Elective	Clinical	Faculty	2002-Present
#93ZI502	Evidence-Based Medicine	Lecture	Faculty	2006-2015
#93MI710	Clinical Therapeutics	Lecture	Faculty	2006-2015
#93ZM720	Medical Informatics	Lecture	Director	2008-Present
INFO667	Seminar in Health Informatics I	Lecture	Director	2009-2011
INFO668	Seminar in Health Informatics II	Lecture	Director	2009-2011
INFO581	Health Information Standards	Lecture	Director	2011-2013
INFO582	Health Information Exchange	Lecture	Director	2011-2013

Viviene Zhu	Faculty Mentor	2007-2009
Kevin Chang	Faculty Mentor	2008-2010
Jeff Klann	Faculty Mentor	2008-2011
David Shepherd	Faculty Mentor	2008-2010
Zeshan Rajput	Faculty Mentor	2009-2011
Nareesa Mohammed-Rajput	Faculty Mentor	2009-2011
Mustafa Fidahussein	Faculty Mentor	2010-2012
Matthew Stephens	Faculty Mentor	2010-2011
Jeanne Ballard	Faculty Mentor	2011-2013
Jason Cadwallader	Faculty Mentor	2011-2013
Tim Imler	Faculty Mentor	2011-2013
Robin Chisholm	Faculty Mentor	2011-2013
Adam Culbertson	Faculty Mentor	2011-2013
Jianmin Wu	Faculty Mentor	2013-2015
Mohammed Said Malas	Faculty Mentor	2013-2015

Latifat Oyekola	Faculty Mentor	2014-2016
Erica Green	Faculty Mentor	2015-2017
David Chartash	Faculty Mentor	2015-2018
Zachary Gordon	Faculty Mentor	2016-2018
Matthias Kochmann	Faculty Mentor	2016-2018
Dan Seitz	Faculty Mentor	2016-2018
Keaton Morgon	Faculty Mentor	2016-Present
Jennica Siddle	Faculty Mentor	2016-Present
Eric Puster	Faculty Mentor	2016-Present

TEACHING ADMINISTRATION AND CURRICULUM DEVELOPMENT

Fellowship Program Director for Clinical Informatics (ACGME)

Indiana University, Department of Emergency Medicine

Indiana University School of Medicine Scholarly Concentration Program Director, Health IT

ACTIVE

None

COMPLETED

University Based Training Grant	Office of the National Coordinator for Health Information Technology	Primary Investigator	$1,400,000	2010-2013
Medical Informatics Training Grant	NIH, National Library of Medicine	Primary Investigator	$ 495,856	2011-2013

INVITED PRESENTATIONS - TEACHING

NATIONAL

Rotating Residents Emergency Medicine	SAEM Annual Meeting	1996
Round Table Discussion	SAEM	1999
Getting Connected and Organized	CORD Navigating the Academic Waters	2000

Wellness in Emergency Medicine	CORD Navigating the Academic Waters	2001
Negotiating Skills and Effective Communication	CORD Navigating the Academic Waters	2002
"A Conversation with President Bush"	Transforming Health Care for Americans with Health Information Technology	2004
"Information Technology in the ED"	Regions Emergency Medicine Grand Rounds	2005
"Residency IT Tools"	Navigating the Academic Waters	2009
Indiana PDMP Interconnect	HIMSS	2013

INTERNATIONAL

Innovations in EM Medical Student Resident Education	AAEM 1st Mediterranean Congress, Stresa, Italy	2002
Approach to Abdominal Pain	Karolinska Hospital	2002

SERVICE

Emergency Medicine

Emergency Medicine Research Committee	Member	2002-Present
Emergency Medicine Residency Education Committee	Member	2002-Present

Informatics Division	Director	2004-2010
Information Technology Committee	Chair	2004-2010
Clinical Informatics Fellowship	Director	2014-Present

Indiana University School of Medicine

Faculty Advisor for Medical Students	2004-Present
Student Mentor Program: Faculty Member	2006-Present

Indiana University School of Informatics

Director, Health Informatics	2010-2013

Campus

Regions Hospital	Associate Residency Director	1997-2002
	Assistant Residency Director	
	Co-Medical Director, American Red Cross	
	GME Committee	
	Patient's Rights and Ethics	
	Internet Committee-Chair	
	Resident Education Committee	

Wishard Memorial Hospital/ Eskenazi Health	Emergency Department Informatics Committee-Chair	2002-Present
	Emergency Department Operations Committee	
	Chief Architect – ED Tracking System / EHR	
	Emergency Medicine CMIO	
	ED Epic Physician Lead	

Regenstrief Institute, Inc

University of Michigan Department of Biomedical Informatics	External Advisory Board Member	2015
	Director, Biomedical Informatics Division	2010-Present
	Co-Director Medical Informatics Fellowship	2007-2010

LOCAL

American College of Emergency Physicians – Minnesota Chapter:	Legislative Affairs Committee	1996-2001
	Education Committee	1998-2002
	Editor, MN EPIC	1999-2002
	Counselor, MN Chapter	2000-2002
	Chair, Communications Committee	2001-2002
American College of Emergency Physicians – Indiana Chapter:	Board of Directors	2009-Present
	President INACEP	2013-2014
	Past-President INACEP	2014

NATIONAL

Agency for Healthcare Research and Quality (AHRQ)	HITRC Study Section (Ad Hoc) Reviewer	2013
American Board of Emergency Medicine	Oral Board Examiner	2002-Present
	Item Writer	2014-Present
	Oral Exam Team Leader	2015-Present
	Senior Case Examiner Reviewer	2016-Present
	Case Development Panel	2016-Present
	Modified Singles Advisory Panel	2018-2019
American College of Emergency Physicians	Academic Affairs Committee	1999-2003
	Secretary Informatics Section	2002-2003
	Clinical Policies Committee	2004-2007
	Reference Committee Member	2010-2013
	State Leader 911 Network	2010-Present
	Tellers, Credentials Committee Member	2010-2013
	Indiana Counselor	2010-Present
	Council Steering Committee	2013-2015
	Education Committee	2014-Present
	Chairman Reference Committee	2014
	Nominated: ACEP Board of Directors	2016-2018
	Member, ACEP Board of Directors	2018-Present
AMIA (American Medical Informatics Association)	Abstract Reviewer	2006-Present
	Chief Editor, Practice Examination	2012-2017
	President Elect, Academic Forum	2015
	Clinical Informatics RRC Expert Reviewer	2015-Present

	President, Academic Forum	2016
	Member, Board of Directors	2016
	Education Committee	2016-2018
	Chair, InSpire Scientific Program Committee	2016
	Past-President, Academic Forum	2017
Council of Residency Directors (CORD)	ERAS Task Force	1996-1999
	Program Committee	1999
	Technology Committee	1999-2003
	Co-Chair Program Committee	2000-2001
	Navigating the Academic Waters Program Committee	2000-2002
Manuscript Peer Reviewer	*The Journal of Emergency Medicine*	1999-Present
	Annals of Emergency Medicine	1999-Present
	Academic Emergency Medicine	2002-Present
	American Medical Informatics Association	2007-Present
National Library of Medicine (NLM)	Informatics Study Section Reviewer	2013-2015
Patient-Centered Outcomes Research Institute (PCORI)	Informatics Study Section Reviewer	2013-2015
Society of Academic Emergency Medicine	Faculty Development Committee	2000-2002
	Web Task Force	2004-2005
	Web Redesign Task Force	2005-2009
	Grants Committee	2004-2009
	External Collaboration Committee	2010-2012

PATIENT CARE/CLINICAL SERVICE

Wishard Memorial Hospital/ Eskenazi Health	Emergency Department Informatics Committee-Chair Emergency Department Operations Committee Chief Architect – ED Tracking System / EHR Emergency Medicine CMIO ED Epic Physician Lead Attending Physician

GRANTS/FELLOWSHIPS IN SERVICE

Infobuttons	Columbia University	Site Primary Investigator	$300,000	2004-2007
Emergency Care Partnership	Health and Hospital Corporation	PI	$500,000	2007-2009
MITRE	Contract to connect INSPECT data with Wishard Hospital	PI	$111,877	2012
1R13LM012293 New Paths for Biomedical Informatics: A Mini-Symposium for High School Scholars	NLM	Co-PI	$200,000	8/31/2017-8/31/2021

INVITED PRESENTATIONS - SERVICE

LOCAL

Information Technology to improve quality and patient safety	VHA Central Work Group Executive Lecture	July 2005
Emergency Medicine Information Exchange Cost Savings and Quality Improvement	Indiana HIMSS	May 2005
Drug-Seeking Behavior	Burnett Medical Center	May 1999
Introduction to Emergency Medicine	University of Minnesota	February 1998
Evaluation of Asthma Patient	American Academy of Physician Assistants National Conference	May 1997
Emergency Medicine and the Internet	Minnesota Emergency Medicine Forum	September 1996
GI Bleeding	Rural Emergency Nurses Seminar	May 1996

NATIONAL

Wellness in Emergency Medicine	Iowa ACEP State Chapter Meeting	June 2020
Integrating HIE Data into EMR Workflow (Part III), Scottsdale Institute Teleconference		May 2019
Charleston, West Virginia Residency Program	Financial Management Top 10 Graduation Tips	May 2019
UCSF Fresno Emergency Medicine Residency	Conflict Management	March 2019

Indiana PDMP Interconnect	HIMSS – New Orleans	March 2013
Residency IT Tools	Navigating the Academic Waters	March 2009
Data Exchange in the Acute Care Setting	American Medical Informatics Meeting	November 2007
Information Technology in the ED	Regions Emergency Medicine Grand Rounds	October 2005
A Conversation with President Bush	Transforming Health Care for Americans with Health Information Technology	May 27, 2004
Community Clinical Data Exchange	AMIA Annual Symposium	November 2003
Community Clinical Data Exchange	NLM Training Meeting	July 2003
Wellness in Emergency Medicine	CORD Navigating the Academic Waters Negotiating Skills and Effective Communication	March 2002
Wellness in Emergency Medicine	CORD Navigating the Academic Waters	March 2001
Wellness in Emergency Medicine	CORD Navigating the Academic Waters Getting Connected and Organized	March 2000
Round Table Discussion	SAEM Medical Student Forum	May 1999
Four Week Course to Teach Rotating Residents Emergency Medicine	Poster Presentation SAEM Annual Meeting	May 1996

INTERNATIONAL

Innovations in EM Medical Student and Resident Education	AAEM 1st Mediterranean Congress, Stresa, Italy	September 2002
Approach to Abdominal Pain	Karolinka Hospital	August 2002

PUBLICATIONS

TEACHING

Refereed

1. Greenberger SM, **Finnell JT**, Chang BP, et al. Changes to the ACGME Common Program Requirements and Their Potential Impact on Emergency Medicine Core Faculty Protected Time. *AEM Educ Train*. 2020;4(3):244-253. Published 2020 Jan 19. doi:10.1002/aet2.10421

2. Unertl K, **Finnell JT***, Sarkar, N. Developing New Pathways Into The Biomedical Informatics Field: The AMIA High School Scholars Program. JAMIA (in press).

3. Lehmann CU, Longhurst CA, Hersh W, Mohan V, Levy BP, Embi PJ, **Finnell JT***, Turner AM, Martin R, Williamson J, Munger B. Clinical Informatics Fellowship Programs: In Search of a Viable Financial Model: An open letter to the Centers for Medicare and Medicaid Services. Appl Clin Inform. 2015 Apr 15;6(2):267-70.

3. Finnell JT*, Dixon BE. Clinical Informatics Study Guide: Text and Review. New York:Springer, 2015.

3. Schleyer TKL, Rahurkar S, Baublet AM, Kochmann M, Ning X, Martin DK, **Finnell JT*†**, Kelley KW, FHIR Development Team and Schaffer JT . Preliminary evaluation of the Chest Pain Dashboard, a FHIR-based approach for integrating health information exchange information directly into the clinical workflow. AMIA 2019 Informatics Summit. 2019 March 26. San Francisco, CA.

RESEARCH/CREATIVE ACTIVITY

Refereed

1. Vreeman DJ, **Finnell JT***, Overhage JM. A Rationale for Parsimonious Laboratory Term Mapping by Frequency. Proc AMIA Symp 2007 Oct 11:771-5 *Distinguished Paper Award – AMIA.*

2. Nielson JA, Melnick ER, **Finnell JT*†**. Delphi Consensus on the Feasibility of Translating the ACEP Clinical Policies into Computerized Clinical Decision Support. Ann Emerg Med. 2010 Oct;56(4):317-20.

3. Wilbur L, **Finnell JT*.** The Use of a Clinical Informatics System in an Emergency Department non-targeted HIV Screening Program. Ann Emerg Med. 2011 Jul;58(1 Suppl 1):S71-3.e1.

4. Stephens MJ, **Finnell JT*†**, Simonaitis L, Overhage JM. Variability in Drug Formularies. AMIA Annu Symp Proc. 2011;2011:1327-36. Epub 2011 Oct 22.

5. Gichoya, J, Gamache R, Vreeman D, Dixon B, **Finnell JT*†**, Grannis S. An Evaluation of the Rates of Repeat Notifiable Disease Reporting and Patient Crossover Using a Health Information Exchange-based Automated Electronic Laboratory Reporting System. AMIA Annu Symp Proc. 2012;2012:1229-36. Epub 2012 Nov 3. *"Best Paper Award-AMIA 2012" in the category of Public Health Informatics.*

6. Wu J, **Finnell JT*†**, Grannis S. A practical method for predicting frequent use of emergency department care using routinely available electronic registration data. *BMC Emergency Medicine.* 2016.

7. Park S, **Finnell JT*†**. Indianapolis Emergency Medical Service and the Indiana Network for Patient Care: Evaluating the Patient Match Algorithm. AMIA Annu Symp Proc. 2012;2012:1221-8. Epub 2012 Nov 3.

8. Chisholm R, **Finnell JT*†.** Emergency Department Physician Internet Use during Clinical Encounters. AMIA Annu Symp Proc. 2012;2012:1176-83. Epub 2012 Nov 3.

9. Wu J, **Finnell JT*†**, Vreeman D. Impact of Selective LOINC Mapping Strategies on Electronic Clinical Quality Measures. AMIA Annual Symposium, November 2013, Washington DC. AMIA Annu Symp Proc. 2013 Nov 16;2013:1525-32. eCollection 2013.

10. Wu J, Xu H, **Finnell JT*†**, Grannis S. A Practical Method for Predicting Frequent Use of Emergency Department Care Using Routinely Available Electronic Registration Data.AMIA Annual Symposium, November 2013, Washington DC. Submitted for presentation.

11. Abedtash H, **Finnell JT*†**. A Pilot Study: Integrating an Emergency Department with Indiana's Prescription Drug Monitoring Program. HCII Meeting, Las Vegas, NV. July 2013.

12. Comer AR, Apathy N, Waite C, Bestmann Z, Bradshaw J, Burchfield E, Harmon B, Legg R, Meyer S, O'Brien P, Sabec M, Sayeed J, Weaver A, D'Cruz L, Bartlett S, Marchand M, Zepeda I, **Finnell JT**, Grannis S, Silverman SD, Embi PJ. Electric Scooters (e-scooters): A Threat to Public Health and Safety. Chronicles of Health Impact Assessment. 2020: *In Press.*

SERVICE

Refereed

1. **Finnell JT***, Overhage JM, McDonald CJ. In Support of Emergency Department Health Information Technology. Proc AMIA Symp 2005; 246-50.

2. Clinical policy: Critical issues in the evaluation and management of adult patients presenting to the emergency department with acute heart failure syndromes. **Finnell JT*** (informatics liason) Ann Emerg Med. 2007 May;49(5):627-69. Epub 2007 Apr 3.

3. Clinical Policy: Critical Issues in the Evaluation and Management of Adult Patients Presenting to the Emergency Department With Acute Headache. **Finnell JT*** (Informatics liason) Ann Emerg Med. 2008 Oct;52(4):407-36.

4. **Finnell JT*,** McMicken D,: *Acute and Chronic Alcoholism*: *Rosen's Emergency Medicine,* ed 7, St Louis, 2009.

5. **Finnell JT*,** Overhage JM. Emergency Medical Services: The Frontier in Health Information Exchange. AMIA Annu Symp Proc. 2010; 2010: 222-226.

6. **Finnell JT*,** Alberto G, Wilbur LG. Effective Administration of Influenza and Pneumococcal Vaccines in the Emergency Department Using a Computer Reminder System. Ann Emerg Med. 2011 Jul;58(1 Suppl 1):S71-3.e1.

7. **Finnell JT***: *Acute and Chronic Alcoholism*: *Rosen's Emergency Medicine,* ed 8, St Louis, 2013.

8. **Finnell JT***, Overhage JM, Grannis S. All Health Care is Not Local: An Evaluation of Emergency Department Care Delivered in Indiana. AMIA Annu Symp Proc. 2011; 2011: 409–416*Distinguished Paper Award - AMIA 2012 3rd place Award, 2012 for Outstanding Research Article in Biosurveillance -Impact on Field of Biosurveillance Category.*

9. **Finnell JT***: *Acute and Chronic Alcoholism*: *Rosen's Emergency Medicine,* ed 9, St Louis, 2017.

PUBLICATIONS - ABSTRACTS

TEACHING

1. **Finnell JT**, Seupaul R: Experiential Learning in Emergency Medicine. Abstract Presented at ACEP Meeting, October 2005, Washington, DC.

2. **Finnell JT*†,** Seupaul R, Raines A, Callisto A: Experiential Learning in Emergency Medicine. Oral Presentation: 7th Annual SAEM Midwest Regional Meeting, September 2007, Detroit MI.

RESEARCH/CREATIVE ACTIVITY

1. Dawson L, Wilbur L, Huffman G, Alberto G, **Finnell JT*†**: Effective Administration of Influenza and Pneumococcal Vaccines in the Emergency Department Using a Computerized Reminder System. Abstract Presented 2006 SAEM Meeting, San Francisco.

2. **Finnell JT*†**, Bagwell S: The Value of Emergency Department Vital Signs. ACEP Scientific Assembly, October 2006, New Orleans, LA.

3. Wolff E, Kreuter T, Fuhrman J, **Finnell JT*†**: Serial Cardiac Marker Testing and 30 Day Outcomes. 2008 SAEM Meeting, Washington DC.

4. Riutta A, **Finnell JT*†:** Determination of Clinical Criteria to Rule Out Intracranial Abnormalities in Patients without evidence of Trauma. 2008 ACEP Scientific Assembly, Chicago.

5. Noormohammad S, Grannis S, **Finnell JT*†:** Changes in patient mortality based upon increased patient load in the Emergency Department. 2008 AMIA Symposium, Washington DC.

6. Tanner L, Matthews J, Riutta A, Zenarosa R, **Finnell JT*†**: Determination of Clinical Criteria To Rule Out Intracranial Abnormalities in Patients without Evidence of Head Injury. 2010 SAEM Meeting, Phoenix AZ.

7. Abedtash H, **Finnell JT*†**. Integrating an Emergency Department with a Prescription Drug Monitoring Program. Panel Discussion, AMIA Annual Symposium, November 2013, Washington DC. Submitted for presentation.

8. Cadwallader J, **Finnell JT*†**. Opioid Abuse Risk Scoring within an Emergency Department. AMIA Annual Symposium, November 2013, Washington DC. Submitted for presentation.

SERVICE

1. Towns J, **Finnell JT*†.** mERlin: Development of an Emergency Department Tracking System. Poster Presentation, HCII Annual meeting, July 2013, Las Vegas, NV.

2. **Finnell JT***, Yeaman B, Allain M, Bolin J, Line C. Integration and Interoperability of Prescription Drug Monitoring Programs. Panel Discussion, AMIA Annual Symposium, November 2013, Washington DC.

3. Takesue B, Meeks-Johnson J, Warvel J, **Finnell JT***. Emergency Department Information Systems Integration: Meaningful Use. AMIA Annual Symposium, November 2013, Washington DC.

(Date) (Signature of Candidate)

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2021 BOARD OF DIRECTORS CANDIDATE WRITTEN QUESTIONS

Rami R. Khoury, MD, FACEP

Question #1: **How do you build confidence that the College prioritizes the interests of our members and our specialty?**

As a practicing physician in an equal-partnership democratic group, I know first-hand the challenges that face today's front-line physicians. And as a leader in my group, I've been privileged to help address those challenges, most recently developing solutions to the operational, financial, and wellness challenges that we faced related to the COVID pandemic. Our group is stronger than it has ever been due to our concerted efforts to achieve our unwavering commitment to openness and transparency with our physician partners. We consistently invite and invest in the development of the next generation of leaders within our group. In our group, all partners are invited and encouraged to share their viewpoints. Our group's vision and focus are representative of the shared vision of the collective.

Today, ACEP members are clear about the issues that are most pivotal to the future of Emergency Medicine: fair reimbursement for our skill and expertise, a rational approach to EM workforce and scope of practice for non-physician providers of emergency department care, and employment models that are equitable and transparent. Since its founding in 1968, ACEP has been an organization dedicated to serving its members—emergency physicians and physicians-in-training—who for over fifty years worked tirelessly to advance the specialty of emergency medicine. Each fall during ACEP's Scientific Assembly, councillors representing each of ACEP's fifty-three chapters, forty sections, EMRA, ACOEP, AACEM, CORD, and SAEM gather to elect ACEP's leaders and to vote on resolutions that frame the agenda for the College. The passed resolutions are then reviewed by the ACEP Board, which subsequently assigns these objectives to one or more of ACEP's thirty Committees or to new ACEP Task Forces.

Building confidence that the College prioritizes our member's interests begins with engaging our members in the process—through committee or task force membership, council involvement, and active participation in ACEP state chapter affairs. Additionally, confidence in ACEP's dedication is further enhanced through robust communication with members regarding the amazing work that is being done on behalf of emergency physicians and the patients they care for.

Our specialty certainly has its share of challenges. I believe that challenges create opportunities, and when I look at how much our specialty has grown over the past 50 years, I am optimistic that emergency physicians will continue to innovate, adapt, evolve, and lead in delivering the best care possible for our patients—within the emergency department and beyond. As your next ACEP Board member, I commit to ensuring that the interests of our members, our patients, and our specialty will be prioritized above all else.

Question #2: **Now that you have risen to a high level of leadership within ACEP, how do you transition from accomplishing tasks as an individual to guiding others and leading strategically?**

Individual achievement is an essential trait of all leaders. Yet, being a great leader is not about individual accomplishments. Great leaders inspire others to drive meaningful change. Over the last thirteen years, I have been fortunate to serve in several leadership roles for my department, hospital, group and ACEP chapter. During this time, I learned that my success as a leader is a direct consequence of the success of my colleagues. This approach is mirrored in my leadership roles in our group and in my ACEP chapter. As a department chair, I focus my team on doing what is best for patients through creating a high-functioning workplace. This allows our physicians and other team members to focus on providing exceptional emergency care. As a member of the Michigan College of Emergency Physicians (MCEP) Executive Board and as MCEP Legislative Chair, through our strategic approach to the opioid epidemic, we ensured that the 10-bill legislative package included each of MCEP's priorities. Moving forward, I served as a mentor to the next MCEP Legislative Chair in navigating issues related to balanced billing in our state. My participation in the ACEP Emergency Department Directors Academy (EDDA) and our state chapter leadership development program also contributed to my leadership acumen.

The challenges we face demand strategic thinkers who can lead change while better aligning our Board, Council, and organizational leadership. “If you could get all the people in an organization rowing in the same direction, you can dominate any industry, in any market, against any competition, at any time.”
(Patrick Lencioni, The Five Dysfunctions of a Team: A Leadership Fable)

Question #3: **What areas of improvement do you see that are needed within the College and what are your proposed solutions?**

As a large membership organization, there will always be opportunities to improve communication, engagement, and transparency with our members, as well as opportunities to increase the level of collaboration between national ACEP and ACEP chapters. It is essential that our members feel connected. Like all other organizations, COVID demanded that the College become better financial stewards than ever before. And while there are many areas of improvement that the College could focus on, the biggest need that I see for our College and our specialty is unification behind our primary objectives—the issues that worry most of our members. The issues that affect our patients and our specialty are the same regardless of our geography or employment models.

I once heard an expert on health policy state that the insurers like nothing more than the house of medicine divided. In the current politically-charged environment, our leaders must remain nonpartisan and balanced—considering each side of an issue. They must represent and support emergency physicians irrespective of their practice model, while demanding fairness and transparency in all practice models. When we are divided, everyone loses. It is important that our College leadership be willing to confront and discuss potentially divisive issues; however, this must be done in a constructive manner that respects various perspectives and opinions. We should welcome the participation of dissenting voices in our deliberative processes. Opposing viewpoints compel us to consider collaborative, potentially superior solutions. ACEP is THE body that will lead our specialty into the future.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DATA SHEET

Rami R. Khoury, MD, FACEP

Contact Information

21265 Equestrian Trail
Northville, MI 48167
Phone: M: (248) 259-1329
E-Mail: rrkhoury@gmail.com

Current and Past Professional Position(s)

Vice President of Operations-West, Independent Emergency Physicians-PC (1/2018-Present)
Chair/ Medical Director, Department of Emergency Medicine, Henry Ford Allegiance Health (12/2015-12/ 2017)
Assistant Medical Director, Department of Emergency Medicine, Allegiance Health (10/2008-12/2015)
Interim Medical Director, Independent Hospitalist Physicians, Henry Ford Allegiance Health (12/2018-8/ 2018)
Core Faculty, EM Residency, Henry Ford Allegiance Health (7/2014-6/2021)
Staff Physician, Henry Ford Allegiance Health (10/2008-Present)
Staff Physician, Ascension Providence Southfield/Novi (7/2004-Present)
Staff Physician, Garden City Hospital (5/2005-12/2009)
Board Member, Henry Ford Allegiance Health Specialty Hospital (2018-Present)
Oakland Country Medical Control Authority, Medical Control Committee Chair (2007-2009)
Assistant Medical Director, Jackson County Medical Control Authority (1/2009-6/201)
Assistant Clinical Professor, Dept of Osteopathic Medical Specialties, MSU College of Osteopathic Medicine (7/2014-Present)
Assistant Clinical Professor, Department of Emergency Medicine, MSU College of Human Medicine (3/2016-Present)

Education (include internships and residency information)

BA Chemistry, Wayne State University, Detroit, MI, 1997
Medical Degree, Wayne State University School of Medicine, Detroit, MI, 2001
EM Residency, St John Hospital and Medical Center, Detroit, MI, June 2004

Specialty Board Certifications(e.g., ABEM, AOBEM, AAP, etc.) and dates certified and recertified)

ABEM Certification 2006-Present, Recertification 2015

Professional Societies

Michigan College of Emergency Physicians (2001-Present)
American College of Emergency Physicians (2001-Present)
Emergency Medicine Residents' Association (2001-2004, 2021-Present)
American Medical Association (1997-Present)
Michigan State Medical Society (2010-Present)
Jackson County Medical Society (2010-Present)

National ACEP Activities

Member, State Legislative and Regulatory Affairs Committee (2015-Present)
Member, Tellers, Credentials, and Elections Committee (2018-Present)
Member, ACEP Council Steering Committee (2019-Present)
Co-Editor/ Lecturer of CORE/REMS (Opioid) Education for ACEP (2015-2016)
Councillor, Michigan Chapter (2014-Present)

ACEP Chapter Activities

Michigan College of Emergency Physicians, Legislative Chair (2015-2020)
Michigan College of Emergency Physicians, Board of Directors (2013-2020)
Michigan College of Emergency Physicians, Executive Board (2016-2020)
Michigan College of Emergency Physicians, President (2018-2019)

Practice Profile

Total hours devoted to emergency medicine practice per year: **2100** Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.

Direct Patient Care **25** % Research **0** % Teaching **10** % Administration **65** %

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

Physician partner in a democratic, equal-partner four hospital emergency medicine group. Attending physician at a community level 2 trauma center with an EM residency.

Provide specific title(s) or position(s) within your group, hospital, department, system (e.g., Medical Director, Regional Director, Director of Quality, Vice President, Chief of Staff, etc.)

Assistant Medical Director, Department of Emergency Medicine, Henry Ford Allegiance Health
Chair, Department of Emergency Medicine, Henry Ford Allegiance Health
Interim Medical Director, Hospitalist Medicine, Henry Ford Allegiance Health
Physician Lead, Pain Steering Committee and Service, Henry Ford Allegiance Health
Member At Large, Medical Executive Committee, Henry Ford Allegiance Health
Vice President of Operations, Independent Emergency Physician-PC
Board of Directors, Independent Emergency Physicians-PC
Board of Directors, Henry Ford Allegiance Health Specialty Hospital
Core Faculty, Henry Ford Allegiance Health, Emergency Medicine Residency

Expert Witness Experience

If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony. 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 DISCLOSURE STATEMENT

Rami R. Khoury, MD, FACEP

1. Employment – *List current employers with addresses, position held and type of organization.*

Employer: Independent Emergency Physicians-PC

Address: 37000 Grand River Ave, Suite 310

Farmington Hills, MI 48335

Position Held: Vice President of Operations

Type of Organization: Democratic EM Group

2. Board of Directors Positions Held – *List all organizations and addresses for which you have served as a board member – including ACEP chapter Board of Directors. Include type of organization and duration of term on the board.*

Organization: Michigan College of Emergency Physicians

Address: 6647 W St. Joseph Hwy

Lansing, MI 48917

Type of Organization: ACEP Chapter

Duration on the Board: 2014-2020

Organization: IEP-PC

Address: 37000 Grand River Ave, Suite 310

Farmington Hills, MI 48335

Type of Organization: Democratic EM Group

Duration on the Board: 2015-Present

Organization: Henry Ford Allegiance Specialty Hospital

Address: 110 N Elm Ave

Jackson, MI 49201

Type of Organization: Long-term Acute Care Hospital

Duration on the Board: 2018-Present

I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

☒ NONE
☐ If YES, Please Describe:

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) a an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☒ NONE
☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☒ NONE
☐ If YES, Please Describe:

5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE
☐ If YES, Please Describe:

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO
☐ If YES, Please Describe:

I certify that the above is true and accurate to the best of my knowledge:

Rami Khoury, MD, FACEP Date June 25, 2021

MICHIGAN COLLEGE OF EMERGENCY PHYSICIANS

6647 West St. Joseph Highway ♦ Lansing, Michigan 48917 ♦ 517-327-5700 ♦ FAX 517-327-7530 ♦ mcep@mcep.org

48th Michigan EM Assembly
July 18-21, 2021
Grand Traverse Resort

Dear Councillors:

It is with great pleasure that the Michigan College of Emergency Physicians and the ACEP Democratic Group Practice Section endorse Rami R. Khoury, MD, FACEP for a position on the ACEP Board of Directors.

Rami served with distinction as a member of MCEP's Board of Directors for six years. He was President of our Chapter from 2018-19, at which time he worked to make the College more legislatively prominent as well as promoted advocacy among our members. During his presidency he testified and advocated against surprise billing and workplace violence in the emergency department. He met with lawmakers continuously throughout his time on our board and continues to be our liaison with key legislators. He has been a strong supporter of the MCEP Leadership and Development program and education programs. He continues his involvement as a valuable member of the College, remaining active with our Legislative and Health Finance Committee. Dr. Khoury will be the recipient of the 2021 Ronald L. Krome, MD Meritorious Service Award.

During his work with MCEP, he has presented numerous times to our chapter members and is a highly sought-after speaker by our residents. He has also presented at numerous conferences and symposiums as faculty on topics such as pain management, the opioid epidemic, physician metrics and patient management.

In addition to his work at the state level, Rami has been an asset to national ACEP. He has been active in ACEP leadership, Chapter support, as well as the ACEP Council, where he has served as a Councillor for nine years. He has experience and involvement with the ACEP State Legislative and Regulatory Committee for the last four years, as well as sits on the Tellers Committee and the Council Steering Committee, which has allowed him to cultivate successful relationships with current and past leaders. With each endeavor, Dr. Khoury has built upon and proven his ability to lead by his determination and dedication to strengthening the future of ACEP.

In addition to these activities, he is a full-time active clinician at Henry Ford Allegiance Health, where he was the recipient of the 2018 Trailblazer Award and the 2020 Physician Excellence Award. Furthermore, Dr. Khoury, as the Regional Vice President for his medical group, continues to look ahead to the future of emergency medicine and how he can assist the specialty in reaching new heights. His work in Michigan has prepared him well for the national stage.

I would respectfully ask that you join our Chapter and the ACEP Democratic Group Practice Section in supporting the nomination of Rami R. Khoury, MD, FACEP for the Board of Directors of the American College of Emergency Physicians.

Regards,

Nicholas Dyc, MD, FACEP
President, MCEP

Jay Mullen, MD, MBA, FACEP
Chair, ACEP Democratic Group Practice Section

DEMOCRATIC GROUP PRACTICE SECTION

Rami R. Khoury, MD, FACEP

Greetings Friends and Colleagues,

I want you to imagine a world where emergency medicine leads the US healthcare system, where emergency medicine expertise extends beyond the walls of the emergency department, and where emergency physicians facilitate all aspects of acute and transitional care medicine—and even collaborate in the management of some chronic diseases. In fact, we do many of these things now but simply do not broadcast our involvement. Let us redefine what emergency medicine is in the minds of all Americans. We must embrace healthcare's evolution and apply our superior ability to pivot in the face of a new challenge. We do this every day. As emergency physicians, we are perfectly positioned to deliver on the future of value-based care. We are the *best* value in healthcare.

As the 2021 Council Meeting approaches, ACEP and Emergency Medicine stand on the verge of an opportunity, one that has emerged for a variety of reasons. We can feel dismay over our challenges—the COVID pandemic, coordinated attempts to expand PA and NP scopes of practice, the recent workforce analysis suggesting a glut of EM residencies, and reimbursement challenges related to bad behavior by insurers. Yet, I am convinced that these challenges create important opportunities for sustained success. My recent outreach to ACEP members—from multiple chapters and representative of a variety of practice models—makes clear that the same issues are paramount across the entire emergency medicine community. This signals to me that, despite a variety of opinions, we all want the same things in the end. ACEP leaders must assimilate a diversity of ideas and opinions in order to guide the organization to success.

As your next ACEP Board member, I bring significant experience in leadership, innovation, advocacy, and negotiating know-how while working clinically in an equal partner democratic group. During my time as Department Chair, Medical Staff Officer, and now Vice President of Operations, I developed an ability to navigate a comprehensive healthcare system, to deploy incentive-based reimbursement models, and achieve return on investment for both emergency physicians and hospital partners. During my tenure as the Legislative Chair for the Michigan Chapter of Emergency Physicians, the chapter championed a Medicaid increase of 9 million dollars annually for emergency physicians. I served as a Physician Advisor for the successful passage of opioid legislation in the state, and negotiated with Blue Cross Blue Shield to end a new model of reimbursement that was harmful to physicians and patients. Our chapter fought as part of a united front with other specialties to add arbitration to out-of-network billing legislation—and we won.

As an ACEP Board member, I will continue to encourage engagement by ACEP members in the important work of the Council. And, I will welcome dissenting opinions as part of Board deliberations. Communication must be bidirectional between national ACEP and the chapters and sections. A well-informed, united membership provides the strength necessary to battle the influence of payors in our state and national legislative bodies. Unity between emergency physicians makes possible powerful partnerships with other specialty organizations and state medical societies.

Join me on this journey to engage and unite our membership. We will be powerful, unwavering advocates for fair and equitable reimbursement, healthy work environments, and abundant opportunities for emergency physicians now and in the future.

Please cast your vote for Rami Khoury, MD, FACEP.

Rami Khoury, MD, FACEP
for ACEP Board of Directors

Focused on the Future

Rami is a practicing emergency physician and leader in an equal-partner democratic group, Past President of the Michigan College of Emergency Physicians (MCEP), Past Chair of the MCEP Legislative Committee, and an EM residency faculty member affiliated with Michigan State University. Rami understands the reimbursement and workforce issues that face our speciality, and is dedicated to exploring the value that emergency physicians can provide beyond the four walls of the emergency department.

Proudly Endorsed By:

MICHIGAN COLLEGE OF EMERGENCY PHYSICIANS

ACEP DEMOCRATIC GROUP PRACTICE SECTION

Skilled Negotiator

- As MCEP Legislative Chair, Rami was instrumental in increasing Michigan Medicaid reimbursement by $9m annually
- Stopped BCBS from initiating a detrimental payment model that would have created a blended payment rate for level 3-5 visits

Servant Leader

- Helped residents create an outpatient harm reduction clinic
- ACEP Councillor since 2012
- Member of ACEP State Legislative/Regulatory Committee
- Member of Council Steering Committee & Tellers/Credentials

Effective Advocate for Patients and Physicians

- As MCEP President, advocated to stop MOC bill expansion in MI State Senate that would have allowed for independent practice by PAs/NPs
- Ensured Michigan Balanced Billing Legislation was amended to include arbitration
- Served as lead physician advisor for 10-bill opioid reform package in MI

Contact Rami

- Email: rrkhoury@gmail.com
- Twitter: @RamiRKhoury1
- Cell: 248-259-1329

"It pays to listen when Rami Khoury is speaking. He is cogent, insightful, and gets to the heart of the issue. If you're not paying attention, you might miss something important."

Curriculum Vitae
Rami R Khoury, MD, FACEP

Personal:

Address:
21265 Equestrian Trl.
Northville, MI 48167
M: (248) 259-1329
O: (517) 205-4938

DOB: 6-29-1975

Education:

Undergraduate: Wayne State University
Detroit, MI 1993-97
Bachelor of Arts
Chemistry

Medical School: Wayne State University
School of Medicine
Detroit, MI 1997-2001
Doctor of Medicine

Training:

Emergency Medicine Residency, 2001-2004
St. John Hospital and Medical Center/
Wayne State University School of Medicine
Detroit, Michigan

ACEP Director's Academy Phase 1
February 2010

Privileges:

Assistant Medical Director
Department of Emergency Care
Allegiance Health
Oct 2008-December 2015

Medical Director/ Chair
Department of Emergency Care
Henry Ford Allegiance Health
December 2015- December 31, 2017

Regional Vice-President
IEP-PC
January 2018-present

Interim Medical Director
Independent Hospitalist Physicians
Henry Ford Allegiance Health

Staff Physician
Department of Emergency Medicine
Providence Hospital and Medical Center
July 2004-present

Staff Physician
Department of Emergency Medicine
Garden City Hospital
May 2005- December 2009

Professional Memberships:

American Medical Association
American College of Emergency Physicians
Michigan College of Emergency Physicians
Michigan State Medical Society
Jackson County Medical Society

Licensure and Certification:

Michigan Medical License, 2003
ABEM Certified thru 2026
ATLS 2013

Honors:

Chief Resident- Emergency Medicine
St. John Hospital and Medical Center
Detroit, MI. 2003-2004

Diplomat- American Board of Emergency Medicine 2006

Fellow American College of Emergency Physicians
2007

Clinical Assistant Professor
Department of Osteopathic Medical Specialties
Michigan State University College of Osteopathic Medicine
July 2014- Present

Clinical Assistant Professor
Department of Emergency Medicine
Michigan State University College of Human Medicine
March 2016- Present

Henry Ford Allegiance Health
Trailblazer Award, 2018

Henry Ford Allegiance Health
Physician Excellence Award, 2020

Service:

Trauma Committee
St. John Hospital and Medical Center
2003-04

Emergency Department QA Committee
St. John Hospital and Medical Center
2003-04

Oakland County Medical Control Committee
Representing Providence Hospital and Medical Center
2005-2009

Oakland County Protocols Committee
2006-2009

Southfield Fire Department
Project Assistant Medical Director
2006-Aug 2008

Medical Director for Oakland County
Rapid Response EMS
March 2007-Aug 2008

Oakland County Medical Control Committee Chair
Oct 2007-2009

Oakland County PSRO Committee
Oct 2007-2009

ED Process Improvement Committee
Providence Hospital and Medical Center
Sept 2007-Sept 2008

Assistant Medical Director
Jackson County Medical Control Authority
Jan 2009-June 2013

Medical Director
Stockbridge Ambulance
April 2010- April 2013

Physician Advisory Council
Henry Ford Allegiance Health
Jan 2009- 2014

Pain Steering Committee
Henry Ford Allegiance Health
March 2009- 2016

Pain Steering Committee Chair
Henry Ford Allegiance Health
Jan 2013- Feb 2014

Cardiovascular Committee
Henry Ford Allegiance Health
Jan 2009- 2014

Pediatric Best Practice Committee
Henry Ford Allegiance Health
July 2011- 2017

Trauma Committee
Henry Ford Allegiance Health
July 2010- July 2018

Medical Executive Committee
Henry Ford Allegiance Health
October 2012- Present

Emergency Department Steering Committee
Henry Ford Allegiance Health
Jan 2013- 2017

Code Blue Committee
Henry Ford Allegiance Health
Jan 2017-July 2020

Supervising Physician
Pain Service Line
Henry Ford Allegiance Health
Jan 2018-December 2019

Pain Champion
Henry Ford Allegiance Health
January 2018-June 2020

Pain Committee Chair
Henry Ford Allegiance Health
March 2018- June 2020

Pain Steering Committee
Henry Ford Health System
July 2017-Present

Pain Medication Management Subcommittee
Henry Ford Health System
Jan 2018-Present

Opioid Steering Committee
Henry Ford Health System
September 2016-Present

District 1 Regional Trauma Network
July 2011- Jan 2014

Cardiovascular Quality Committee
Henry Ford Allegiance Health
Aug 2015- 2017

Core Faculty
Henry Ford Allegiance Health
Emergency Medicine Residency
September 2013- Present

Michigan Hospital Association
Pain Management Advisory Committee
November 2013- 2016

Jackson County Task Force on Heroin and Prescription Drug Abuse
November 215-present

American Heart Association Heart Ball
Executive Committee
2018

Board Member
Henry Ford Allegiance Health Specialty Hospital
April 2018-Present

Emergency Department ALTO Subcommittee
Henry Ford Health System
Jan 2019-preesent

Michigan Dept of Health and Human Services
PDO Stakeholder Committee
July 2018-Present

IEP Leadership Development Program
Chair
July 2020- Present

EMBC Finance Committee
September 2020- Present

Scholarly Activities:

Michigan College of Emergency Physicians
Leadership Development Program
2012

MCEP Alternate Councilor
2012-2014

MCEP Councilor
2014-present

MCEP Legislative Committee
January 2013- Present

MCEP Legislative Committee Chair
January 2105-Present

MCEP Health Finance Committee
January 2013- Present

Michigan College of Emergency Physicians
Member, Board of Directors
July 2013-Present

Michigan College of Emergency Physicians
Treasurer
July 2016-July 2017

Michigan College of Emergency Physicians
President-Elect
August 2017-July 2018

Michigan College of Emergency Physicians
President
August 2018-July 2019

Michigan College of Emergency Physicians
Immediate Past-President
August 2019-July 2020

American College of Emergency Physicians
State Legislative and Regulatory Committee
October 2016- present

American College of Emergency Physicians
Council Tellers Committee
2019-Present

American College of Emergency Physicians
Council Steering Committee
2020-Present

Michigan College of Emergency Physicians
Policy Co-Author
"Emergency Department Opioid Prescribing Recommendations" July 2013

Michigan College of Emergency Physicians
EMCC Review
Presenter November 2013

Ingham County Health Department
"Pain Management Standards of Care and Opiate Use-
Three Part Series"
Presenter September 12, 2014 Part 1
"Model Practices and Referral to Treatment"
"The Emergency Department Perspective"

Michigan Osteopathic Association
Annual Spring Convention
Pain Management: Point vs. Counterpoint
May 16, 2016
"Prescription Opioid Epidemic: Emergency Department
Model Practices"

Michigan Hospital Association
Keystone: Pain Management Workshop
May 28, 2015
"Prescription Opioid Epidemic: Emergency Department
Model Practices"

American College of Emergency Physicians
CO*RE REMS Faculty
2015

Michigan College of Emergency Physicians
Michigan Emergency Medicine Assembly
July 26, 2015
"ER/LA OPIOID REMS: Achieving Safe Use While
Improving Patient Care in the Emergency Department"

Michigan College of Emergency Physicians
ED Directors Course
August 13, 2015
"Physician Metrics and Numbers: How to Use Them"

Michigan Hospital Association
Keystone: Safe Care
September 9, 2015
"Allegiance Patient Management Program"

South Dakota ACEP
Winter Conference
March 4, 2016
"ER/LA OPIOID REMS: Achieving Safe Use While Improving Patient Care in the Emergency Department"

Michigan Hospital Association
Keystone: Pain Management Workshop
May 10, 2016
"Post-operative Pain Management" written by Dr. Cory Waller
"Pain Management in the Emergency Department"

IEP Risk Management
Sept. 14, 2016
"Pain management during the opioid epidemic: our chronic pain dilemma"

Jackson Health Network
Sept. 15, 2016 and Oct. 4, 2106
"ER/LA OPIOID REMS: Achieving Safe Use While Improving Patient Care"

Sparrow Pain Symposium
Sept. 29, 2016
"ED Prescribing and Pain Management in the Face of the Opioid Epidemic"

Jackson Trauma Symposium
Sept. 30, 2016
"Case Scenarios: Traumatic Pain Management"

The Healthcare Roundtable
THR/Chief Medical Officers
October 21, 2016
"Pain Management in the Chronic Pain Patient"
Community Mental Health
Coordination of Care Presentation
February 21, 2017
"Chronic Pain Management During the Opioid Epidemic"

The Healthcare Roundtable
THR/Chief Medical Officers
March 17, 2017
"Team Triage and Resident QI Projects"

Jackson Trauma Symposium
September 2017
Moderator

Henry Ford Allegiance Health
Medical Staff CME Talk
March 27, 2108
“Pain Management and The Opioid Epidemic”

Faith Community Nursing Talk
Sept 10, 2018
“Opioids in the New Michigan”

Michigan State Medical Society
Opioid Townhall
Feb 25, 2019

Henry Ford Health System Quality Symposium
Poster
“Reduction in the Opioid Crises at HFHS”
Feb 2019

Henry Ford Health System Quality Symposium
Poster
“Alternatives to Opioids (ALTO) in the Emergency Department”
Feb 2019

Marson Ma Endowment Lecture
Ascension St. John Hospital
Emergency Medicine Faculty Retreat
“Curiosity in the US Healthcare System: “Why are we here and where do we go next””
September 18, 2020

A rare case of right lower quadrant abdominal pain
Mark Macedo, DO, Brian Kim, MD, FACEP, Rami Khoury, MD, FACEP, Larry Narkiewicz, MD
The American Journal of Emergency Medicine
2016 Nov 3. pii: S0735-6757(16)30821-X
PMID: 27842925

Research: Conversion of Atrial Fibrillation to Sinus Rhythm During Treatment With Intravenous Esmolol or Diltiazem: A Prospective, Randomized Comparison

Sohail Hassan, MBBS, FACC, Ahmad Slim MD, Desikan Kamalkannan, MD, MRCP, Rami Khoury MD, Edward Kakish DO, Vikar Maria, MBBS, Sujood Ahmed, MD, Luis Pires MD, FACC, Steve L. Kronick, MD, MS, Hakan Oral, MD, FACC, and Fred Morady MD, FACC

Journal of Cardiovascular Pharmacology and Therapeutics
Volume 12, Number 3, September 2007

References upon request

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2021 BOARD OF DIRECTORS CANDIDATE WRITTEN QUESTIONS

Heidi C. Knowles, MS, MD, FACEP

Question #1: **How do you build confidence that the College prioritizes the interests of our members and our specialty?**

Confidence – "the feeling or belief that one can rely on someone or something; firm trust" - is critical to an organization's members' interest, involvement, and commitment. Currently, there is a divide amongst emergency medicine physicians, one side committed to ACEP and the other questioning the priorities and loyalties of ACEP. At this time, it is essential that ACEP commit to building confidence in all emergency medicine physicians, not only to retain members but also to gain new ones, so that ACEP can continue to be the voice of EM.

Communicating a clear strategic picture, one that allows members to gain awareness of the historical precedence set by the College will help members to better understand future goals and strategies implemented by the Board. Strategic planning that occurs at the national level must be clearly communicated to every member. This transparency will go a long way in building confidence that ACEP is prioritizing the interests of its members and our specialty. The challenge lies in determining which method of communication is best to accomplish this goal. Since ACEP's membership is diverse this communication must continue to be multi-modal – via traditional and electronic methods, with emphasis being placed on identifying the most efficacious means of getting the message across. Video conferencing is another method that can be taken advantage of to allow members the opportunity to hear this information live as well as have interactive discussions / Q&A sessions. Video conferencing allows members to voice their opinions, feel validated and importantly, to be heard. The COVID pandemic made this modality common-place, and most of our members are now familiar with its use. ACEP should embrace this opportunity to set up regional meetings with EM physicians for virtual "town hall" discussions across the country. Communicating the hard work that the ACEP staff and Board members are doing on a daily basis will give members an understanding and insight into how these activities affect them and their practice. This will ultimately lead to a confident and loyal member.

Question #2: **Now that you have risen to a high level of leadership within ACEP, how do you transition from accomplishing tasks as an individual to guiding others and leading strategically?**

Leaning heavily on the skills learned during my time as President of the Texas College of Emergency Physicians, I will redirect my focus from the "street-level view" to the "10,000 foot view." This transition to a strategic leader will require a shift from "doing" to delegating / empowering others and communicating a vision while staying connected and authentic.

Important initial steps in this will involve educating myself to determine what resources and support tools are available. This self-education must include listening to the members I represent, hearing their needs and expectations. The information gathered can be taken back to the Board for incorporation into discussions, debate and strategic planning.

Additionally, strategic leadership should involve not only looking back historically, but also looking forward to identify the next generation of leaders. These future leaders should be aligned with the ACEP mission and mentored into more demanding roles. I would ensure they are provided with opportunities for further development, as I have done with many Texas EM residents throughout the years.

Collectively, these efforts will allow me to elevate others, anticipate member needs and contribute at the Board level in a way that is meaningful, strategic, and will challenge myself and others.

Question #3: **What areas of improvement do you see that are needed within the College and what are your proposed solutions?**

Within the College, communication is the area that needs the most focus for improvement. Due to the increasing demands on Emergency Medicine physicians, communication must be concise and impactful. It is essential that members be made aware of the myriad of ways that ACEP is working behind the scenes to defend and protect this profession. Use of multiple modalities of information dissemination (mail / internet / video, etc.) allows the physician to self-select which of these best fits their lifestyle, increasing the likelihood that the ACEP message can be successfully heard. The real challenge is in getting the member to read / listen to the message – a challenge that can potentially be overcome by repeated, high-value messaging.

Conversely, another challenge is mitigating misinformation that is constantly present on the internet, from both members and non-members. For this, I would propose the creation of a "rapid response team" that closely monitors and is empowered to quickly respond to misinformation posted on social media. It is clear that the longer misinformation is allowed to stand, the more challenging it becomes to correct. Currently, the Emergency Medicine world seems divided. Identifying common goals, fighting the misinformation and bringing the two together would make ACEP a stronger organization.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DATA SHEET

Heidi C. Knowles, MS, MD, FACEP

Contact Information

11901 Ridge Rd
Forney, Texas 75126
Phone: (903)681-3762
E-Mail: heidiknowles17@gmail.com

Current and Past Professional Position(s)

Integrative Emergency Services
John Peter Smith Hospital System: 2/11 to current
Level 1 Trauma Center, EM Residency Program
Associate Medical Director 8/20 to current
Assistant Medical Director, 7/19 to 7/20
Director-Leadership and Advocacy, 7/15 - 6/19
Core Faculty, 7/15 - current

TCU and UNTHSC School of Medicine
Assistant Professor, Department of Emergency Medicine 9/18-current

Southlake Emergicare
Texas Health Southlake ED: 12/16 to current
Multi-specialty surgical hospital, prn ED staff physician

Trinity Valley Community College
EMS Program Medical Director: 4/2011 to current

EmCare - Emergency Department Physician
Palestine Regional Medical Center 01/02/12 to 10/2017
Rural ED, 32,000 volume, Level 3 Trauma Center
(change of contract holder from ESP to EmCare, 01/02/12)

University of Texas Health Science Center - Houston
Memorial Hermann Hospital: 10/11 to 8/15
Level 1 Trauma Center, EM Residency Staff Physician

Pegasus
Metroplex Hospital-Killeen: 08/12 to 12/12
Staff physician (temporary position for new contract start-up)

Emergency Service Partners - Emergency Department Physician
Palestine Regional Medical Center: 07/06 to 01/01/2012

Education (include internships and residency information)

Emergency Medicine Residency
University of Texas Health Science Center at Houston
Memorial Hermann Hospital, Houston, Texas 07/03 – 06/06

University of Texas at Houston, Medical School
Houston, Texas
Doctor of Medicine 08/99 – 06/03

Southwest Texas State University
San Marcos, Texas

Master of Science-Microbiology	01/96 – 08/98
Bachelor of Science-Biology/Chemistry minor	08/90 – 05/94

Medical degree: MD, 6/2003

Specialty Board Certifications(e.g., ABEM, AOBEM, AAP, etc.) and dates certified and recertified)

American Board of Emergency Medicine (ABEM)- certified 1/1/2007; recertified 1/1/2017

Professional Societies

Texas College of Emergency Physicians
American College of Emergency Physicians
Texas Medical Association

National ACEP Activities – List your most significant accomplishments

Fellowship Status - 2011
Reference Committee 2010, 2016
Membership Committee 2010-2016
Tellers and Credentials Committee 2011-2012, 2012-2013
Steering Committee 2014, 2015
Ethics Committee 2015-current
ACEP Representative at the Federation of State Medical Boards 2019-current
ACEP Representative on the Society of Critical Care Medicine Committee to create Guideline to Identify Critical Patients Outside the Emergency Department 2020-2023

ACEP Chapter Activities – List your most significant accomplishments

Texas College of Emergency Physicians (TCEP)

Board of Directors, President 2017-2018
Board of Directors, President-elect 2016-2017
Board of Directors, Immediate Past President 2018-2019
Board of Directors, Treasurer 2015-2016
Board of Directors, Regular Member 2013-2016
Board of Directors, Young Physician Representative 2012-2013
Residency Visit Lecture Program
- Co-coordinator 2011-2013
- Coordinator 2014-2018

Board Liaison to Resident Committee 2014-2016
Fellow of TCEP Leadership and Advocacy Program 2010
Education Committee 2009-2013
Bylaws Review Committee 2010-2011
Membership Committee 2010 - 2018
Elections Committee 2010
Finance Committee 2017-current

Emergency Medicine Political Action Committee of Texas (EMPACT)

Executive Board / Controlling Member – 2018 to current

Practice Profile

Total hours devoted to emergency medicine practice per year: **1632** Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.

Direct Patient Care **47** % Research **1** % Teaching **17** % Administration **35** %

Other: _____ %

Describe current emergency medicine practice. (e.g., type of employment, type of facility, single or multi-hospital group, etc.)

I work for Integrative Emergency Services (IES), a regional multi-hospital physician group. I am the Associate Medical Director at John Peter Smith Health Network, a Level 1 Trauma Center, county hospital that sees >120,000 patients per year.

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.)

Associate Medical Director
Core Faculty

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 (0)** **Plaintiff Expert** **Cases (0)**

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DISCLOSURE STATEMENT

Heidi C. Knowles, MS, MD, FACEP

1. Employment – *List current employers with addresses, position held and type of organization.*

Employer: Integrative Emergency Services at John Peter Smith Health Network

Address: 1500 South Main Street, Fort Worth, Texas 75106

Position Held: Associate Medical Director; Core Faculty Member

Type of Organization: Regional multi-hospital physician group

Employer: Southlake Emergicare

Address: 1545 East Southlake Blvd

Southlake, Texas 76092

Position Held: Staff physician

Type of Organization: Single hospital EM physician group

2. Board of Directors Positions Held – *List all organizations and addresses for which you have served as a board member – including ACEP chapter Board of Directors. Include type of organization and duration of term on the board.*

Organization: Texas College of Emergency Physicians

Address: 401 W. 15th Street, Ste 695 Austin, Texas 78701

Type of Organization: ACEP Chapter

Duration on the Board: 2012-2019

Organization: Emergency Medicine Political Action Committee of Texas (EMPACT)

Address: 401 W. 15th Street, Ste 695 Austin, Texas 78701

Type of Organization: Political Action Committee for Texas EM physicians

Duration on the Board: 2018-current

Organization: United Way Henderson County

Address: PO Box 1435 Athens, Texas 75751

Type of Organization: Volunteer organization to raise funds and give support to many community organizations

Duration on the Board: 2009-2013

I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

✓ NONE

☐ If YES, Please Describe:

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) a an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

✓ NONE

☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

✓ NONE

☐ If YES, Please Describe:

5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

✓ NONE

☐ If YES, Please Describe:

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

✓ NO

☐ If YES, Please Describe:

I certify that the above is true and accurate to the best of my knowledge:

Heidi Knowles July 4, 2021

July 6, 2021

Dear ACEP Councillors:

On behalf of the Texas College of Emergency Physicians (TCEP), it is my great pleasure to write this endorsement for Heidi Knowles, MD, FACEP as a candidate for the ACEP Board of Directors.

Dr. Knowles has been a member of ACEP since 2002 and brings experience and accomplishments in clinical practice (both rural and community), national ACEP, and our Chapter that, at this time of challenge to our profession, will be of great value in advancing emergency care. Within ACEP, Dr. Knowles has served with distinction as a Councilor, member of several committees including Ethics and the 911 Network.

But her service within TCEP most exemplifies the skills that will be of value to the ACEP Board of Directors. You can see from her CV, that she has served on many committees including participating in our yearlong Fellows (TLAF) program. She continues to serve on the Finance committee, EMPACT board, and the residency visit programs. She was co-director, and then director of our very successful Residency visit programs (now held at all 13 medical residencies).

And she has served in every capacity on the TCEP Board, moving up through the offices to President in 2018. It was her service as President that really set the bar. When she served as President of the Chapter, was a time of great turmoil for our association, as we did not have any staff for over a year. During her term, the board made the decision to move the "office" to Irving for a year as many of the board members lived in that area. Dr. Knowles went to the TCEP office 4-5 days a week, after her shifts, and work on association business. Her hard work and many months of work kept the association afloat during that year long transition. This works gives her a unique perspective on all the things a state chapter does. She has continued her involvement with TCEP and represents TCEP on several Texas Medical Association committees and in their House of Delegates.

The Texas Chapter is proud to give her our highest endorsement.

Thank you for your consideration, and please do not hesitate to reach out to me or our Executive Director Beth Brooks, (tcep@texacep.org) with any questions.

Sincerely,

Craig Meek, MD, FACEP
President

Heidi C. Knowles, MS, MD, FACEP

Fellow Councillors and Colleagues,

I am honored to be a candidate for the ACEP Board of Directors.

My alignment with ACEP's vision as the *leading advocate for emergency physicians* cannot be overstated. I have been a member for over 15 years, becoming very active 10 years ago in the TCEP Leadership and Advocacy Fellowship. Since then, I have participated in many TCEP and ACEP committees, working my way up to TCEP President. Currently, I continue to serve as a past President of the chapter and member of the TCEP PAC Executive Board. Throughout this time, I have developed a passion for service and a real respect for the role active involvement and advocacy play in the preservation of our specialty. It is for this reason I would like to represent you on the ACEP Board.

In this role, I will support changes that include a reinvigorated focus on the needs of the emergency physician, including improved communication, increased transparency and protection from the external forces that are affecting all physicians.

When the going gets tough, emergency physicians are undeniably resilient. They should be proud to be ranked among the most trusted and honorable in our society. Recently, however, physicians have been toppled from their status as heroes, vilified by the community's perceived lies and myths surrounding COVID. ACEP must have a vocal presence on social media to combat these types of misperceptions regarding physicians, so that the negativity can be reversed, restoring the community's faith and confidence in emergency physicians.

There is safety in numbers, and yet I see a growing and stressful divide among my colleagues that creates potential for ACEP to lose its relevance. Increasing transparency will help members, current and future, to have confidence that the College will not be influenced by outside forces. This confidence that the College has members' interests first and foremost will allow physicians to regain trust and proudly renew / maintain their membership status.

Importantly, I will advocate for physician rights– rights for a safe work environment that will allow physicians to provide quality care, free from the malignant effects of corporate medicine; the right to job security, both for graduating residents and practicing physicians, for jobs that are secure with adequate due process and guarded from the encroachment of non-EM physicians and APPs; and the right to have fair payment as well as financial stability, free from worry of threats to income from litigation, regulatory / legislative demands and insurance company failures (i.e. network inadequacy).

As a practicing physician, I have worked in a variety of EM environments, including rural, community (large and small) and currently as core faculty in an extremely busy, Level 1 Trauma Center. I have worked as an employee, an independent contractor and as a locum tenens physician. Additionally, I am the Medical Director for an EMS program at a local community college. Such wide exposure equips me to represent physicians across the country in diverse and unique practice types.

With your support, I know that I can be the leader and voice that physicians increasingly need. I have the passion, the desire and the commitment to give my all as your representative. I look forward to seeing everyone in Boston and I respectfully ask for your vote.

Sincerely,

Heidi Knowles, MD, FACEP
Past President, Texas ACEP Chapter
HeidiKnowles17@gmail.com
Cell: 903)681-3762

Heidi Knowles

MS, MD, FACEP

Board of Directors Candidate

American College of Emergency Physicians

STATE AND NATIONAL INVOLVEMENT

TCEP
Past President, Board of Directors
Bylaws Review Committee
Elections Committee
Finance Committee
Membership Committee
Leadership and Advocacy Fellow
Residency Visit Coordinator
EMPACT (TCEP PAC) Executive Board

TEXAS MEDICAL ASSOCIATION
Inter-specialty Society TCEP Representative

ACEP
Federation of State Medical Boards-ACEP representative
Society of Critical Care Medicine-ACEP representative
Steering Committee
Tellers and Credentials Committee
Reference Committee
Ethics Committee
Membership Committee

Committed • Proven Service • Dedicated

ACTIVE INVOLVEMENT IS ESSENTIAL TO DEFINE AND PROTECT THE ROLE OF EMERGENCY PHYSICIANS IN THE CARE OF OUR COMMUNITIES. I HAVE BEEN, AND WILL CONTINUE TO BE, A DEDICATED, PASSIONATE REPRESENTATIVE FOR EMERGENCY PHYSICIANS. MY EXPERIENCE IN EMS EDUCATION, RURAL AND COMMUNITY EMERGENCY MEDICINE, AS WELL AS ACADEMIC TRAUMA CENTERS, ALLOWS ME TO HAVE THE BROAD PERSPECTIVE NECESSARY TO REPRESENT A WIDE VARIETY OF PHYSICIANS AND PATIENTS.

WITH YOUR VOTE, I WILL CONTINUE TO BE THE ADVOCATE OUR SPECIALTY NEEDS.

Heidi Christine Knowles, MS, MD, FACEP

home: (903)681-3762
email: heidiknowles@yahoo.com

EDUCATION:

Emergency Medicine Residency
University of Texas Health Science Center at Houston
Memorial Hermann Hospital, Houston, Texas 07/03 – 06/06

University of Texas at Houston, Medical School
Houston, Texas
Doctor of Medicine 08/99 – 06/03

Southwest Texas State University
San Marcos, Texas
Master of Science-Microbiology 01/96 – 08/98
Bachelor of Science-Biology/Chemistry minor 08/90 – 05/94

Licensure: Texas Medical License #M3818

Certifications:
Board Certified American Board of Emergency Medicine 12/17 – 12/27
Advanced Cardiac Life Support (ACLS) 10/15– 10/17
Advance Trauma Life Support (ATLS) 10/14 – 10/18

WORK EXPERIENCE:

Integrative Emergency Services
John Peter Smith Hospital System: 2/11 to current
Level 1 Trauma Center, EM Residency Program
Associate Medical Director 8/20 to current
Assistant Medical Director, 7/19 to 7/20
Director-Leadership and Advocacy, 7/15 - 6/19
Core Faculty, 7/15 - current

TCU and UNTHSC School of Medicine
Assistant Professor, Department of Emergency Medicine 7/19-current

Southlake Emergicare
Texas Health Southlake ED: 12/16 to current
Multi-specialty surgical hospital, prn ED staff physician

Trinity Valley Community College
EMS Program Medical Director: 4/2011 to current

EmCare - Emergency Department Physician
Palestine Regional Medical Center 01/02/12 to 10/2017
Rural ED, 32,000 volme, Level 3 Trauma Center
(change of contract holder from ESP to EmCare, 01/02/12)

University of Texas Health Science Center - Houston
Memorial Hermann Hospital: 10/11 to 8/15
Level 1 Trauma Center, EM Residency Staff Physician

Pegasus
Metroplex Hospital-Killeen: 08/12 to 12/12

Staff physician (temporary position for new contract start-up)
Emergency Service Partners - Emergency Department Physician
Palestine Regional Medical Center: 07/06 to 01/01/2012

PUBLICATIONS:

Freeman, L, Carvajal, M, Knowles, H. Treating Hypertension in the Emergency Department, Part 1. *Emergency Medicine Reports*. Vol 26, No. 7. March 21, 2005.

Freeman, L, Carvajal, M, Knowles, H. Treating Hypertension in the Emergency Department, Part 2. *Emergency Medicine Reports*. Vol 26, No. 7, April 4, 2005.

Morgan, D., Wainscott, M., Knowles, H. Emergency Medical Services Liability Litigation in the United States: 1987 to 1992, *Prehospital and Disaster Medicine* (vol. 9, No. 4) October – December 1994.

Allen, N., Jesus, J., Knowles, H., Larkin, G., Schears, R. Extracorporeal Membrane Oxygenation in the ED: Exciting Medicine, Ethical Challenges. *ACEP Now*, July 19, 2016

Holmes, M., Stanzer, M., Schrader, C., Knowles, H. Chapter 27, Getting Involved in the House of Medicine, *Emergency Medicine Advocacy Handbook*, 4th edition, 2016.

Marco CA, Venkat A, Baker EF, Jesus JE, Geiderman JM, et al. Prescription Drug Monitoring Programs: Ethical Issues in the Emergency Department. *Annals of Emergency* Medicine. Nov 2016. 68(5):589-598, November 2016. Epub May, 2016.

Huggins, C., Knowles, H., Wang, H. Large Observation Study on Risks Predicting Emergency Department Return Visits and Associated Disposition Deviations. *Clinical and Experimental Emergency Medicine*. In press July 2018.

Knowles, H., Huggins, C., Robinson, R., et al. Status of Emergency Department Seventy-Two Hour Return Visits Among Homeless Patients. Journal of Clinical Medical Research. 2019 Mar;11(3):157-164. doi: 10.14740/jocmr3747. Epub 2019 Feb 13.

Mazur, B., Jennings, A., Knowles, H. Chapter 195, Globe Luxation Reduction, Reichman's Emergency Medicine Procedures, 3rd edition, 2018.

Wolfshohl JA, Bradley K, Bell, C, Hodges C, Knowles H, Chaudhari B, Kirby R, Kline J, Wang H. Association Between Empathy and Burnout Among Emergency Medicine Physicians. Journal of Clinical Medical Research. 2019 Jul; 11(7): 532-538.

Byrd J, Knowles H, Moor S, Acker V, Bell S, Alanis N, Zhou Y, d'Etienne J, Kline J, Wang H. Emergency Medicine Journal. 2020 Nov 25: emermed-2019-209393.

Jyothindran R, d'Etienne J, Marcum K, Tijerina A, Graca C, Knowles H, Chaudhari B, Zenarosa N, Wang H. Fulfillment, burnout and resilience in emergency medicine – Correlations and effects on patient and provider outcomes. PLoS One. 2020 Oct 19;15(10): e0240934.

TEACHING ACTIVITIES / PRESENTATIONS:

ABCD (Airway, Breathing, Circulation & Difficult Delivery) Simulation Course
Course Director, 11/2017 and 2/2019
Texas College of Emergency Physicians Annual Meeting 4/2019, 3/2020
LLSA Review state presentation
American College of Emergency Physicians Leadership and Advocacy Meeting 2/2018
Succession Planning Panel Presentation
JPS Department of Pharmacy Lecture: Burnout Identification and Prevention 6/2019
JPS Emergency Medicine Residency Lectures
Difficult Airway Course
Acute Coronary Syndrome Update
HEENT Tricks of the Trade
Orthopedic Emergencies
Emotional Intelligence
Leadership and Advocacy – How to Get Involved
OB Emergencies Simulation Day Coordinator
Vaginal Bleeding in Pregnancy
Trinity Valley Community College EMS Medical Director
Classroom lectures and clinical teaching for paramedic and EMT students
Texas College of Emergency Physicians Residency Visit Coordinator (2011 to 2020)
Lecture to residents on topics including Leadership / Advocacy / Life After Residency / Myths of EM / Hot Topics of EM / Importance of Getting Involved / Maximizing Efficiency in the ED / Motivation
UTHSC San Antonio Residency Grand Rounds - Emerging Infectious Diseases 4/15
ACLS Course Instructor 2003-2006
EMS Continuing Education Instructor, Intermedix, 2005-2006

PROFESSIONAL DEVELOPMENT

Harvard Extension School
Certificate of Completion, Managing Yourself and Leading Others for Healthcare Professionals October 21-November 13, 2020

PROFESSIONAL MEMBERSHIPS:

Texas College of Emergency Physicians (TCEP)
Board of Directors, President 2017-2018
Board of Directors, President-elect 2016-2017
Board of Directors, Immediate Past President 2018-2019
Board of Directors, Treasurer 2015-2016
Board of Directors, Regular Member 2013-2016
Board of Directors, Young Physician Representative 2012-2013
Residency Visit Lecture Program
Co-coordinator 2011-2013
Coordinator 2014-2018
Board Liaison to Resident Committee 2014-2016
Fellow of TCEP Leadership and Advocacy Program 2010
Education Committee 2009-2013
Bylaws Review Committee 2010-2011
Membership Committee 2010 - 2018
Elections Committee 2010

Finance Committee 2017-current

Emergency Medicine Political Action Committee of Texas (EMPACT)

Executive Board / Controlling Member − 2018 to current

American College of Emergency Physicians (ACEP) 2002-current

Fellowship Status - 2011
Reference Committee 2010, 2016, 2020
Membership Committee 2010-2016
Tellers and Credentials Committee 2011-2012, 2012-2013
Steering Committee 2014, 2015
Ethics Committee 2015-2021
ACEP Representative at the Federation of State Medical Boards 2019 - current
ACEP Representative on the Society of Critical Care Medicine Committee to create Guideline to Identify Critical Patients Outside the Emergency Department 2020-2023

Texas Medical Association

Young Physician Section Delegate 2012-2014
Young Physician Section Steering Committee 2012-2014
TexPAC Vice Chair, Region 3
Inter-specialty Society Committee
Texas College of Emergency Physicians Representative
Alternate Delegate 2013-2014; Delegate 2014-2021
Member Anderson-Leon County Medical Society 2006-2019
Member Tarrant County Medical Society 2019 − current

Society of Academic Emergency Medicine

Faculty Development Committee 2016-2018
Speed Mentoring Faculty 2017-2018

AWARDS

James E. Hayes Award − 2019

Award for outstanding contributions to Texas Emergency Medicine

Outstanding Emergency Medicine Resident- UT Houston 2006

VOLUNTEER ACTIVITIES:

Henderson County United Way Board of Directors, 2009-2013
Hurricane Katrina Disaster Relief, Astrodome Physician Services, 09/05
Kiwanis Club of Athens, Sponsored Youth Director 2009-2013
Trinity Habitat for Humanity – Cowtown Brush-up 10/2017, 02/2018, 10/2018 Team Captain / Coordinator
North Texas Alliance for Clinical Resilience 2018-2019

PERSONAL:

Born in McKinney, Texas
Married to Michael Ely, DC
Hobbies / interests include travel, scuba diving, gardening and beekeeping

REFERENCES: Available upon request

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2021 BOARD OF DIRECTORS CANDIDATE WRITTEN QUESTIONS

Michael Lozano, Jr., MD, MSHI, FACEP

Question #1: **How do you build confidence that the College prioritizes the interests of our members and our specialty?**

The objective reality is that ACEP does indeed prioritize both our members' interest and specialty. College publications, policy statements, and advocacy efforts all provide support for that statement in both words and deeds. The challenge is in properly and effectively communicating this reality to our rank-and-file membership. Without that connection to membership, confidence wanes and the weeds of misinformation will flourish. To combat this, we need to be purposeful in framing our communications to always be viewed through the lens of member interest. Additionally, we can educate the membership on our governance structure and provide additional degrees of transparency in our governance processes.

A casual review of the June issue of ACEP*Now* is representative of how the breadth of our practice is supported by ACEP. There are articles on clinical issues such as the management of pulmonary embolism, marine envenomation, and urticaria. COVID-19 vaccination challenges are discussed alongside the global health aspects of vaccine sharing. Professional development is promoted through conferences (ED Directors Academy, Scientific Assembly, and Leadership & Advocacy), and didactic materials (Critical Decision in EM, and PEERcert+). All are relevant and relatable to physicians practicing emergency medicine. Similarly, when visiting the newly updated ACEP website, one sees categories of content that can resonate on a professional or personal level. Additionally, the myriad committees and sections available for participation also reflect the priorities of our membership.

The content and services are indicative of the big umbrella that is emergency medicine, and which is represented by ACEP. Although some of our efforts, like advocacy, raise all boats, we should make it a point to indicate the personal benefits of membership, and not just when we want people to renew. We should include terms such as "member-benefit" and prominently illustrate the savings due to membership at the point of purchase for all our products. Messaging is but one aspect of restoring confidence. Actions speak louder than words, and to that end, we should actively reach out to the membership to determine their preferred mode of communication. We are a multi-generational organization, and our members have individual preferences for connection with us. In tandem we should embark on an educational journey to better inform on the governing structure of ACEP. I would hazard to guess that many members are not clear on the role of Council and how it connects with the Board. There is probably a larger number of members that are unaware of the staff at the ACEP offices (both) and the great and varied work that they do on our behalf. Finally, I would advocate for greater transparency. Let us take advantage of the pandemic and continue to open Board meetings and Council electronically to the general membership. Transparency goes a long way in restoring confidence.

ACEP is an organization that represents the interests of emergency physicians and their patients. In doing so there are multiple touch points across the career range of membership. Promoting confidence, and in turn commitment, can be achieved through effective communication, education, and transparency.

Question #2: **Now that you have risen to a high level of leadership within ACEP, how do you transition from accomplishing tasks as an individual to guiding others and leading strategically?**

To borrow the aviation metaphor, I would argue that a modern leader needs to be comfortable at both the tree-top level and at 30,000 feet even though they may spend most of the time in the clouds. Additionally, they need the skill to transition smoothly between them and the wisdom to judge when it is necessary. Fortunately, I have had the opportunities to attain and hone these skills over the course of my career. I look forward to applying them toward ACEP activities.

For many of us, residency was our first exposure to transitioning from individual tasks to group work supervision. In my case, it was as an internal medicine and then as an emergency medicine resident in the New York City public hospital system. Progressive responsibility in that setting teaches you to trust but verify. Early experiences at the hospital and group level were also formative for me. Hospital committees are one place the early-career physician can learn how the hospital really works and how the deliberative process is implemented, and consensus attained. Early on in my career, my partners and I formed a single-site democratic privately held group de novo at an academic level-2 trauma center. At that point it was all-hands-on-deck approach as much of the work was tasked out to different individuals. In tandem with the new practice, I was starting my EMS position and volunteering for the Florida chapter in earnest. Although being an EMS medical director teaches you about leadership at a distance, much of the work with your agency remains your own. My participation in Florida chapter activities exposed me to strong leaders who led by example.

Upon becoming an ED medical director, I had my first substantial exposure to guiding others and leading strategically. At that time, I had joined a national physician staffing and practice management group and over time gained increasing

responsibility. As I grew professionally, I became keenly aware of the difference between the business concepts of Circle of Control and Circle of Influence. Understanding their interplay helped me to better lead groups in an effective manner. As one grows in leadership it is critical to develop a sense of trust and respect for those that work alongside you. No one has ever said that they felt that they were not micromanaged enough. It is important to allow others to flourish and be there when they need support. It is also essential as a good leader to have open lines of communication and trust that individuals will try to do their best. It is the leader's responsibility to provide the support, tools, and guidance needed by those reporting to them. My time in the corporate world allowed me to gain experience in finance, budgeting, and strategic planning. Most satisfying to me, however, was mentoring clinicians. I derive deep satisfaction from helping others to succeed – clinically or otherwise. Although I am not in that world anymore, the skills will stay with me and can be applied to helping the College. A tremendous amount of hard detailed work for ACEP is done at the task force, committee, and section level. One of the board's most important roles is to translate these work products into action items in accord with ACEP's strategic plan.

The development of leadership skills is a slow process and sometimes can be a bit of trial and error. I am thankful to have had the opportunity to learn from those who were exceptionally good at it. To be a good and strategic leader one needs trust, empathy, and respect for others. These are necessary skills to make the transition from individual accomplishment to strategic leadership. I feel that I have learned them along the journey of my career and am prepared to apply them to support ACEP.

Question #3: **What areas of improvement do you see that are needed within the College and what are your proposed solutions?**

ACEP is a vibrant and active organization that supports emergency physicians and their patients. Identifying areas of improvement is an important exercise in strategic planning for organizations. I feel that there are three areas in which there could be some improvement – communication, transparency, and inclusion. Addressing these areas will further strengthen our organization by promoting more engagement, encouragement of new ideas, and energizing the early-career members who are our future.

With nearly 40,000 members, ACEP supports the broad range of activities that constitute emergency medicine practice and is the leading organization that represents all our interests. Unfortunately, our ability to showcase our efforts and successes has not always been as good as it could have been. Consequently, it may be misinterpreted that ACEP is not active in one area or another. Good communication requires not only a strong message, but also choosing the proper vehicle for delivering that message. Part of the latter process involves understanding the needs and preferences of the target audience. While print media has been the traditional mainstay for professional communication, we have seen ACEP move more into the social media and electronic sphere. That move needs to continue and strengthen. We also need to have a better sense of message receptiveness, especially in the group of early-career physicians in the first few years out of residency and fellowship – a group where we have traditionally seen a drop-off in College participation. We need to confirm which mode of communication is preferred and resonates with our members – and respond accordingly.

Together with better communication should be a commitment to greater transparency and member education on the governance of ACEP. While one can research our website and learn about ACEP Council, we need to be able to push that information out to the membership at large in an easy to digest formt. In recent years we have seen a move by Council leadership to expand away from just the two days prior to Scientific Assembly to a more year-round approach to resolution creation and discussion. This effort should continue as it promotes engagement on the issues debated. One silver lining of the pandemic was to shift us into the broadcast of reference committee debate – both synchronous and asynchronous. I would recommend that some sort of online Council presence continue to further promote engagement. Another practice that should be encouraged is a better accounting of the fate of the various resolutions that are passed by Council, especially the ones that were referred to the board of directors for action. I feel that these transparency efforts will underscore the good work that ACEP does on our behalf and encourage greater participation.

Finally, I anticipate that a natural consequence of effective communication and greater transparency will be more inclusiveness in our membership. There has been great work done by ACEP in terms of diversity and inclusion in the past few years, and I anticipate that it will continue as we have such a strong Diversity, Inclusion, and Health Equity Section. In addition to highlighting ways that members can get involved with any of the forty sections in the College. We need to make it easier for our members who cannot necessarily get away for several days to attend Scientific Assembly or LAC to participate in discussions, committees, and sections. This type of inclusiveness encourages engagement and further empowers our membership.

I feel that better and more targeted communication will better disseminate ACEP's message and illustrate our good works. Greater transparency will make us a more approachable organization that is open to new ideas and the energy that comes from an engaged membership. Finally, as we take active measures to make participation easier, we will harvest the many benefits of a truly engaged membership that will in turn promote our mission, vision, and values.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DATA SHEET

Michael Lozano Jr., MD, MSHI, FACEP

Contact Information

4824 Longwater Way
Tampa, FL 33615
Phone: 813-784-6122
E-Mail: theTampaDOC@msn.com

Current and Past Professional Position(s)

Current Professional Positions:

- Attending Physician, Tampa General Hospital
- Attending Physician, Fayetteville North Carolina Veteran's Administration Medical Center
- Medical Director, Hillsborough County Fire Rescue
- Collaborative Assistant Professor, Department of Internal Medicine, Morsani College of Medicine, University of South Florida, Tampa, Florida

Past Professional Positions:

- Attending Physician, BayCare Health System, Morton Plant Mease, Mease Countryside & Mease Dunedin Hospitals, Clearwater, FL 33756
- Associate Medical Director, The Physician's Quality Registry (The PQR), Plantation, Florida
- Senior Vice President, Southeast Group, Envision Physician Services (merged from EmCare, Inc.), Clearwater, Florida
- Executive Vice President, South and Alliance Divisions, EmCare Inc., Clearwater, Florida
- On–Line Medical Control Physician, Pinellas County EMS, Largo, Florida
- Attending Physician, Brandon Regional Hospital, Brandon, Florida
- Attending Physician, Osceola Regional Medical Center, Kissimmee, Florida
- Emergency Department Medical Director (interim), Osceola Regional Medical Center, Kissimmee, Florida
- Medical Director, Emergency Department, Northside Hospital and Tampa Bay Heart Institute, St. Petersburg, Florida
- Attending Physician, Bayfront Medical Center, St. Petersburg, Florida
- Regional Associate Medical Director, Emergency Medical Services Group, Inc., Largo, Florida
- EMS Physician, Pinellas County Emergency Medical Service, Emergency Medical Services Group, Inc., Largo, Florida
- Staff Physician, First Med – Immediate Medical Care, Inc., Queens, New York
- Assistant Attending, Department of Ambulatory Care, Bronx Municipal Hospital Center, Bronx, New York
- Telemetry Control Physician, Office of the Medical Director, New York City Emergency Medical Service, Maspeth, New York

Education (include internships and residency information)

Postgraduate Medical Education:

University of South Florida, College of Medicine, Tampa, Florida
Master of Science in Health Informatics, January 11, 2016, through December 9, 2017

Office of the Medical Director, New York City Emergency Medical Service
New York City Health and Hospitals Corporation, Maspeth, New York
Fellowship in Emergency Medical Services, July 1, 1993, through June 30, 1994

Albert Einstein College of Medicine of Yeshiva University
Bronx Municipal Hospital Center, Bronx, New York

Residency in Emergency Medicine,

- *July 1, 1990, through June 30, 1993*
- *Chief Resident*, July 1, 1992, through June 30, 1993

New York University Medical Center at Bellevue Hospital Center and Tisch Hospital
Department of Medicine, New York, New York
Residency in Internal Medicine, July 1, 1987, through June 30, 1990

Medical Education:

Mount Sinai School of Medicine, New York, New York
Doctor of Medicine, September 1, 1983, through May 29, 1987

Pre–Medical Education:

Syracuse University, College of Arts and Sciences, Syracuse, New York
Bachelor of Science in Biology, September 1, 1980, through December 23, 1982

Specialty Board Certifications(e.g., ABEM, AOBEM, AAP, etc.) and dates certified and recertified)

Diplomate, **American Board of Emergency Medicine, EMS - Emergency Medical Services**
Certificate No. 22725, October 10, 2019, to December 31, 2029
Diplomate, **American Board of Preventive Medicine, Clinical Informatics**
Certificate No. 31-17412, January 1, 2019, to December 31, 2028
Diplomate, **American Board of Emergency Medicine**
Certificate No. 22725, January 1, 2015, to December 31, 2024
Certificate No. 930215, December 23, 2004, to December 31, 2014
Certificate No. 930215, June 2, 1994, to December 31, 2004
Diplomate, **American Board of Internal Medicine**
Certificate No. 130981, September 25, 1991, to December 31, 2001

Professional Societies

2017 – Present	American Medical Informatics Association
2012 – Present	Florida Medical Association
2010 – 2020	American Association for Physician Leadership
2002 – Present	Florida Fire Chiefs Association
1996 – Present	Florida Association of EMS Medical Directors
1998 – 2016	International Trauma Life Support, Florida Chapter
1994 – Present	Florida College of Emergency Physicians
1993 – Present	National Association of EMS Physicians
1990 – Present	American College of Emergency Physicians
1989 – 1999	American College of Physicians
1986 – 1996	American Medical Association
1990 – 1996	Society for Academic Emergency Medicine
1990 – 1993	Emergency Medical Residents Association

National ACEP Activities – List your most significant accomplishments

American College of Emergency Physicians
2021 Member, ACEP Council Tellers, Credentials, and Elections Committee
2020 Member, ACEP Council Tellers, Credentials, and Elections Committee
2017 Chair, ACEP Council Reference Committee
2016 – 2017, Member, ACEP Council Nominating Committee
2016 – 2018, Member, Emergency Medicine Informatics Section
2016 – 2017, Member, Diversity and Inclusion Task Force
2015 – 2016, Member, ACEP Council Steering Committee
Chair, Annual Meeting Subcommittee
Member, Candidate Forum Subcommittee
2014 – 2015, ACEP Council Steering Committee
Member, Bylaws and Council Standing Rules Subcommittee
Member, Resolution Development Subcommittee

2008 – 2022, Councillor, ACEP Council
1992 – 1993, Member, Residents Committee, New York Chapter

ACEP Chapter Activities – List your most significant accomplishments

Florida College of Emergency Physicians
2014 – 2015, Immediate Past President
2013 – 2014, President
2012 – 2013, President Elect
2011 – 2012, Vice President
2010 – 2011, Secretary/Treasurer
2008 – present, Medical Economics committee
2007 – 2015, Board of Directors
2006 – present, EMS/Trauma committee
2006 – 2011, Chair
1996 – 1999, member
2001 – present, Government Affairs committee

Practice Profile

Total hours devoted to emergency medicine practice per year: **720** Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.

Direct Patient Care **40** % Research **0** % Teaching **7** % Administration **53** %

Other: _____ ____%

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

Direct patient care:
Independent contractor, Envision, Fayetteville North Carolina VA Medical Center, Federal hospital Employee, TeamHealth, Tampa General Hospital, Academic tertiary referral center & EM residency
Teaching:
Voluntary faculty, EMS Fellowship, Division of Emergency Medicine, Department of Internal Medicine, Morsani College of Medicine, University of South Florida
Administration:
Independent contractor, Board of County Commissioners, Hillsborough County, Florida, Department of Fire and Rescue

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.)

Attending Physician, Tampa General Hospital
Attending Physician, Fayetteville North Carolina Veterans' Administration Medical Center
Medical Director, Hillsborough County Fire Rescue

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 DISCLOSURE STATEMENT

Michael Lozano Jr., MD, MSHI, FACEP

1. Employment – *List current employers with addresses, position held and type of organization.*

Employer: Envision Physician Services, Fayetteville Emergency Medical Associates, P.C.,
Address: 7700 West Sunrise Boulevard
Fort Lauderdale, FL 33322
Position Held: Attending Physician
Type of Organization: National physician staffing and practice management company

Employer: TeamHealth, InPhyNet Contracting Services, LLC
Address: One Davis Blvd., Suite 503
Tampa, FL 33606
Position Held: Attending Physician
Type of Organization: National physician staffing and practice management company

Employer: Board of County Commissioners, Hillsborough County
Address: 601 East Kennedy Blvd., County Center, 18th floor
Tampa, FL 33602
Position Held: Medical Director, Fire and Rescue Department
Type of Organization: Governmental agency providing EMS services

2. Board of Directors Positions Held – *List all organizations and addresses for which you have served as a board member – including ACEP chapter Board of Directors. Include type of organization and duration of term on the board.*

Organization: Board of Trustees, National Emergency Medicine Political Action Committee
Address: 2121 K Street, NW, Suite 325
Washington, DC 20037
Type of Organization: Political action committee
Duration on the Board: October 2017 – October 2023

Organization: Board of Directors, Florida Emergency Medicine Foundation

Address: 3717 S. Conway Road

Orlando, FL 32812

Type of Organization: 501(c)3 non-profit provider of continuing medical education

Duration on the Board: August 2014 – August 2022

Organization: Board of Directors, Florida College of Emergency Physicians

Address: 3717 S. Conway Road

Orlando, FL 32812

Type of Organization: 501(c)6 non-profit medical specialty organization

Duration on the Board: August 2007 through August 2015

Organization: Managing board, Valesco Physician Services

Address: 6200 S Syracuse Way, Suite 200

Greenwood Village, CO 80111

Type of Organization: Joint venture between EmCare and HCA providing practice management

Duration on the Board: March 2014 through September 2015

Organization: Executive Board, Florida Association of EMS Medical Directors

Address: 3717 S. Conway Road

Orlando, FL 32812

Type of Organization: 501(c)6 non-profit medical specialty organization

Duration on the Board: July 2002 through July 2008

Organization: Board of Directors, International Trauma Life Support, Florida Chapter

Address: 3717 S. Conway Road

Orlando, FL 32812

Type of Organization: 501(c)6 non-profit medical specialty organization

Duration on the Board: July 2006 through July 2010

Organization: Pinellas County, Florida - EMS Medical Control Board

Address: 12490 Ulmerton Road

Largo, FL 33774

Type of Organization: Governmental public utility model EMS agency

Duration on the Board: September 1994 through December 2006

Organization: Board of Directors, Emergency Physicians of St. Petersburg

Address: 603 Seventh Street, Suite 360

St. Petersburg, FL 33701

Type of Organization: Democratic, physician-owned emergency medicine group practice

Duration on the Board: November 1999 through December 2006

I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

☒ NONE
☐ If YES, Please Describe:

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) a an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☒ NONE
☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☒ NONE
☐ If YES, Please Describe:

5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE
☐ If YES, Please Describe:

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO
☐ If YES, Please Describe:

I certify that the above is true and accurate to the best of my knowledge:

Michael Lozano Jr. Date Tuesday, August 3, 2021

Florida College of Emergency Physicians

A CHAPTER OF THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS
3717 South Conway Road • Orlando, FL 32812
(407) 281-7396 • FAX (407) 281-4407
(800) 766-6335 • www.fcep.org

August 19, 2021

Dear Councillors,

The Florida College of Emergency Physicians (FCEP) is proud to unequivocally and enthusiastically endorse our colleague Dr. Michael Lozano Jr., MD, MSHI, FACEP for election to the American College of Emergency Physicians (ACEP) Board of Directors.

Dr. Lozano brings a breadth of experience and service to emergency medicine combined with a stellar commitment to transparency and engagement. His election to the Board of Directors will further deepen the lasting contribution he has made to ACEP and FCEP. In addition to serving as Past President of FCEP & FEMF, he continues his extensive work in EMS and servant leadership in that arena, having served on the Governor's EMS Advisory Council and led as the Past President of the Florida EMS Medical Directors.

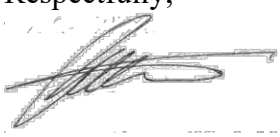
An ACEP member since 1990 and current member of the Council Tellers & Credentials Committee, former Reference Committee Chair and former member of the Steering Committee, Nominating Committee, EM Informatics Section and the Diversity & Inclusion Task Force, it is easy to see how and why Mike provides such dynamic leadership and knowledgeable expertise wherever he serves.

Mike is currently serving on our foundation board and recently led FCEP as our workforce liaison. He brought his unmatched mix of practical, clinical and operational experience to the task of moderating and leading state and national leaders and members during our workforce listening session and then again for our expert panel and member Q & A session conducted at our annual symposium.

His ability to engage members and leaders at all levels and through all mediums promotes the outreach and inclusivity we need for our emerging physician leaders. Yet, he is also recognized as a leader who bridges our veteran and new physicians. Mike is keenly aware of the needs of chapters, large and small, and he collaborates nationally on issues from practice management to informatics and from EMS to advocacy.

FCEP is pleased to provide this chapter endorsement to support Michael Lozano Jr., MD, MSHI, FACEP in his candidacy for the ACEP Board of Directors. If you would like to learn more about Mike as a physician leader and person, please contact me, our Chapter Executive, or any of the Florida Councillors.

Respectfully,



Sanjay Pattani, MD, MHSA, FACEP
President

Michael Lozano Jr., MD, MSHI, FACEP

Dear Fellow Councillors,

Thank you for the opportunity to present myself as a candidate for the ACEP board of directors. Like many large organizations, ACEP is facing significant headwinds. There are several complex challenges looming in the coming years. Emergency physicians – particularly new graduates - are facing potentially limited practice opportunities. We have not yet cleared the COVID-19 pandemic nor the fallout from the emotional toll it has placed on us. There is also the constant threat to our reimbursement – with insult added to injury by attempts to devalue our work after the fact. Our ACEP board will need to address these as well as other issues in the coming years.

Moving forward together is essential for our organization to thrive and to overcome these upcoming challenges. My vision for navigating toward the future is a three-pronged approach - **engagement** through communication; **transparency** of processes; and **inclusion** at all levels. Addressing these areas will further strengthen our organization by promoting more engagement, encouraging new ideas, and energizing the early-career members who are our future.

Engagement of our membership needs to be spurred on by effective communication. A constructive dialog begins with a connection. To effectively communicate with our multi-generational organization, we need to connect with them on their preferred platform. We need to reach out to the membership and tailor our communication plan to their needs. It may be paper-based, mobile phone-based, or somewhere in between. After making the connection, we need to continually assess what resonates with our membership.

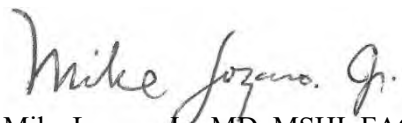
Transparency of processes means demystifying and explaining how ACEP functions. As an organization, ACEP supports a wide range of activities for the benefit of emergency physicians and the specialty as a whole. Recent moves like the year-round Council discussion board, the asynchronous resolution discussion process, and the new searchable resolution archive, have all already helped increase transparency within the Council. Effective communication channels need to be utilized to provide education on governance structure and processes in order to reach all members.

Inclusion of all of our members is critical as we face difficult times. A diversity of opinions is the lifeblood of any effective organization. We need to facilitate participation by members who have difficulties in physically attending meetings. One silver lining of the pandemic is the widespread adoption of teleconferencing. Let's not put that aside after the pandemic wanes. We also need to evaluate our structures and processes to lower the barriers to participation - especially by our early- and mid-career physicians.

The skill set that I bring to the Board will help achieve my vision. I have a broad range of experience in our specialty. I've been a partner in a democratic single-site group, and I've been an executive in a large national group. I understand the challenges of the former and the motivations of the latter. I've been an EMS medical director for 20 years, and I am an informatician. Recently I strengthened my relationship with an academic program in Tampa. I have a proven track record of working constructively with numerous stakeholders on boards covering various aspects of emergency medicine. While some focus on the negative, I choose to look at the positive and I am willing and able to roll up my sleeves to work on solutions that serve all emergency physicians.

Thank you for taking the time to get to know me better. I ask for your support and vote as a candidate for the ACEP board of directors.

Sincerely,



Mike Lozano Jr., MD, MSHI, FACEP
TheTampaDOC@msn.com
813-784-6122

ACEP BOARD OF DIRECTORS CANDIDATE:

Michael Lozano Jr.

MD, MSHI, FACEP

Proudly endorsed by the Florida College of Emergency Physicians

VISION

- **Engagement** through communication
- **Transparency** of process
- **Inclusion** at all levels

SERVICE TO ACEP

ACEP Member since 1990

ACEP Councillor since 2008

- Current Member, ACEP Council Tellers and Credentials Committee
- Past Chair, ACEP Council Reference Committee
- Past Member, ACEP Council Nominating Committee
- Past Member, Emergency Medicine Informatics Section
- Past Member, Diversity and Inclusion Task Force
- Past Member, ACEP Council Steering Committee
- Past Chair, Annual Meeting Subcommittee

ORGANIZATIONAL EXPERIENCE

Board of Trustees
NEMPAC

Past President & current Board Member
FLORIDA EMERGENCY MEDICINE FOUNDATION

Past President & Executive Board Member
FLORIDA COLLEGE OF EMERGENCY PHYSICIANS

Past President & Executive Board Member
FLORIDA ASSOCIATION OF EMS MEDICAL DIRECTORS

Past State Co-Medical Director
INTERNATIONAL TRAUMA LIFE SUPPORT, FLORIDA CHAPTER

Past Member (Governor appointed)
STATE OF FLORIDA EMS ADVISORY COUNCIL

STRENGTHS

- Breadth of business and practice experience
- Broad strategic perspective
- Responsible leader for stewardship of College resources
- EM practice management in multiple environments
- Board-certified in EMS
- EMS fellowship program faculty
- Board-certified in Clinical Informatics
- Advocacy at the state and federal level

CONTACT

thetampadoc@msn.com

(813) 784-6122

Michael Lozano Jr., M.D., M.S.H.I., F.A.C.E.P.

4824 Longwater Way

Tampa, Florida 33615

Cellular number: (813) 784-6122 | Email: TheTampaDOC@msn.com

Current Professional Positions:

8/23/2001 – Present	Medical Director, Hillsborough County Fire Rescue 9450 East Columbus Drive, Tampa, Florida 33619
7/03/2018 – 6/8/2022	Attending Physician, Fayetteville North Carolina VA Medical Center 2300 Ramsey Street, Fayetteville, NC 28301

Professional Service Activities:

6/1/2020 – Present	Health Informatics Advisory Committee, Health Informatics Master's Program, Morsani College of Medicine, University of South Florida
1/10/2020 – Present	Assistant Medical Director, Joint Special Operations Medical Training Center, Fort Bragg, North Carolina
10/2017 – 10/2023	Board of Trustees, National Emergency Medicine Political Action Committee
8/2014 – 8/2022	Board of Directors, Florida Emergency Medicine Foundation 8/2016 – 8/2018, President
6/2002 – 12/2006	Medical Director, Bayflite® Air Medical Transport Service
9/2001 – 12/2004	Physician Leader/Consultant, Weapons of Mass Destruction Education Program, Bayfront Medical Center
8/2001 – Present	Trauma Audit Committee, Hillsborough County Trauma Agency
1/1998 – 6/1999	Medical Director, Event Medicine Department, Bayfront Medical Center
1/1996 – 5/2002	Conference Medical Director and Planning Committee Chair, 1st through 7th "Annual Trauma Day" conference, Bayfront Medical Center
7/31/1995 – Present	Medical Director, Florida Urban Search and Rescue System – Task Force 3

Postgraduate Medical Education:

University of South Florida, College of Medicine, Tampa, Florida
Master of Science in Health Informatics
January 11, 2016 through December 9, 2017

Office of the Medical Director, New York City Emergency Medical Service
New York City Health and Hospitals Corporation, Maspeth, New York
Fellowship in Emergency Medical Services
July 1, 1993, through June 30, 1994

Albert Einstein College of Medicine of Yeshiva University
Bronx Municipal Hospital Center, Bronx, New York
Residency in Emergency Medicine
July 1, 1990, through June 30, 1993

- *Chief Resident*, July 1, 1992, through June 30, 1993

New York University Medical Center at Bellevue Hospital Center and Tisch Hospital
Department of Medicine, New York, New York
Residency in Internal Medicine
July 1, 1987, through June 30, 1990

Medical Education:

Mount Sinai School of Medicine, New York, New York
Doctor of Medicine
September 1, 1983, through May 29, 1987

Pre–Medical Education:

Syracuse University, College of Arts and Sciences, Syracuse, New York
Bachelor of Science in Biology
September 1, 1980, through December 23, 1982

Certifications and Achievements:

Diplomate, **American Board of Emergency Medicine, EMS - Emergency Medical Services**
Certificate No. 22725, October 10, 2019 to December 31, 2029
Diplomate, **American Board of Preventive Medicine, Clinical Informatics**
Certificate No. 31-17412, January 1, 2019 to December 31, 2028
Fellow, American College of Emergency Physicians, October 16, 1997
Diplomate, **American Board of Emergency Medicine**
Certificate No. 22725, January 1, 2015 to December 31, 2024
Certificate No. 930215, December 23, 2004 to December 31, 2014
Certificate No. 930215, June 2, 1994 to December 31, 2004
Diplomate, **American Board of Internal Medicine**
Certificate No. 130981, September 25, 1991 to December 31, 2001
Diplomate, **National Board of Medical Examiners**
Certificate No. 336998, July 1, 1988

Medical Licenses:

State of Florida	ME 0065626 (active | first issued 2/4/1994; current expires 1/31/2022)
State of New York	177813 (inactive | first issued 3/29/1989; inactivated 7/3/1994)
State of North Carolina	2018-02600 (active | first issued 10/9/2018; current expires 6/20/2021)
State of South Carolina	MD 81588 (active | first issued 9/10/2018; current expires 6/30/2021)

Academic Positions and Experience:

12/2015 – 7/31/2023	Collaborative Assistant Professor, Department of Internal Medicine Morsani College of Medicine, University of South Florida, Tampa, Florida
7/1/2009 – 6/30/2013	Adjunct Clinical Associate Professor of Emergency Medicine Lake Erie College of Osteopathic Medicine, Bradenton, Florida
7/1/2002 – 6/30/2008	Affiliate Assistant Professor, Department of Family Medicine College of Medicine, University of South Florida, Tampa, Florida

7/1/1988 – 6/30/1990	Teaching Assistant in Medicine, Department of Medicine New York University School of Medicine, New York, New York
6/1/1985 – 8/31/1985	Teaching Assistant, Department of Anatomy Mount Sinai School of Medicine, New York, New York
6/1/1984 – 8/31/1984	Teaching Assistant, Summer Enrichment Program Department of Medical Education Mount Sinai School of Medicine, New York, New York

Past Professional Positions:

6/12/2018 – 9/18/2020	Attending Physician, BayCare Health System, Morton Plant Mease, Mease Countryside & Mease Dunedin Hospitals, 300 Pinellas Street – MS19, Clearwater, FL 33756
7/1/2017 – 8/7/2020	Senior Vice President, Southeast Group Envision Physician Services (merged from EmCare, Inc.), Clearwater, Florida
6/24/2019 – 8/7/2020	Associate Medical Director, The Physician's Quality Registry (The PQR) Plantation, Florida
1/2009 – 7/1/2017	Executive Vice President, South and Alliance Divisions, EmCare Inc., Clearwater, Florida
10/2012 – 1/2018	On–Line Medical Control Physician, Pinellas County EMS Largo, Florida
11/1/2010 – 10/1/2014	Attending Physician, Brandon Regional Hospital, Brandon, Florida
4/23/2008 – 4/23/2009	Attending Physician, Osceola Regional Medical Center, Kissimmee, Florida
4/23/2008 – 9/1/2008	Emergency Department Medical Director (interim), Osceola Regional Medical Center, Kissimmee, Florida
1/2007 – 12/2009	Medical Director, Emergency Department, Northside Hospital and Tampa Bay Heart Institute, St. Petersburg, Florida
1/2008 – 5/2009	Professional Practice Evaluation Committee
1/2008 – 12/2008	Bylaws Committee
1/2008 – 12/2008	Post Graduate Medical Education Committee
1/2007 – 12/2009	Chair, Department of Emergency Medicine
1/2007 – 5/2009	Medical Executive Committee
1/2007 – 12/2007	Credentials Committee
7/1994 – 12/2006	Attending Physician, Bayfront Medical Center, St. Petersburg, Florida
1/2006 – 12/2006	Medical Council
1/2006 – 12/2006	Chairman, Department of Emergency and Trauma Services
7/2001 – 6/2005	Pharmacy and Therapeutics Committee
7/2000 – 12/2006	Continuing Medical Education Committee 7/2005 – 12/2006, Chair
7/1999 – 6/2001	Joint Pharmacy and Therapeutics Committee, Bayfront/St. Anthony's Health System
7/1999 – 6/2000	Joint Safety Committee, Bayfront/St. Anthony's Health Care System
7/1998 – 6/2000	Leader, Emergency Radiology Quality Improvement Team, Reducing Delays Project
7/1997 – 12/2006	Standards and Credentials Committee
7/1997 – 6/1999	Neurology Continuous Quality Improvement Team, Subcommittee on Thrombolytics for Acute Stroke

	7/1996 – 6/1998	Safety Committee
	7/1994 – 6/1998	Pharmacy and Therapeutics Committee
	7/1994 – 12/2006	Quality Improvement Subcommittee, Section of Emergency Medicine
	7/1994 – 12/2006	Assistant Emergency Department Medical Director for EMS
12/1996 – 8/2001	Regional Associate Medical Director, Emergency Medical Services Group, Inc., Largo, Florida	
7/1994 – 12/1996	EMS Physician, Pinellas County Emergency Medical Service Emergency Medical Services Group, Inc., Largo, Florida	
7/1993 – 6/1994	Staff Physician, First Med – Immediate Medical Care, Inc. Queens, New York	
7/1992 – 6/1993	Assistant Attending, Department of Ambulatory Care Bronx Municipal Hospital Center, Bronx, New York	
7/1992 – 6/1994	Telemetry Control Physician, Office of the Medical Director New York City Emergency Medical Service, Maspeth, New York	

Honors, Awards and Distinctions:

2017	Phi Kappa Phi, University of South Florida
1986	Mount Sinai School of Medicine, Department of Neurology, honors, Neurology clerkship
1986	Mount Sinai School of Medicine, Department of Obstetrics and Gynecology, honors, Obstetrics and Gynecology clerkship
1986	Mount Sinai School of Medicine, Department of Psychiatry, honors, Psychiatry clerkship

Professional Organization Membership and Activities:

2017 – Present	American Medical Informatics Association 7/2019 – Present, Clinical Informatics Board Review Course Item Writing Team
2012 – Present	Florida Medical Association 7/2019 – 8/2020, Council on Medical Economics and Practice Innovation 1/2019 – 8/2020, Advisory Committee for Facility-Based Physicians
2010 – 2020	American Association for Physician Leadership
2002 – Present	Florida Fire Chiefs Association 2002 – Present, Florida Association for Search and Rescue 2009 – 2010, 2016, FASAR Medical Working Group
1996 – Present	Florida Association of EMS Medical Directors 2006 – 2008, President 2004 – 2006, Vice President 2002 – 2004, Secretary/Treasurer

1998 – 2016 International Trauma Life Support, Florida Chapter
- 2006 – 2010, State Co–Medical Director
- 1998 – 2016, Affiliate Faculty
- 1998 – 1999, 2007 – 2009, National Faculty and delegate to International Congress

1994 – Present Florida College of Emergency Physicians
- 2014 – 2015, Immediate Past President
- 2013 – 2014, President
- 2012 – 2013, President Elect
- 2011 – 2012, Vice President
- 2010 – 2011, Secretary/Treasurer
- 2008 – present, Medical Economics committee
- 2007 – 2015, Board of Directors
- 2006 – present, EMS/Trauma committee
  - 2006 – 2011, Chair
  - 1996 – 1999, member
- 2005 Joint Florida College of Emergency Physicians and Florida Hospital Association Workgroup on Burn Treatment and Triage Protocols for Hospital Emergency Departments
- 2001 – present, Government Affairs committee

1993 – Present National Association of EMS Physicians
- 1/2020 – present, Item Writer, EMS In-Training Exam

1990 – Present American College of Emergency Physicians
- 2020 Member, ACEP Council Tellers and Credentials Committee
- 2017 Chair, ACEP Council Reference Committee
- 2016 – 2017, Member, ACEP Council Nominating Committee
- 2016 – 2018, Member, Emergency Medicine Informatics Section
- 2016 – 2017, Member, Diversity and Inclusion Task Force
- 2015 – 2016, Member, ACEP Council Steering Committee
  - Chair, Annual Meeting Subcommittee
  - Member, Candidate Forum Subcommittee
- 2014 – 2015, ACEP Council Steering Committee
  - Member, Bylaws and Council Standing Rules Subcommittee
  - Member, Resolution Development Subcommittee
- 2008 – 2020, Councillor, ACEP Council
- 1992 – 1993, Member, Residents Committee, New York Chapter

1989 – 1999 American College of Physicians

1986 – 1996 American Medical Association

1990 – 1996 Society for Academic Emergency Medicine

1990 – 1993 Emergency Medical Residents Association
- 1992 – 1993, Executive Committee, New York/New Jersey Chapter

Past Committee Activity:

7/2013 – 7/2017 Florida EMS Advisory Council, Florida Department of Health
- 7/2013 – 7/2017, Chair, Disaster Response Committee
- 7/2006 – 1/2013, Medical Care Committee
- 7/2006 – 7/2012, Legislative Committee

9/2009 – 6/2010 Strategic Health Initiatives Committee, American Heart Association Greater Southeast Affiliate

8/2009 – 7/2010	Program Planning Committee, Disaster 2010: The International Disaster Management Conference, Emergency Medicine Learning and Resource Center
2008 – 2010	Stroke Systems of Care Task Force, American Heart Association Greater Southeast Affiliate
2007 – 2010	Florida State Stroke Systems Team, Florida Cardiovascular Health Council 2010, Chair, Notification and Response of EMS Subcommittee
8/2007 – 7/2008	Program Planning Committee, Bill Shearer International ALS/BLS Competition 2008, Emergency Medicine Learning and Resource Center
8/2005 – 7/2008	Program Planning Committee, Disaster: The International Disaster Management Conference, Emergency Medicine Learning and Resource Center
8/2006 – 7/2008	EMS Advisory Council, State Medical Director's Advisory Committee, Florida Department of Health
8/2005 – 7/2006	Program Planning Committee, Bill Shearer International ALS/BLS Competition 2006, Emergency Medicine Learning and Resource Center
7/1994 – 12/2006	Pinellas County EMS Medical Control Board 2005 – 2006, Chairman 1998 – 2005, Vice Chairman 1994 – 1998, member
8/2003 – 7/2005	Program Planning Committee, Disaster - the International Disaster Management Conference, Florida Emergency Medicine Foundation 8/2004 – 7/2005, Co-Chair
10/2001 – 5/2004	St. Petersburg/Pinellas County Metropolitan Medical Response System Member, Steering Committee
10/2001 – 5/2004	Tampa Bay Metropolitan Medical Response System Member, Steering Committee Member, Hospitals Subcommittee
2002	Planning Committee, CPR Day 2002, American Heart Association, Florida and Puerto Rico Chapter
8/1998 – 7/2002	Program Planning Committee, Disaster – the International Disaster Management Conference, Florida Emergency Medicine Foundation 8/2000 – 7/2001, Co-Chair
8/1996 – 7/2002	Program Planning Committee, ClinCon – the National Conference on Out–of–Hospital Care, Florida Emergency Medicine Foundation 8/1996 – 7/1999, Chair
8/1996 – 7/1998	Program Planning Committee, 1997 & 1998 International ALS/BLS Competition, Florida Emergency Medicine Foundation
1996	Pinellas County Jail Medical Task Force Committee, Pinellas County Sheriff's Office.
7/1995 – 6/1996	Program Planning Committee, 1996 International Basic Trauma Life Support Conference, Basic Trauma Life Support International, Florida Chapter
7/1994 – 6/1995	Chair, Training and Testing Subcommittee, Advanced Life Support Committee, New York City Regional Emergency Medical Advisory Committee
7/1994 – 6/1995	Advanced Life Support Committee, New York City Regional Emergency Medical Advisory Committee
9/1986 – 5/1987	Admissions Committee, Mount Sinai School of Medicine

Languages: English and Spanish

Scholarly Activity

Original Contributions

Olsen, J. Å., Brunborg, C., Steinberg, M., Persse, D., Sterz, F., Lozano Jr., M., … Wik, L. (2019). Clinical paper: Survival to hospital discharge with biphasic fixed 360 joules versus 200 escalating to 360 joules defibrillation strategies in out-of-hospital cardiac arrest of presumed cardiac etiology. *Resuscitation*, 136, 112–118. https://doi-org.ezproxy.lib.usf.edu/10.1016/j.resuscitation.2019.01.020

Parker, R. B., Stack, S. J., Schneider, S. M., Bowman, S. H., Broderick, K. B., Brown, N. A., … Wollard, C. (2017). Health policy/editorial: Why Diversity and Inclusion Are Critical to the American College of Emergency Physicians' Future Success. *Annals of Emergency Medicine*, 69, 714–717. https://doi-org.ezproxy.lib.usf.edu/10.1016/j.annemergmed.2016.11.030

Nürnberger, A., Herkner, H., Sterz, F., Olsen J. Å., Lozano Jr., M., Grunsven, P. M., … Wik, L. (2017). Observed survival benefit of mild therapeutic hypothermia reanalyzing the Circulation Improving Resuscitation Care trial. *European Journal of Clinical Investigation*, 47(6), 439–446. https://doi-org.ezproxy.lib.usf.edu/10.1111/eci.12759

Wik, L., Olsen J. Å., Persse, D., Sterz, F., Lozano Jr., M., Brouwer, M. A., … Lozano, M., Jr. (2016). Why do some studies find that CPR fraction is not a predictor of survival? *Resuscitation*, 104, 59–62. https://doi-org.ezproxy.lib.usf.edu/10.1016/j.resuscitation.2016.04.013

Steinberg, M. T., Olsen J. Å., Brunborg, C., Persse, D., Sterz, F., Lozano Jr, M., … Wik, L. (2016). Clinical paper: Defibrillation success during different phases of the mechanical chest compression cycle. *Resuscitation*, 103, 99–105. https://doi-org.ezproxy.lib.usf.edu/10.1016/j.resuscitation.2016.01.031

Olsen J. Å., Lerner, E. B., Persse, D., Sterz, F., Lozano Jr., M., Brouwer, M. A., … Wik, L. (2016). Chest compression duration influences outcome between integrated load-distributing band and manual CPR during cardiac arrest. *Acta Anaesthesiologica Scandinavica*, (2), 222. https://doi-org.ezproxy.lib.usf.edu/10.1111/aas.12605

Olsen, J.-A., Brunborg, C., Steinberg, M., Persse, D., Sterz, F., Lozano Jr., M., … Wik, L. (2015). Clinical paper: Pre-shock chest compression pause effects on termination of ventricular fibrillation/tachycardia and return of organized rhythm within mechanical and manual cardiopulmonary resuscitation. *Resuscitation*, 93, 158–163. https://doi-org.ezproxy.lib.usf.edu/10.1016/j.resuscitation.2015.04.023

Steinberg, M. T., Olsen, J.-A., Brunborg, C., Persse, D., Sterz, F., Lozano Jr, M., … Wik, L. (2015). Clinical paper: Minimizing pre-shock chest compression pauses in a cardiopulmonary resuscitation cycle by performing an earlier rhythm analysis. *Resuscitation*, 87, 33–37. https://doi-org.ezproxy.lib.usf.edu/10.1016/j.resuscitation.2014.11.012

Wik, L., Olsen, J.-A., Persse, D., Sterz, F., Lozano, Jr., M., Brouwer, M. A., … Brooke Lerner, E. (2014). Corrigendum: Corrigendum to 'Manual vs. integrated automatic load-distributing band CPR with equal survival after out of hospital cardiac arrest. The randomized CIRC trial' [Resuscitation 85 (2014) 741–8]. *Resuscitation*, 85, 1306. https://doi-org.ezproxy.lib.usf.edu/10.1016/j.resuscitation.2014.06.017

Wik, L., Olsen, J.-A., Persse, D., Sterz, F., Lozano, Jr., M., Brouwer, M. A., … Lerner, E. B. (2014). Clinical Paper: Manual vs. integrated automatic load-distributing band CPR with equal survival after out of hospital cardiac arrest. The randomized CIRC trial. *Resuscitation*, 85, 741–748. https://doi-org.ezproxy.lib.usf.edu/10.1016/j.resuscitation.2014.03.005

Lerner, E. B., Persse, D., Souders, C. M., Sterz, F., Malzer, R., Lozano, Jr., M., … Wik, L. (2011). Clinical paper: Design of the Circulation Improving Resuscitation Care (CIRC) Trial: A new state of the art design for out-of-hospital cardiac arrest research. *Resuscitation*, 82, 294–299. https://doi-org.ezproxy.lib.usf.edu/10.1016/j.resuscitation.2010.11.013

Travis, D. T., & Lozano Jr, M. (2004). No-fly zones: Hillsborough County defines urban grids where ground transport of trauma patients makes the most sense. *JEMS: A Journal of Emergency Medical Services*, 29(5) 116-8, 120, 123-4, 126, 128, 131, 133. PMID: 15148481

Lozano, M., McIntosh, B. A., & Giordano, L. M. (1995). Effect of Adenosine on the Management of Supraventricular Tachycardia by Urban Paramedics. *Annals of Emergency Medicine,* 26(6), 691-6. http://dx.doi.org/10.1016/S0196-0644(95)70039-0

Hollander, J. E., Lozano Jr., M., Fairweather, P., Goldstein, E., Gennis, P., Brogan, G. X., ... Gallagher, E. J. (1994). Selected topic: "Abnormal" Electrocardiograms in Patients with Cocaine-Associated Chest Pain Are Due to 'Normal' Variants. *Journal of Emergency Medicine*, 12(2), 199-205. https://doi.org/10.1016/0736-4679(94)90699-8

Hollander, J. E., Lozano Jr., M., Goldstein, E., Gennis, P., Slater, W., Fairweather, P., … Gallagher, E. J. (1994). Variations in the Electrocardiograms of Young Adults: Are Revised Criteria for Thrombolysis Needed? Academic Emergency Medicine, 1(2), 94-102. *Academic Emergency Medicine*, 1(2), 94. https://doi:10.1111/j.1553-2712.1994.tb02729.x

Barbera, J. A., Lozano Jr., M. (1993). Urban Search and Rescue Medical Teams: FEMA Task Force System. *Prehospital and Disaster Medicine*, 8(4), 349–55. https://doi.org/10.1017/S1049023X00040656

Abstracts and Poster Presentations

Steinberg, M. T., Olsen, J.Å., Brunborg, C., Persse, D., Sterz, F., Lozano Jr, M., ... & Wik, L. (2014) Abstract 85: Defibrillation during mechanical chest compressions should be avoided during the down–stroke phase of the chest compression cycle. *Circulation*, 130: A85.

Olsen, J. Å., Steinberg, M., Souders, C. M., Brunborg, C., Persse, D., Sterz, F., & ... Wik, L. (2014). AS010: Defibrillation during different phases of the mechanical chest compression–decompression cycle – Effects on termination of ventricular fibrillation/pulseless ventricular tachycardia. *Resuscitation*, 85(Supplement 1), S8-S9. https://doi:10.1016/j.resuscitation.2014.03.030.

Wik, L., Olsen, J. Å., Persse, D., Sterz, F., Lozano Jr, M, Brouwer, M. A., & Lerner, E. B. (2013) Abstract 308: There is a correlation between neurologic score and discharge location for patients with out–of–hospital cardiac arrest of presumed cardiac origin. *Circulation*, 128(22 supplement), A308.

Steinberg, M., Olsen, J. Å., Bendz, B., Persse, D., Sterz, F., Lozano Jr, M., ... & Wik, L. (2013) Abstract 304: Conversion of ventricular fibrillation to an organized rhythm without a defibrillator. *Circulation*, 128(22 supplement), A304.

Olsen, J. Å., Brunborg, C., Steinberg, M. T., Persse, D., Souders, C. M., Sterz, F., Lozano Jr, M., ... & Wik, L. (2013) Abstract 286: Survival to hospital discharge with fixed 360 joules versus 200 escalating to 360 joules defibrillation strategies in out–of–hospital cardiac arrest of presumed cardiac etiology. *Circulation*, 128(22 supplement), A286.

Wik, L, Olsen, J. Å., Persse, D., Sterz, F., Lozano Jr., M., Brouwer, M.A., ... & Lerner, E. B. (2013) Abstract 168: Integrated Auto–Pulse CPR improves survival from out–of–hospital cardiac arrests compared to manual CPR after controlling for EMS response times, *Circulation*, 128(22 supplement), A168.

Wik, L, Olsen, J. Å., Persse, D., Sterz, F., Lozano Jr., M., Brouwer, M. A., ... & Lerner, E. B. (2013) Abstract 167: EMS provider documentation changes the predictive value of bystander CPR. *Circulation*, 128(22 supplement), A167.

Steinberg, M. T., Olsen, J. Å., Brunborg, C., Persse, D., Sterz, F., Lozano Jr., M., ... & Wik, L. (2013) Abstract 162: During a cardiopulmonary resuscitation cycle it is necessary to re–verify a shockable rhythm prior to defibrillation attempts. *Circulation*, 128(22 supplement), A162.

Olsen, J. Å., Souders, C. M., Steinberg, M., Brunborg, C., Persse, D., Sterz, F., Lozano Jr., M ... & Wik, L. (2013) Abstract 155: Duration of Pre–shock Compression Pause Does Not Affect Defibrillation Success in Out–of–Hospital Cardiac Arrest Treated with Either Manual or Load–Distributing Band Compressions. *Circulation*, 128(22 supplement), A155.

Wik L, Olsen J.Å., Persse D, Sterz F, Lozano Jr., M., Brouwer M. A., ... & Lerner, E. B. (2013) The impact of CPR duration on survival to hospital discharge between integrated Auto–Pulse CPR and manual CPR during out–of–hospital cardiac arrest of presumed cardiac origin. *Prehospital Emergency Care*, 17(1): 116.

Wik L, Olsen J.Å., Persse D, Sterz F, Lozano Jr., M., Brouwer M. A., ... & Lerner, E. B. (2013) The impact of hypothermia treatment on survival to hospital discharge for out–of–hospital cardiac arrest patients in the Circulation Improving Resuscitation Care (CIRC) Trial. *Prehospital Emergency Care*. 17(1), 126.

Wik, L., Olsen, J. Å., Persse, D., Sterz, F., Lozano Jr., M., Brouwer, M. A., & ... Lerner, E. B. (2012). AS038: The Impact of CPR Duration on Survival to Hospital Discharge between Integrated AutoPulse-CPR and Manual-CPR during Out-Of-Hospital Cardiac Arrest of Presumed Cardiac Origin Status: Pending Category: Mechanical Devices. *Resuscitation*, 83(Supplement 1), e19. https://doi:10.1016/j.resuscitation.2012.08.043.

Wik, L., Olsen, J. Å., Persse, D., Sterz, F., Lozano Jr., M., Brouwer, M. A., & ... Lerner, E. B. (2012). AP169: The impact of hypothermia treatment on survival to hospital discharge for out-of-hospital cardiac arrest patients in the Circulation Improving Resuscitation Care (CIRC) trial Status: Pending Category: Post Resuscitation Care. *Resuscitation*, 83(Supplement 1), e99. https://doi:10.1016/j.resuscitation.2012.08.228.

Wik L, Olsen J. Å., Persse D, Sterz, F., Lozano Jr., M., Brouwer, M. A., ... & Lerner, E. B. (2012) Abstract 159: The impact of hypothermia treatment on survival to hospital discharge for patients with out–of–hospital cardiac Arrest in the Circulation Improving Resuscitation Care (CIRC) Trial. *Circulation*, 126, A159.

Wik, L., Olsen, J. Å., Persse, D., Sterz, F., Lozano Jr., M., Brouwer, M. A., ... & Lerner, E. B. (2011). Comparison of survival to hospital discharge between integrated Auto–Pulse CPR and manual CPR during out–of–hospital cardiac arrest of presumed cardiac origin: The Circulation Improving Resuscitation Care (CIRC) Trial. *Circulation*, 124(21), 2374.

Davidoff, J., Fowler, R., Gordon, D., Klein, G., Kovar, J., Lozano, M., ... & Miller, L. (2005). Clinical evaluation of a novel intraosseous device for adults: prospective, 250 patient, multi–center trial. *JEMS: A Journal of Emergency Medical Services*, 30(10), suppl.–20.

Lozano Jr., M., Wolfangel, K. P., Kordecki, S. E. (1996) Home Health Care and EMS: An emergency department perspective. *JEMS: A Journal of Emergency Medical Services*, March (supplement); 20.

Hollander, J. E., Lozano, M., Fairweather, P., Goldstein, E., Gennis, P., Brogan, G. X., ... & Gallagher, E. J. (1993). Electrocardiographic "abnormalities" in patients with cocaine–associated chest pain may be due to "normal" variations. *Annals of Emergency Medicine* May, 22(5), 944.

Nashed, A. H., Nelson, L., Lozano, M., et al. (1993) Wellness–Related Characteristics of Emergency Medicine Residencies: A Resident's Perspective. *Annals of Emergency Medicine*, May, 22(5), 909.

Hollander J. E., Hoffman R. S., Gennis P, Fairweather, P., DiSano, M. J., Schumb, D. A., ... & Schwarzwald, E. (1992) Prospective multicenter evaluation of cocaine associated chest pain. *Veterinary and Human Toxicology*, 34, 324.

Miscellaneous

Lozano, M. (2014). A Perfect Storm Brewing for Florida's Emergency Care System. *Florida Trend*, 56(12), 30.

Strom, J. A., Sand, I. C., Travis, D. T., Mercer, D., Vanoer, S., Maronic, D. N., Costello, P., Lozano Jr, M., Nelson, J. A. (2011) Development of an integrated community–based program to treat sudden cardiac arrest. In, *Sudden cardiac arrest: Meeting the challenge* (pp. 57 – 63). The Joint Commission.

Lozano Jr., M. (December 1996) Designing the hospital plan. In, Landesman, L.Y. Ed., *Emergency preparedness in health care organizations*, (Edition 1, pp. 39–58), Oakbrook Terrace, IL: Joint Commission on Accreditation of Healthcare Organizations. ISBN–13: 978–0866885027.

Lozano Jr., M. (December 1996) Organization within the hospital. In, Landesman, L.Y. Ed., *Emergency preparedness in health care organizations, edition 1* (pp. 59–74), Oakbrook Terrace, IL: Joint Commission on Accreditation of Healthcare Organizations. ISBN–13: 978–0866885027.

Hollander, J. E., & Lozano Jr., M. (1993). Correspondence: Cocaine-associated myocardial infarction secondary to a contaminant. *American Journal of Emergency Medicine*, 11, 681-682. https://doi:10.1016/0735-6757(93)90040-I.

Invited Lectures and Presentations

Informational Summit between Emergency Medical Personnel in the Tampa Bay Area and the USF Athletic Training Student Association
University of South Florida, Tampa, Florida, "Heat Stress & Exertional Heat Stroke" – August 12, 2019

Advanced Practice Provider Skills Camp
Emergency Medicine Learning & Resource Center, Orlando, Florida, "Tips & Tricks of Plain Films" – May 3, 2019

Medical Specialist Training Course, Hillsborough County Public Safety Operations Center, Tampa, Florida
November 27 – December 1, 2017

ClinCon 2017 – The National Conference on Out–of–Hospital Care
Florida Emergency Medicine Foundation, Caribe Royale Hotel, Orlando, Florida
"Remember that Call? – Benign Presentations of Life-Threatening Conditions" – July 13, 2017

Advanced Practice Provider Skills Camp
Emergency Medicine Learning & Resource Center, Orlando, Florida, Skills station: Slit lamp – April 21, 2017

EmCare Leadership Conference, Las Vegas, Nevada
"Dynamic Forces Affecting Medicine in 2016" – March 15, 2016

Trauma Grand Rounds, Regional Medical Center at Bayonet Point, Hudson, Florida
"Elder Gray and Other Pre–Hospital Trauma Criteria" – October 4, 2012

Regional Systems of Care Demonstration Project: Mission: Lifeline™ STEMI Systems Accelerator – Tampa Bay
Regional Systems of Care Demonstration Project Meeting, Clearwater, Florida, Panel discussion – September 29, 2012

Medical Specialist Training Course, Hillsborough County Fire and Rescue Training Facility, Tampa, Florida
"Crush Injury and Crush Syndrome" – March 14, 2012
"Blast and Explosive Injuries" – March 14, 2012
"USAR Medical Conditions" – March 14, 2012

Tercer Simposio de Trauma del Oeste [Third Annual Western Trauma Symposium],
Casa del Médico del Oeste, Mayaguez, Puerto Rico
"Aspectos Legales del Transporte Prehospitalario e Interhospitalario: La ley EMTALA"
[Legal Aspects of Prehospital and Interhospital Transport: The EMTALA Law] – March 3, 2012

Medical Specialist Training Course, Hillsborough Co. Fire Rescue Training Facility, Tampa, Florida
"Crush Injury and Crush Syndrome" – February 8, 9, & 10, 2012
"Blast and Explosive Injuries" – February 8, 9, & 10, 2012
"USAR Medical Conditions" – February 8, 9, & 10, 2012

Inaugural Florida Emergency Medicine Resident Career Day, Tampa, Florida
"Employer Expectations" – August 25, 2010

EmCare Leadership Conference, Grapevine, Texas
"Using 5S Principles in Your Emergency Department" – May 6, 2010

EmCare Regional Leadership Workshop, Tampa, Florida
"Core Measures and the ED" – March 14, 2008

Medical Specialist Training Course, Mobile Fire Rescue/Alabama USAR Task Force 1, Mobile, Alabama
"Introduction to the Medical Specialist Training Course" – January 14, 2008
"History of USAR in America" – January 14, 2008
"Non–Medical Roles for the Medical Specialist" – January 16, 2008
"Canine Care" –January 15, 2008
"Crush Syndrome" – January 17, 2008
"USAR Medical Problems" – January 16, 2008

EmCare Leadership Conference, Grapevine, Texas
"RME (Rapid Medical Evaluation): The Northside Experience" – November 16, 2007
"2007 Pneumonia Core Measure Initiative" – November 16, 2007

Symposium by the Sea – 2007 Annual Meeting of the Florida College of Emergency Physicians, Naples, Florida
Preconference 3: EM Administrators Forum for ED Medical Directors, ED Nurses, EM Administrators – Panel Discussion – August 3, 2007

On Our Watch V,
Illinois College of Emergency Medicine, Hyatt Regency McCormick Place, Chicago, Illinois
"Crush Injuries: The Transition from Rubble Pile to ICU" – June 6, 2007

General Meeting, Department of Surgery
Hilton Head Regional Medical Center, Hilton Head Island, South Carolina
"Venothromboembolic Disease in Hospitalized Patients" – June 5, 2007

The 28th Annual International Disaster Management Conference
Emergency Medicine Learning & Resource Center, Rosen Centre Hotel, Orlando, Florida
"Crush Injuries" – February 9, 2006

Medical Specialist Training Course, Florida State Fire College, Ocala, Florida
"Introduction to the Medical Specialist Training Course" – June 5, 2006
"History of USAR in America" – June 5, 2006
"Canine Care" – June 6, 2006
"Crush Syndrome" – June 6, 2006
"USAR Medical Problems" – June 6, 2006

Grand Rounds; Bayfront Medical Center, St. Petersburg, Florida
"Disaster Preparedness: Dispelling Common Myths" – May 25, 2006

Medical Specialist Training Course, Florida State Fire College, Ocala, Florida
"Introduction to the Medical Specialist Training Course" – April 10, 2006
"History of USAR in America" – April 10, 2006
"Team Organization" – April 10, 2006
"Non–Medical Roles for the Medical Specialist" – April 10, 2006
"Canine Care" – April 11, 2006
"Crush Syndrome" – April 11, 2006
"USAR Medical Problems" – April 12, 2006

The 27th Annual International Disaster Management Conference
Emergency Medicine Learning & Resource Center, Rosen Centre Hotel, Orlando, Florida
"Force Protection in Urban Search and Rescue: Hurricane Katrina Response in Mississippi" – February 10, 2006

EMS Expo 2005, Ernest N. Morial Convention Center, New Orleans, Louisiana
"Medical Support for Post–Hurricane Urban Search and Rescue" – August 25, 2005
"Electrolytes 101" – August 25, 2005
"Making Sense of X–rays of the Cervical Spine" – August 26, 2005

Fire–Rescue East 2005, Florida Fire and Emergency Services Foundation
Terminal Convention Center, Jacksonville, Florida
"Medical Support for Post–Hurricane Urban Search and Rescue" – February 11, 2005

The 26th Annual International Disaster Management Conference
Emergency Medicine Learning & Resource Center, Rosen Centre Hotel, Orlando, Florida
"Medical Support for Post–Hurricane Urban Search and Rescue" – February 5, 2005

Resident Conference, Northside Hospital and Vascular Institute, St. Petersburg, Florida
"DVT and PE: An Evidence Based Approach" – October 22, 2003

Grand Rounds, Manatee Memorial Hospital, Bradenton, Florida
"An Evidence Based Approach to Anticoagulation in Acute Coronary Syndrome" – September 18, 2003

First Annual Critical Care Conference, Bayfront Medical Center, St. Petersburg, Florida
"Medical Management of Chemical Casualties: Terrorism and Chemical Warfare Agents" – August 8, 2003

Current Concepts in Thrombosis – CME Lecture Series III, Sarasota, Florida
"The Clinical Challenge of DVT and PE Treatment in Special Patient Groups" – May 13, 2003

Current Concepts in Thrombosis – CME Lecture Series III, Jacksonville, Florida
"Current Trends in the Management of ST–Segment Elevation Acute Myocardial Infarction" – April 24, 2003

Medical Specialist Training Course, Tampa Fire Training Facility, Tampa, Florida
"Urban Search and Rescue Medical Problems: General" – April 7, 2003

Medical Specialist Training Course, Tampa Fire Training Facility, Tampa, Florida
"Crush Syndrome" – April 4, 2003
"Taking Care of Your Own" – April 4, 2003
"Medical Team Roles" – April 4, 2003

Grand Rounds, Regional Medical Center at Bayonet Point, Hudson, Florida
"Current Concepts in the Management of Acute ST Elevation Myocardial Infarction" – March 20, 2003

Medical Specialist Training Course, Tampa Fire Training Facility, Tampa, Florida
"Introduction to the Medical Specialist Training Course" – March 17, 2003
"History of USAR in America" – March 17, 2003
"Disaster Response" – March 17, 2003
"USAR Medical Team Organization" – March 17, 2003

Grand Rounds, St. Petersburg General Hospital, St. Petersburg, Florida
"Management of Acute ST Elevation Myocardial Infarction: Are our Protocols Evidenced Based?" – March 12, 2003

Grand Rounds, Blake Hospital Center, Bradenton, Florida
"An Evidenced Based Approach to Anticoagulation with Low Molecular Weight Heparins" – February 14, 2003

Fire–Rescue East 2003, Florida Fire and Emergency Services Foundation
Terminal Convention Center, Jacksonville, Florida

"USAR Medical Awareness Course" – January 30, 2003
Medical Specialist Training Course, Tampa Fire Training Facility, Tampa, Florida
"Urban Search and Rescue Medical Problems: General" – January 27, 2003

Medical Specialist Training Course, Tampa Fire Training Facility, Tampa, Florida
"Crush Syndrome" – January 21, 2003

Medical Specialist Training Course, Tampa Fire Training Facility, Tampa, Florida
"Taking Care of Your Own" – January 15, 2003
"Medical Team Roles" – January 15, 2003

Medical Specialist Training Course, Tampa Fire Training Facility, Tampa, Florida
"Disaster Response" – January 6, 2003
"USAR Medical Team Organization" – January 6, 2003
"History of USAR in America" – January 6, 2003
"Introduction to the Medical Specialist Training Course" – January 6, 2003

Journal Club, Emergency Medical Associates of Florida, Tampa, Florida
"An Evidenced Based Approach to Anticoagulation with Low Molecular Weight Heparins" – December 6, 2002

Grand Rounds, Naples Community Hospital Center, Naples, Florida
"An Evidenced Based Approach to Anticoagulation with Low Molecular Weight Heparins" – December 3, 2002

Medical Specialist Training Course, Tampa Fire Training Facility, Tampa, Florida
"Urban Search and Rescue Medical Problems: General" – November 6, 2002

Medical Specialist Training Course, Tampa Fire Training Facility, Tampa, Florida
"Crush Syndrome" – October 28, 2002

Medical Specialist Training Course, Tampa Fire Training Facility, Tampa, Florida
"Taking Care of Your Own" – October 22, 2002
"Medical Team Roles" – October 22, 2002
"Disaster Response" – October 22, 2002
"USAR Medical Team Organization" – October 22, 2002

Medical Specialist Training Course, Tampa Fire Training Facility, Tampa, Florida
"History of USAR in America" – October 16, 2002
"Introduction to the Medical Specialist Training Course" – October 16, 2002

Medical Staff Meeting, Northside Hospital and Vascular Institute, St. Petersburg, Florida
"An Evidenced Based Approach to Anticoagulation with Low Molecular Weight Heparins" – September 5, 2002

Symposium by the Sea – 2002 Annual Meeting of the Florida College of Emergency Physicians
Registry Resort, Naples, Florida
"Life During Wartime: Hospital Disaster Planning in the Modern Age"– August 23, 2002

Clinical Staff WMD Training, Bayfront Medical Center, St. Petersburg, Florida
"Weapons of Mass Destruction: Chemical and Biological" – August 14, 2002

Physicians' Process Improvement Team, Bayfront Medical Center, St. Petersburg, Florida
"An Evidenced Based Approach to Anticoagulation in the Emergency Department" – August 8, 2002

Trauma Day 2002, St. Petersburg College, Pinellas Park, Florida
"Surfing the Web for Trauma" – May 24, 2002

Sexual Violence in America: The Hidden Crime,
Safe Place and Rape Crisis Center of Sarasota (SPARC), Inc.
The Hyatt Sarasota, Sarasota, Florida
"Sexual Assault: Medical Perspectives" – April 17, 2002

Healthcare Learning Series; St. Petersburg Chamber of Commerce
St. Petersburg Yacht Club, St. Petersburg, Florida
"Community Update on Bioterrorism" – April 11, 2002

2002 Paramedic Update; Hillsborough County Fire Rescue
Emergency Operations Center, Tampa, Florida
"Diltiazem" – April 3–5, 2002

Grand Rounds; Bayfront Medical Center, St. Petersburg, Florida
"Bioterrorism: A Guide for Medical Professionals" – December 20, 2001

Grand Rounds; St. Anthony's Hospital, St. Petersburg, Florida
"Bioterrorism: A Guide for Medical Professionals" – December 11, 2001

Grand Rounds; Helen Ellis Memorial Hospital, Tarpon Springs, Florida
"Bioterrorism: A Guide for Medical Professionals" – December 10, 2001

Emergency Department Medical Rounds, Bayfront Medical Center, St. Petersburg, Florida
"Bioterrorism: A Guide for Medical Professionals" – November 26, 2001

Grand Rounds; Sun Coast Hospital, Largo, Florida
"Bioterrorism: A Guide for Medical Professionals" – November 7, 2001

Department Managers' Meeting; Sun Coast Hospital, Largo, Florida
"Bioterrorism: A Guide for Medical Professionals" – October 29, 2001

Journal Club, Emergency Medical Associates of Florida,
St. Anthony's Hospital Center, St. Petersburg, Florida
"Bioterrorism: What Every Physician Needs to Know" – October 18, 2001

Long Term Care Networking Session; St Anthony's Healthcare
St. Anthony's Hospital Auditorium, St. Petersburg, Florida
"Navigating the World of EMS and Emergency Departments" – with Teresa Bradley, MD, FACEP – February 13, 2001

Florida AHEC Network/Florida Department of Health, Manatee Convention Center, Palmetto, Florida
End of Life Care: Legislative Changes Affecting Healthcare Providers – series
"Implications for Healthcare Providers" panel discussion – June 16, 2000

20th Anniversary Orlando National Primary Care Conference
Nurse Practitioner Associates for Continuing Education (NPACE)
Caribe Royale Resort Suites & Villas, Orlando, Florida
"Differential Diagnosis of Chest Pain" – April 28, 2000

Emergency Department Medical Rounds, Bayfront Medical Center, St. Petersburg, Florida
"Electrocardiography in the Emergency Department" – January 6, 2000

Symposium by the Sea, 1999 Annual Meeting of the Florida College of Emergency Physicians
Ritz–Carlton Palm Beach, Manalapan, Florida
"Exceeding Expectations – Radiology Studies" – with Mr. Jeff See, RN, BS, CEN – August 13, 1999

Medical Specialist Training Course
St. Petersburg Fire Rescue Department, Master Station #1, St. Petersburg, Florida
"Confined Space Medicine" – August 5, 1999
"Urban Search and Rescue Medical Problems: General" – August 4, 1999
"Roles of the Urban Search and Rescue Medical Team" – August 3, 1999
"Crush Syndrome" – August 3, 1999
"Taking Care of Your Own" – August 2, 1999

Medical Specialist Training Course
Hillsborough County Emergency Operations Center, Tampa, Florida
"Confined Space Medicine" – June 17, 1998

Medical Specialist Training Course
Hillsborough County Emergency Operations Center, Tampa, Florida
"Urban Search and Rescue Medical Problems: General" – June 16, 1998.
"Crush Syndrome" – June 16, 1998

EMS Division Orientation; Hillsborough County Fire Rescue
Hillsborough County Fire Rescue Headquarters, Tampa, Florida
"Trauma: Mechanisms and Management" – May 20, 1998

The 1998 International Disaster Management Conference
Florida Emergency Medicine Foundation, Clarion Plaza Hotel, Orlando, Florida
"Treatment Interventions for the Entrapped/Confined Space Victim" – February 21, 1998

EMS Division Orientation; Hillsborough County Fire Rescue
Hillsborough County Fire Rescue Headquarters, Tampa, Florida
"Trauma: Mechanisms and Management" – January 14, 1998

FENA New Year '98 Symposium; Florida Emergency Nurses Association
Florida Hospital, Orlando, Florida
"Triage Standing Orders" – with Ms. Victoria Weaver, RN, BSN, CEN – January 9, 1998

EMS Division Orientation; Hillsborough County Fire Rescue
Hillsborough County Emergency Operations Center, Tampa, Florida
"Trauma: Mechanisms and Management" – October 7, 1997

Medical Specialist Training Course
Training Facility, St. Petersburg Fire Rescue Department, St. Petersburg, Florida
"Confined Space Medicine" – August 19 and 20, 1997

The Far Side of Medicine – Leadership Forum
Florida Emergency Medicine Foundation/Florida Emergency Nurses Association
Bayfront Medical Center, St. Petersburg, Florida
"Triage Standing Orders" – with Ms. Victoria Weaver, RN, BSN, CEN – August 8, 1997

ClinCon '97 – The National Conference on Out–of–Hospital Care
Florida Emergency Medicine Foundation/Florida College of Emergency Physicians
Omni Hotel, Orlando, Florida
"Disaster Medical Operations: What to Expect" – July 18, 1997

Medical Specialist Training Course
Hillsborough County Emergency Operations Center, Tampa, Florida
"Urban Search and Rescue Medical Problems: General" – April 22, 23, and 24, 1997
"Crush Syndrome" – April 22, 23, and 24, 1997

Medical Specialist Training Course
St. Petersburg Fire Rescue Department Headquarters, St. Petersburg, Florida
"Roles of the Urban Search and Rescue Medical Team" – February 19, 20, and 24, 1997
"Taking Care of Your Own" – February 19, 20, and 24, 1997
"Medical Disaster Response" – February 19, 20, and 24, 1997
"Urban Search and Rescue Medical Team Organization" – February 19, 20, and 24, 1997
"FEMA Urban Search and Rescue Response System Overview" – February 19, 20, and 24, 1997
"Introduction to the Medical Specialist Training Course" – February 19, 20, and 24, 1997

Emergency Medicine Society, Albert Einstein School of Medicine
Albert Einstein School of Medicine, Bronx, New York
"Introduction to Electrocardiography" – April 5, 1994

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2021 BOARD OF DIRECTORS CANDIDATE WRITTEN QUESTIONS

Henry Z. Pitzele, MD, FACEP

Question #1: **How do you build confidence that the College prioritizes the interests of our members and our specialty?**

So much of what we do as organizational leaders is based in symbolism; what we say in public matters, and what we do in public matters even more. Every day, hundreds of people within ACEP spend countless person-hours working for the betterment of our specialty – unfortunately, this fact does not always permeate down to the members who are busy scanning heads and admitting chest pain. We need to do significantly better with messaging, so that the tremendous and significant value which ACEP generates for the specialty (and for front-line docs) is conveyed to the people whose hard-earned money and time make up the foundation of our organization.

The other thing we can do is to elect leaders within ACEP who have no other interests than the betterment of the specialty, and the improvement in the lives of front-line doctors and ED patients. The physicians who hold leadership-level positions within national staffing companies necessarily have to balance the interests of ACEP with the interests of their company – when those two are at odds (for instance, with the business model of oversupplying EM residents to drive down EP compensation in the long-term, or with the tactic of using non-physician practitioners to drive down demand), it is not realistic to think that these leaders would act as strongly to set guardrails for their own companies as leaders who do not have this other set of corporate goals. The best we can hope for is abstention on these issues – and why should we settle for that from our leaders? I am not maligning these individuals – they clearly work hard for EM and bring significant talent to the organization. But it would be unexpected and weird if these highly efficient executives ignored or worked against their company – if they didn't represent their companies' interests well, they wouldn't have risen so highly. It's not evil; it's just that *their* goals aren't the same as *our* goals. And although it has seemed for years that electing these leaders to the ACEP Board (and indirectly, to the Presidency) has been a benign and victimless endeavor, the findings of the Workforce Task Force have shown us that unchecked corporate action in this arena has left us hobbled; we must course-correct, and we must do so now. The membership knows this – they are waiting for us (the Council and the collective ACEP leadership) to show them that nothing is more important to ACEP than the long-term well-being of EP's. I believe in Dr. Schmitz, and I think she's the right leader for this heavy task; the multifactorial framework approach to Workforce is absolutely the right way to go – I just want to make certain that we give her the utmost support in the 'limit corporate interests' plank of that framework, and that starts with an unconflicted Board. The specialty can and will continue to grow and flourish, and this is the most immediate way to show the membership that ACEP is the best way forward.

Question #2: **Now that you have risen to a high level of leadership within ACEP, how do you transition from accomplishing tasks as an individual to guiding others and leading strategically?**

This is probably the most difficult issue I can think of while readying to step up to the next level of leadership. I can think of two things that I have gleaned from leaders I know and respect which aid this goal; the first is trying to surround myself with deep pools of talent, and the other is to schedule periodic looks forward.

I heard something from the CEO of YouTube that I've thought a lot about – she said that, if she's done her job well as a manager, and hired the right people, her job should be easy every day. This resonated with me, in both my leadership positions as Chair of EM at my hospital, and on the Board (and the Presidency) of ICEP, but in both of those positions, I couldn't just hire whatever talent I required – I had to develop it. It was of utmost importance that I would find and support the growth of people at multiple stages of their careers, so that, when I needed them, I had young colleagues with huge energy and ambition, mixed with older colleagues with wisdom and experience. Together, we were able to handle the issues when they arose, and I know that dedicating significant resources to identifying and developing talent within the pipeline of leadership will entirely be the difference between success and failure as a leader.

The idea of scheduling periodic steps back to look at the future came from my successor as Chair of EM. It did not take long after she took over the Department to realize that she was a better Chief than I was (I'm very good, but I know when someone is better), and this fact did not go unnoticed – she was rapidly promoted to be the hospital's Chief of Staff. One of the things she did that I felt was instrumental to her success was to actually put time on her schedule (daily and weekly, for differing amounts

of time) to examine short and long-term strategic goals, and to see how the day's and week's work had contributed to those goals (or not). It was a powerful lesson to me, because in management positions, it is easy to get caught up in reactionary, fire-extinguishing procedure, and stop making progress toward the goals which motivated the movement into leadership in the first place.
.

Question #3: **What areas of improvement do you see that are needed within the College and what are your proposed solutions?**

I see several areas for potential improvement – and in almost all of the cases, communication would be my proposed answer. I think we could definitely improve engagement and productivity in membership, chapter relations, and online presence.

As far as membership, part of our consistent challenge in the past has been conveying our value to members and potential members. In addition to the emblematic changes in leadership I discussed in Question 1, I feel that a coordinated campaign directed at the members themselves (and current residents) would be the most efficient – not just print ads, but a multimodal campaign including SocMed, video, and live engagement from the superstars of the College who, shockingly, no one really knows – for example, Laura Wooster or Jeff Davis taking us through their day and showing the membership how their dues money is being translated into the shifting of political weight on the Hill (a behind-the-scenes look, different from Capital Minute, although hopefully synergizing engagement with it). Or someone from Reimbursement, showing the ways that the organization is instrumental in making sure the members continue to be paid for their hard work. I think that, while we may be immersed among all of these parts of ACEP which are clearly delivering real-world improvements to the specialty and to the lives of EM docs, the members generally don't see this, and we need to personalize these stories so that the hard work inside the organization is seen.

Chapter relations could also profit from improved communication channels. The workings of ACEP leadership sometimes seems independent from the chapters, which for years has caused me some confusion – I always thought that the chapters were the direct representation of the front-line physician membership, a way to convey the voices of the dues-payers to a sprawling national organization to which many docs might have conceptual or practical difficulty expressing their thoughts. How, then, could there be any daylight between the chapters and ACEP leadership? And yet, there is. The chapter execs already have regular calls with ACEP leadership, but the physician leadership could, with very little added time investment, also check in with some regularity; if each BOD member had a territory of 4-5 chapters, a quick quarterly check in with the chapter president (even a text!) would take so little time, but would still bind the presence of the chapters (and indirectly, the membership) to ACEP leadership.

The last improvement I want to discuss is online engagement. We already have an online channel in which most emergency physicians participate daily or near-daily to communicate, discuss clinical care, etc; it is difficult to argue that this Facebook group is not far-and-away the most important method of idea exchange in our specialty. Unfortunately, this channel's origins as a single EM doc's social media presence, combined with its nature as a Facebook group are beginning to show some of its implicit limitations as it scales up. Even more significantly, ACEP has no real involvement in, or influence on it. It would be ideal for this to change, one way or another – either to make agreements or structures which allow more (some?) ACEP involvement in this now invaluable communication medium, or to start our own medium which delivers the value and convenience which will not only bring our members to use it, but even more would be a way of reaching out to potential new members and bringing them into the fold. This would probably require some financial outlay, but could best be directed by an internal task force (and/or co-branding with EMRA) of young EP's, rather than an outside consultant, who might bring us another off-the-shelf and corporate-appearing platform which no one wants to use.

Obviously, the real trick in leadership is to move toward the goals and vision for the future of the organization, while not damaging the parts that work well already – and to that end, we have a tremendous group of physician leaders and staff who continue to bring their huge talent and energy to make the specialty a better place for everyone.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DATA SHEET

Henry Z. Pitzele, MD, FACEP

Contact Information

617 S. Loomis
Chicago, IL 60607
Phone: (312) 523-6080
E-Mail: pitzele@gmail.com

Current and Past Professional Position(s)

Attending Physician (full time), Jesse Brown VA Medical Center, Chicago (2007-present)
Deputy Section Chief of Emergency Medicine 2007-2012
Section Chief of Emergency Medicine 2012-2015
Attending Physician (part time) Advocate Illinois Masonic Medical Center, Chicago (2010-present)
Attending Physician (part time) Mesa View Regional Medical Center, Mesquite NV (2011-present)
Attending Physician, Mercy Hospital, Chicago (full time 2003-2007, part time 2007-2010)

Education (include internships and residency information)

Univ. of Illinois at Chicago, Emergency Medicine residency 2000-2003
Univ. of Illinois at Chicago College of Medicine:
MD 2000

Specialty Board Certifications(e.g., ABEM, AOBEM, AAP, etc.) and dates certified and recertified)

ABEM 2004, 2014

Professional Societies

ACEP, AAEM, ICEP (Illinois Chapter)

National ACEP Activities – List your most significant accomplishments

ACEP Chapter Activities – List your most significant accomplishments

ICEP president 2020-21
ICEP Board of Directors 2015-2021
ICEP EMBRi Written Board Review Course, course and committee chair 2012-2019

Practice Profile

Total hours devoted to emergency medicine practice per year: **2200** Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.

Direct Patient Care **95** % Research ____ % Teaching ____ % Administration **5** %

Other: _____ ____ %

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

Full time in tertiary VA teaching hospital. Moonlighting 1-2 times per month at an urban Level I trauma center (also an EM residency program site), as well as at a rural CAH in Nevada.

Provide specific title(s) or position(s) within your group, hospital, department, system (e.g., Medical Director, Regional Director, Director of Quality, Vice President, Chief of Staff, etc.)

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 DISCLOSURE STATEMENT

Henry Z. Pitzele, MD, FACEP

1. Employment – *List current employers with addresses, position held and type of organization.*

Employer: US Dept of Veterans Affairs—Jesse Brown VAMC
Address: 820 S. Damen
Chicago, IL 60612
Position Held: Attending Physician
Type of Organization: VA Hospital

Employer: Advocate Medical Group—Advocate Illinois Masonic Hospital
Address: 836 W. Wellington
Chicago, IL 60657
Position Held: Attending Physician—part-time/moonlighting
Type of Organization: Regional medical group

Employer: American Physician Partners (Mesa View Regional Hospital)
Address: 5121 Maryland Way #300
Brentwood, TN 37027
Position Held: Attending Physician—part-time/moonlighting
Type of Organization: National CMG

2. Board of Directors Positions Held – *List all organizations and addresses for which you have served as a board member – including ACEP chapter Board of Directors. Include type of organization and duration of term on the board.*

Organization: Illinois College of Emergency Physicians
Address: 3000 Woodcreek
Downers Grove, IL 60515
Type of Organization: State chapter of ACEP
Duration on the Board: 6 years (2015-2021)

I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

☒ NONE
☐ If YES, Please Describe:

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) a an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☒ NONE
☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☒ NONE
☐ If YES, Please Describe:

5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE
☐ If YES, Please Describe:

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO
☐ If YES, Please Describe:

I certify that the above is true and accurate to the best of my knowledge:

Henry Pitzele, MD Date 7/4/2021

Illinois College of Emergency Physicians
ADVANCING EMERGENCY CARE ICEP.org
3000 Woodcreek Drive, Suite 200, Downers Grove, IL 60515 phone: 630.495.6400 toll-free: 888.495.ICEP fax: 630.495.6404

The Illinois College of Emergency Physicians (ICEP) enthusiastically endorses Henry Pitzele, MD, FACEP for election to the Board of Directors of the American College of Emergency Physicians.

Dr. Pitzele began his service to ICEP as a lecturer for our Written Board Review Course in 2004. His dynamic speaking style brought excellent reviews, and the planning committee invited him to give him additional lectures at each course. By 2012, seeing his understanding of teaching and communication skills, ICEP leadership asked Dr. Pitzele to be course director for a planned rebranding of the course. Dr. Pitzele led the course for seven years, curating and managing speakers, supervising the modernization of marketing efforts, and engaging leadership development to assure the continued excellence of the course…. until its forced obsolescence with the advent of MyEMCert.

Dr. Pitzele joined the ICEP Board of Directors in 2015 and has been an invaluable member of the leadership team during a time when ICEP faced significant challenges--changes to the membership, the physical structure of the organization, and the support and maintenance of the medical education crown jewels which drive ICEP finances. He has always served as a clear voice on the Board when potential issues of conflict arose regarding corporate sponsorship or financial contribution.

Dr. Pitzele's year as President in 2020 – 2021 was, of course, dominated by COVID. Despite the shutdown and physical isolation, and through the tireless efforts of the ICEP staff, the year was still a resounding success; educational programs made a successful transition to online formats, and the Social EM Committee offered an influential series of webinars on social justice and systemic racism. State-level advocacy efforts were successful in making headway towards improved reimbursement for sexual assault exams and in changing EMS laws to improve access to (and decrease wait times for) mental health evaluations. And during the crisis, Dr. Pitzele was able to fight to support front-line Illinois EP's when hospital systems were not providing first-wave immunizations to doctors who were independent contractors.

Dr. Pitzele has consistently shown that he is not afraid to confront powerful organizations in the defense of his constituency. His internal communication, with the ICEP staff, with the physician leadership team, and with the membership itself was always timely, carefully crafted, and deployed to build consensus in the aid of achieving the organization's goals. We look forward to working with him in the years to come.

Chrissy Babcock, MD, FACEP
President

Henry Z. Pitzele, MD, FACEP

There is one thing that has become obvious in the tumultuous past year; emergency medicine is at an inflection point. During the short 21 years since I started residency, there has never been a year when we so widely have worried for our safety, the stability of our jobs, and the future of the specialty. And never has ACEP been more important, since no other organization has the power, the reach, or the mission to represent and fight for us at the highest levels. But among the gargantuan, tectonic forces at work to bring us to the point we're at (the virus, the economy, revenue cycle pressures, increasing NPP autonomy, etc.), there is one force we should talk about out loud, since it may be the most difficult to fight: the ever-increasing power, reach, and mission of large EM staffing companies.

When the ACEP Workforce Task Force delivered its findings and suggestions, several important facts came into clear relief; that the corporate proliferation of residencies, combined with a staffing model increasingly reliant on non-physician practitioners would soon have its intended goal of glutting physician supply and decreasing wages, forcing many of us out, and drying up the pipeline of high-performing students going into EM. And while ACEP's multifaceted approach to solving these problems is laudable, it doesn't address the elephant in the room; that unless the corporations stop hyperbolically increasing new resident production and reliance on NPPs, no solution is going to alter our course.

The flipside of that elephant is the presence of CMG officers in the ACEP board. We have, for years, elected these officers, presumably because we felt that the considerable talents and skills they brought to the organization outweighed the cost to our image, and to the specialty through the subtle but persistent protection of the corporations. However, a quick look at decreasing College membership numbers show that this is no longer the case—the combination of high-profile corporate sponsorships of ACEP products and high profile CMG officers in ACEP leadership have us firmly in the red.

I want to improve communications within the College—between leadership and members, chapters and National, and most importantly, amongst members ourselves. I want to change the tone of College (and especially Council) so that we can speak about this openly—this subject should not be taboo, and should not be spoken of in hushed tones. Our members, the front-line ER docs who pay dues and send us to Council to represent them certainly don't feel this way; when I talk to them, they tell me quite frankly that they worry that ACEP doesn't represent their interests, but those of the large corporations. We *can* represent solely their interests, and the interests of ED patients. We should, and we will. And having this discussion, loudly and openly, will not only help us to come together as a specialty, but will show the members who are considering letting their ACEP membership lapse (or the younger physicians, who don't want to join ACEP at all) that we mean what we say when we say we represent *them*.

And when we elect our new Board members, my fervent hope is that, after having this discussion out loud, all summer, each of us in Council will vote for candidates who *only* represent working, frontline physicians—and not anyone else. This action will unify the specialty, and grow the College. And, if you're interested in having someone on the Board who you know will *actively* fight these large and powerful interests, even if it is not an easy road, I hope you'll vote for me.

the time for conflict is *over*

the College must stand together

we represent only frontline EP's

we *can* improve communication and show how much ACEP does for us every day...for us and *not* for corporations

Pitzele for ACEP Board

platform· bio· support· information @ pitzele.com

HENRY ZOLTAN PITZELE, MD

Work Experience

6/07-present	Attending Physician, Section of Emergency Medicine, Jesse Brown VA Medical Center, Chicago (Deputy Chief 6/2007-9/2012, Section Chief 9/2012-9/2015)
11/11-present	Attending physician, Department of Emergency Medicine, Mesa View Regional Hospital, Mesquite NV (part-time/moonlighting)
8/10-present	Attending physician, Department of Emergency Medicine, Advocate Illinois Masonic Medical Center, Chicago (Level I Trauma Center—part-time/moonlighting)
3/16-12/18	Attending physician, Department of Emergency Medicine, Advocate Trinity Hospital, Chicago (Part-time/moonlighting)
6/03-7/10	Attending physician, Department of Emergency Medicine, Mercy Hospital and Medical Center, Chicago (Full-time 2003-2007, part-time 2007-2010)
11/02-6/03	Attending physician at UIC O'Hare Medical Clinic, part-time

Educational Experience

2000-2003	University of Illinois at Chicago Emergency Medicine Residency Chief Resident at Mercy Hospital and Medical Center
1996-2000	University of Illinois at Chicago College of Medicine Graduated top quartile of class
1992-1996	University of Chicago BA in Economics with General Honors

Publications

Pitzele HZ. Scapular Winging (Chapter 62) and Maisonneuve Fracture (Chapter 37) in Atlas of Clinical Emergency Medicine. Edited by Sherman SC, et al, Lippincott 2015.

Pitzele HZ, Kessler CS. Life-threatening Dermatoses. Chapter 96 in Clinical Emergency Medicine, Edited by Sherman SC and Weber JM, Mcgraw-Hill 2013.

Garcia C, Pitzele HZ. Man with Shoulder Pain After a Fall. *Annals of Emergency Medicine.* 2011 58(6) p. 574, 578.

Pitzele HZ, Tolia V. Twenty per Hour: Altered Mental State due to Ethanol Abuse and Withdrawal. *Emergency Medicine Clinics of North America.* 2010 28(3) p. 683.

Unterman S, Kessler CS, Pitzele HZ. Staffing of the Emergency Department by non-Emergency Medicine-trained Personnel: The VA Experience. *American Journal of Emergency Medicine.* 2010 28(5) p. 622.

Pitzele HZ. Acquired Lateral Rectus Palsy: A Case Report. *The Internet Journal of Emergency Medicine.* 2009 Volume 6 Number 1

Aks S, Erickson TB, Paloucek F, Pitzele HZ. Famous Chicago Poisonings. Oral Presentation at North American Congress of Clinical Toxicology Annual Meeting, Chicago, IL, Aug 2003. Published as an article in *Mithridata: Newsletter of the Toxicological History Society* 2004 14(2) p. 6-10.

Pitzele HZ, Eilbert WP. Abdominal CT Scan and Diagnostic Delay in Men and Women Undergoing Appendectomy. Oral Presentation at AAEM Scientific Assembly, New Orleans, LA, Feb 2003. Abstract published in *J Emerg Med* 2003 24(4) p. 479

Awards

Award of Teaching Excellence, UIC Internal Medicine Residency, 2011-2012

Oral Presentations

Lecturer, UIC Internal Medicine Residency Noon Conference (2-3 times per year) 2007-present
Lecturer, Illinois College of Emergency Physicians Written Board Review Course, "EMBRi" 2004-2019
Lecturer, American Academy of Emergency Medicine Scientific Assembly, San Diego 2012
Lecturer, Third Dutch North Sea Emergency Medicine Conference, Netherlands, June 2009
Lecturer, American College of Emergency Physicians Scientific Assembly, Chicago 2008
Lecturer, American College of Emergency Physicians Spring Congress (New Speaker's Forum), Las Vegas 2006

Leadership Experience

Illinois College of Emergency Physicians (Illinois Chapter of ACEP)
- President, 2020-2021
- Secretary/Treasurer 2019-2020
- Board of Directors, 2015-2021
- Chair, Written Board Review Course committee, Illinois College of Emergency Physicians 2012-2019

Medical Director (Section Chief) Emergency Medicine, Jesse Brown VAMC 2012-2015
VA National Emergency Medicine Field Advisory Committee, 2013-2016
Lead Physician for Emergency Medicine, VA Great Lakes Health Care System 2012-2015
Jesse Brown VAMC LEAN Steering Committee 2014-2015
Chair, ED Committee at Jesse Brown VAMC 2012-2015
Site Director, Medical Student Rotation in EM at Jesse Brown VAMC, 2007-2013

Hospital Committees

Peer Review (2014-present)
Inpatient Flow (2012-2015)
Utilization Management (2012-2015)
Emergency Management (2012-2015)
Medical Executive Council (2012-2015)
CPR (2012-2015)
Clinical Products and Resources (2012-2015)
Ebola Preparedness (2014-2015)

Certifications

BLS, ACLS, ATLS
LEAN Green Belt

Professional Organizations

Associate Professor, Department of Emergency Medicine, University of Illinois at Chicago, 2014-present (Clinical Assistant Professor 2003-2014)
Fellow, American College of Emergency Physicians, 2006-present
Examiner, Illinois College of Emergency Physicians, Oral Board Review Course 2004-present
Board Certified in Emergency Medicine, American Board of Emergency Medicine, 2004 and 2014

pitzele@gmail.com
617 S. Loomis, Chicago IL 60607
cell (312) 523-6080

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2021 BOARD OF DIRECTORS CANDIDATE WRITTEN QUESTIONS

Joseph R. Twanmoh, MD, MBA, FACEP

Question #1: **How do you build confidence that the College prioritizes the interests of our members and our specialty?**

One of the biggest issues that we currently face is our workforce.

We witnessed an unpreceded drop in ED volumes at the onset of COVID-19. As a result, many members experienced a reduction in hours--and compensation. Twenty percent of new EM residency grads were unable to find jobs. ACEP's recent study, *Emergency Medicine Physician Workforce: Projections for 2030*, projects a surplus of emergency physicians by 2030. Woven into this challenge is the rising use of non-physician providers (NPPs).

NPPs make up roughly 25% of the total EM workforce. The increasing use of NPPs has reduced the need for emergency physicians. In addition, there is an increased push at the state level for the independent practice of NPPs. Recently, the American Academy of PAs voted to change the name of the clinicians they represent from physician assistants to physician associates. The motivation for this is not surprising. In many EDs where I have worked, PAs effectively work independently. However, they can be geographically separated from physicians, making communication challenging. In addition, physicians can be maxed out taking care of their own patients and have little bandwidth to see and evaluate the NPP's patients. No wonder that some in the NPP world are seeking independent practitioner status.

However, to blame NPPs for this problem misses the root cause. NPPs cost about a third of a physician's salary. Entities that employ physicians and NPPs--hospitals, health systems, contract groups--are financially incentivized to reduce their labor costs and replace physician hours with NPP hours whenever possible. This is true for both for-profit and not-for-profit organizations. However, the use of NPPs isn't all the result of unbridled greed; many physician-owned contracts would not be financially viable without the use of NPPs. Hospitals would have increased labor costs, leaving less money available for other health initiatives that serve the community. Yet, the potential for abuse clearly exists. Indiscriminate substitution of physician coverage with NPPs serves only the bottom line.

The solution to this problem will be complex and nuanced. NPPs are now woven into the fabric of the EM workforce, and there is no going back. There are many competing interests, and it will be difficult, if not impossible for ACEP to take a position that will make everyone happy. However, I believe that our North Star on this issue should be what's in the best interest of our patients. That is where we can all find common ground. Many years ago, ACEP promoted the standard that emergency departments should be staffed by EM-trained physicians, not moonlighting internists or surgeons. Similarly, we need to redefine what a clinically effective, safe, physician-led care team should be. We need to make that definition the standard for emergency departments across the country. We need to develop a model for an ED care team that we'd trust to care for our loved ones, and a model for where we want to work. By placing patients first, we will be true to ourselves, our members, and our specialty.

Question #2: **Now that you have risen to a high level of leadership within ACEP, how do you transition from accomplishing tasks as an individual to guiding others and leading strategically?**

As I transitioned from being a clinician to medical director, I realized that what works as a clinician, doing things yourself, doesn't work at scale. There are simply not enough hours in the day, nor can one be an expert at everything. By engaging others and practicing servant leadership, I could get much more accomplished through support and guidance rather than attempting to complete everything on my own.

During my MBA education at Johns Hopkins, I learned the value of working as a team. Much of the curriculum involved team-based projects. There were times when my teammates and I wouldn't see eye to eye on a project. But it was essential that we found common ground, worked through our differences, and came together as a team to complete the task. Much like my MBA cohort, ACEP's Board has many intelligent and talented individuals with different perspectives. From what I have observed as a candidate, the board of directors encourages different viewpoints and works through those differences to reach consensus. Having served for many years on the Maryland ACEP Board of Directors, as a department chair, and as a member of the hospital's medical executive committee, time often became the rate-limiting factor to address and bring closure to issues.

Subcommittees are the vehicle for the detailed work and heavy lifting. Therefore, when issues come to the board, it's important to understand the background behind the subcommittee's recommendation, question the recommendation, if necessary, but not recreate the work of the subcommittee. Time is the most valuable and limited commodity that the board has, and that time should be used wisely.

As the owner of my own consulting company, I have found it essential to be forward thinking. If one is only reacting to the crisis at hand, then one is behind the curve. Being ahead of the curve involves looking at trends and imaging what could be. For ACEP, there are any number of challenges on the horizon: the push for independent practice by non-physician providers; defining a physician-led emergency department team; how we incorporate telemedicine into the practice of emergency medicine; addressing the shortage of emergency physicians in rural areas; the supply vs. the demand for emergency physicians; the changing demographics of our patients as well as emergency physicians; diversity awareness and inclusion. The list could go on and on. Strategic thinking involves assessing the magnitude of the problem, the risks vs. rewards of action vs. inaction, and one's resources or bandwidth.
.

Question #3: **What areas of improvement do you see that are needed within the College and what are your proposed solutions?**

Like many organizations, ACEP has an opportunity to improve diversity.

As a first-generation Chinese American, I have lived my entire life as a minority. I thought there was little that I need to learn about diversity and racism. But the Black Lives Matter, Me Too, and LGBTQ movements raised questions, sometimes uncomfortable ones, and forced me to think about my own unconscious biases. While I'm considered a member of a minority, I've viewed life through the lens of my upbringing: largely white, suburban, middle-class, straight, and male. I realize that I don't know what it's like to be female, black, poor, or gay. I took for granted what others did not have. ACEP, like any organization, is made up of individuals, and as individuals, we are the product of our background and experiences. This is not to say that any of us should be ashamed of who we are; we simply need to be aware of the baggage we bring with us.

For ACEP, increasing diversity can only help create a more enlightened awareness. As a candidate, I had the opportunity to observe a recent board meeting. There was a discussion regarding a future date for the Scientific Assembly and the potential conflict with a Jewish holiday. The planning committee hadn't realized the ramification of this scheduling conflict and the message that it might send to members of the Jewish faith. This potential conflict probably wouldn't have been an issue if the planning committee had either Jewish members or a higher awareness of the significance of the Jewish holiday.

We cannot change our backgrounds and experiences, and it's not always possible or practical to represent every minority in every group. But we can all be more aware and enlightened. If not already done, ACEP could provide diversity training to staff and board members. We have an opportunity to be leaders in diversity training for physicians. ACEP could provide education to members through sessions at Scientific Assembly or on-line learning platforms. Our patients come from all backgrounds, each with their own cultural differences. As physicians, we must be able to understand those differences to communicate with and care for our patients more effectively. By increasing diversity, awareness, and education, ACEP can better serve its members, emergency medicine, and our patients.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DATA SHEET

Joseph R. Twanmoh, MD, MBA, FACEP

Contact Information

16710 Wesley Chapel Rd., Monkton, MD 21111
Phone: **410-688-2428**
E-Mail: joe@joetwanmoh.com

Current and Past Professional Position(s)

President and Founder, Queue Management, LLC- Current
UPMC- Hanover Hospital Emergency Department- Current
Vice President, MS2 Consulting 2013-2020
Locum Tenens 2013-2020
Envision- Chairman of Emergency Medicine, St. Agnes Hospital, Baltimore, Maryland. 2007-2013
University of Maryland School of Medicine, Dept. of Emergency Medicine, Assistant Professor 2004-2007
Phyamerica- VPMA for the Upper Chesapeake Health contacts consisting of two emergency departments, two intensive care units, and one pediatric hospitalist service. 1994-2004
Emergency Consultants, Inc.- Medical Director and Department Chair, Oakwood-Annapolis Emergency Department, Wayne, Michigan 1991-1994
Emergency Physicians Medical Group- ED Staff physician Hurley Medical Center Flint, MI, and St. Joseph-Mercy Hospital, Ann Arbor, MI 1986-1991

Education (include internships and residency information)

Tufts University, BS, 1975-1979
Rutgers- Robert Wood Johnson Medical School 1979-1983
Spectrum Health- Butterworth Hospital Emergency Medicine Residency 1983-1986
Carey Business School, Johns Hopkins University, MBA, 2011

List Medical Degree (MD or DO) and Year Received Here
MD 1983

Specialty Board Certifications(e.g., ABEM, AOBEM, AAP, etc.) and dates certified and recertified)
ABEM- certified 1987, re-certified 1997, 2007, and 2017

Professional Societies
ACEP
AAEM
American College of Healthcare Executives
American Association of Physician Leaders

National ACEP Activities – List your most significant accomplishments
Alternate councilor 2002-2012
EM Practice Committee 2011-2018

ACEP Chapter Activities – List your most significant accomplishments
Maryland ACEP:
Member of the Legislative Committee 1995-2009
Board of Directors 2002-2012

Secretary 2004-2007
Vice President 2007-2009
President 2009-2011
Immediate Past President 2011-2012
Started and chaired the Chapter Practice Management Committee
2002-2009

Michigan ACEP: Board of Directors 1991-1994

Practice Profile

Total hours devoted to emergency medicine practice per year: **2000** Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.

Direct Patient Care **30** % Research ____% Teaching ____% Administration ____%
Other: Consulting with hospitals on improving patient flow in ED **70** %

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

Owner of a healthcare consultancy that specializes in improving patient flow and reducing ED crowding
Multi-hospital system employee for clinic 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.)

President and Founder of Queue Management, a healthcare consultancy
Per Diem staff physician for UPMC

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.

Not Applicable

Defense Expert	**Cases**	**Plaintiff Expert**	**Cases**

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DISCLOSURE STATEMENT

Joseph R. Twanmoh, MD, MBA, FACEP

1. Employment – *List current employers with addresses, position held and type of organization.*

Employer: Queue Management, LLC
Address: 16710 Wesley Chapel Rd.
Monkton, MD 21111
Position Held: President and Founder
Type of Organization: Healthcare consulting

Employer: UPMC Pinnacle
Address: South Gate Suite 2E, 409 South 2nd St.
Harrisburg, PA 17101
Position Held: ED Attending, Hanover Hospital, Hanover, PA
Type of Organization: Healthcare system

2. Board of Directors Positions Held – *List all organizations and addresses for which you have served as a board member – including ACEP chapter Board of Directors. Include type of organization and duration of term on the board.*

Organization: Maryland ACEP
Address: PO Box 619911
Dallas, TX 75261-9911
Type of Organization:
Duration on the Board: 2002-2009

Organization: Michigan ACEP
Address: 6647 W. St. Joseph Highway
Lansing, MI 48917
Type of Organization:
Duration on the Board: 1991-1994

I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

☐ NONE
☒ If YES, Please Describe:

I have ownership interest in a healthcare consulting entity that contracts with hospitals and physician groups to improve patient flow in emergency departments and inpatient units.

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) a an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☒ NONE
☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☐ NONE
☒ If YES, Please Describe:

I have ownership interest in a healthcare consulting entity that contracts with hospitals and physician groups to improve patient flow in emergency departments and inpatient units.

5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE
☐ If YES, Please Describe:

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO
☐ If YES, Please Describe:

I certify that the above is true and accurate to the best of my knowledge:

Joseph Twanmoh 6/23/21

MARYLAND ACEP CHAPTER
c/o National ACEP
4950 West Royal Lane
Irving, Texas 75063-2524
Direct: 410-727-2237
972-550-0911
www.mdacep.org

Maryland Chapter
AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

Monday, August 23, 2021

Gary R. Katz, MD, MBA, FACEP
Chair
Nominating Committee
P.O. Box 619911
Dallas, TX 75261-9911

Dear Dr. Katz,

On behalf of myself and over seven hundred and twenty-five members of the Maryland ACEP Chapter, it is my pleasure to write to you to proudly endorse **Joseph R. Twanmoh, MD, MBA, FACEP** for Board of Director of the American College of Emergency Physicians.

Dr. Twanmoh served as Chapter President from 2009-2011 and was on the Maryland Chapter Board for 10-years from 2002 to 2012. During that time, he was Chair of the Practice Management Committee from 2002-2009, served as Secretary from 2004 to 2007, Vice President from 2007-2009, and Immediate Past President from 2011-2012.

Dr. Twanmoh's professional background is extensive and varied. He worked for several physician contract management groups, an independent physician group, an academicinstitution, and as an entrepreneur. He has been a full-time clinician, a medical director, a department chair, and a regional medical director. In 2013, he stepped down as Chair of the St. Agnes Emergency Department to pursue his passion working as a consultant to help hospitals address emergency department crowding and patient flow. This led him to work for MS2, a boutique healthcare consulting firm and eventually to establish his own firm. He now leads Queue Management, LLC, a consultancy that uses the scientific methodology of mathematical modeling and data analytics to improve patient flow and solve problems such as emergency department crowding.

Dr. Twanmoh continues to work clinically as a locum's physician after entering the consulting world. This has given him the opportunity to work in a variety of clinical settings from rural critical access hospitals to urban teaching centers and everything in-between.

Prior to moving to Maryland, he served on the Chapter Board of Michigan ACEP from 1991-1994. Since his time with Maryland ACEP, he

has served several roles with AAEM including lecturing on patient throughput and operations management; serving as chair of the Operations Management Committee from 2016-2018; and being the course director for the ED Management Solutions Conference from 2017 to present.

Dr. Twanmoh's career represents a long history of promoting the specialty of Emergency Medicine. We believe that his more than 30-years of experience as a clinician, medical director, consultant, and entrepreneur will bring valuable perspective and to the College.

The Maryland ACEP Chapter is fortunate to have such a dedicated advocate within our Chapter to represent emergency medicine. We hope you vote to elect Dr. Twanmoh as Board of Director of the American College of Emergency Physicians.

Sincerely,

Robert C. Linton, II, MD, FACEP
President
Maryland ACEP Chapter

Joe Twanmoh, MD, MBA, FACEP, FAAEM

There is a looming crisis facing our workforce.
The ACEP Workforce Study is predicting a surplus of Emergency Physicians.
New residency grads can't find a job, while the number of residency programs keeps growing. ED coverage by non-physician providers (NPPs) is increasing despite rising patient acuity, with staffing that does not allow Emergency Physicians to adequately supervise NPPs. All this contributes to stress, burnout, and mental health issues that have been ignored for too long. To add insult to injury, physicians have been terminated for speaking out for patient safety.

To blame any one entity – NPPs, CMGs, Private equity- misses the mark. There used to be many small, independent hospitals and private physician practices. Now, hospitals are part of larger systems and physician groups have been bought by large contract management firms. The economic incentives are to maximize profits: staff with the lowest cost provider; keep staffing to a minimum; increase the supply of physicians to drive down salaries. If we, as physicians, do not unite to protect our patients, stand up for our rights, and defend the practice of emergency medicine, we will get run over by this train.

We must meet this problem head on and prioritize. First, we need to do what's best for our patients. Emergency Medicine has always served as the healthcare safety net. It is who we are as a specialty. Second, we must take care of emergency physicians. We are the American College of Emergency Physicians. Without Emergency Physicians, there is no ACEP. The interests of other stakeholders in Emergency Medicine – CMG's, hospitals, healthcare systems – come behind.

Let's define a true physician-led team. We need enough physician coverage to see all of the sick patients and truly supervise the NPPs, not just sign charts.

Let's support and protect physicians who speak out for patient safety.

Let's take care of our colleagues who themselves need support. The passage of the Lorna Breen Act was a huge win for all of us.

And let's create disincentives in this race to the bottom of reducing staffing costs and maximizing profits. It's time to level the playing field so that responsible groups are not undercut by those whose main interest is the bottom line. We will need the collective talent of ACEP to develop a multiprong approach.

There are many talented people running for the board this year, as every year. So why me?
Like the Farmers insurance commercial, I know a lot because I've seen a lot. I've worked in virtually every practice setting from high-volume tertiary care centers to rural access hospitals. I've worked for contract management groups, independent groups, and health systems.

I can relate to emergency physicians regardless of their employment situation and independently represent them, as I do not hold ownership or leadership positions with any contract management group or healthcare system. I understand the priorities of the different stakeholders. I have the experience and business background that is needed.

I have a proven track record of service to emergency medicine. First, on the Michigan ACEP board and later on the Maryland ACEP board, eventually serving as president. I have served as an alternate councillor and on the EM Practice Committee. I have served on the AAEM Operations Management Committee, promoting education on delivering timely and effective care.

On one level my reason for running is very self-centered. I know that one day, it may be me laying on the stretcher in an ED. When I look up, I want to know that it's one of you, a board-certified emergency physician, that will be taking care of me.

Joe Twanmoh, MD, MBA, FACEP, FAAEM

Candidate for ACEP Board of Directors 2021

We are facing a looming crisis of our workforce.

- The ACEP Workforce Study is projecting a surplus of Emergency Physicians.
- We have new residency grads, who can't find a job.
- The number of residency programs keeps growing, some backed by private equity.
- ED coverage by non-physician providers (NPPs) keeps increasing.
- Staffing in many Emergency Departments does not allow Emergency Physicians to see their own patients and adequately supervise NPPs.
- Stress, burnout, and mental health are real issues that have been ignored for too long.
- Physicians have been terminated for speaking out for patient safety.

We need to prioritize.

- To solve these problems, we must have our priorities in order.
- First, we need to do what's best for our patients. Emergency Medicine has always served as the healthcare safety net.
- Second, we must advocate for emergency physicians. We are the American College of *Emergency Physicians*. Without emergency physicians, there is no ACEP.
- We clearly need to define and promote *Physician-Led Teams*. There should be enough physician coverage to see all of the sick patients and properly supervise NPPs.
- It will be important to create disincentives in this race to the bottom for the lowest staffing costs in order to maximize profits.
- Let's level the playing field. Responsible physician groups, that staff their EDs with the right number and mix of physicians and NPPs, should not be undercut by entities that only care about the bottom line.

Why me?

- I bring a business background. These workforce issues are a systems-based, business problem. Solving them will take an analytic business approach, with quality patient care as its foundation.
- As a consultant, I identify and help solve problems. I don't hesitate to question the status quo to help turn vision into reality.
- Like the Farmers insurance commercial, I know a lot because I've seen a lot. I've worked in virtually every practice setting, from high-volume tertiary care centers to rural access community hospitals, and in a variety of employment models.
- I can independently represent the emergency physician. None of my income comes from the work of other physicians or NPPs.
- I have a proven track record of service to emergency medicine with the Michigan ACEP board, the Maryland ACEP board (including serving as president), as a member on the ACEP EM Practice committee, and with AAEM Operations Management Committee and ED Management Solutions course.

Joe Twanmoh, MD, MBA, FACEP, FAAEM

Candidate for ACEP Board of Directors 2021

Bio

Extensive and diverse career in Emergency Medicine

- Over 30 years as practicing, board-certified emergency physician
- 20 years of experience as a medical director and department chair
- Worked as both an independent contractor and employee in multiple settings:
  - Multiple, different contract management groups
  - One independent, physician-owned practice
  - Faculty at University of Maryland School of Medicine
  - Hospital employee
  - Locums tenens
- Practiced in virtually every clinical setting:
  - Urban, suburban, and rural
  - High volume, trauma centers to rural critical access hospitals
  - Academic centers and community hospitals.
- President and Founder of Queue Management, a consulting firm specializing in patient flow and throughput

Thirty years of service devoted to promoting the specialty of Emergency Medicine

- Michigan ACEP Board of Directors 1991-1994
- Maryland ACEP
  - Board of Directors 2002-2012
    - Secretary 2004-2007
    - Vice President 2007-2009
    - President 2009-2011
    - Immediate Past President 2011-2012
  - Started and chaired the Practice Management Committee 2002-2009
  - Legislative Committee 1995-2009
- ACEP
  - Alternate Councillor 2002-2112
  - EM Practice Committee 2011-2018
- AAEM
  - Chair, Operations Management Committee 2016-2018
  - Course director, ED Management Solutions Conference, 2017- present

To find out more go to joetwanmoh.com or email me at joe@joetwanmoh.com

Curriculum Vitae

Curriculum Vitae

Lean Healthcare, University of Michigan School of Engineering (Jun. 14, 2007)

Lean Sigma Prescription for Healthcare, Center for Innovation in Quality Healthcare, Johns Hopkins Medicine (September 2010)

ATLS
ACLS
PALS

LICENSURE:

State of Maryland Medical	(1994-present)
State of Maryland Controlled Substance License	(1994-present)
State of Michigan Medical	(1987-2016)
State of Michigan Controlled Substance License	(1987-2016)
State of Virginia Medical	(2013-2019)
State of West Virginia Medical	(2013-June 2015)
State of Pennsylvania	(2013-present)
Missouri DEA	(2019-present)
Pennsylvania DEA	(2013-present)
Delaware DEA	(2013-present)
State of Delaware	(2018-present)
State of Missouri	(2020-2021)
State of Missouri Controlled Substance Registration	(2019- 2021)

PROFESSIONAL ORGANIZATIONS:

Maryland Chapter - American College of Emergency Physicians
- President (2009-2011)
- Board of Directors (2002 to 2012) /Vice-President (2007 to 2009)
  - Secretary (2004 to 2007)
- Chair, Practice Management Committee (2002 to 2009)
- Public Policy Committee (1995 to present)/ Vice Chair (2005 to 2009)
- Editor, The EPIC, quarterly newsletter

Michigan College of Emergency Physicians (1986 to 1994) Board of Directors (June 1991 to June 1994)

Fellow, American College of Emergency Physicians (1986 to present)

Curriculum Vitae

Curriculum Vitae

Fellow, American Academy of Emergency Medicine (2002 to present)
Chair, Operations Management Committee (Jan. 2016 to 2018)

American College of Physician Executives (1995 to present)

Med Chi, the Maryland State Medical Society, (1994-2003)

Harford County Medical Society (1995- 2003)

RESEARCH:

Principal Investigator, RESCUE-ACS, Upper Chesapeake Medical Center, Bel Air, Maryland
(2002 to 2003)

Sub-Investigator, RESCUE-ACS, Harford Memorial Hospital, Havre de Grace, Maryland
(2002 to 2003)

Sub-Investigator, GUSTO IV
Fallston General Hospital, Fallston, Maryland (1998-1999)

Emergency Medical Systems:

Medical Advisory Board Harford County EMS,
Maryland Institute of Emergency Medical Services System (1999 to 2003)

Basic Life Support Medical Director Harford County EMS
Maryland Institute of Emergency Medical Services System (1996 to 2003)

Paramedic Course Director Hurley Medical Center
Flint, Michigan (1987-1988)

PUBLICATIONS:

"Case Study- Anne Arundel Medical Center, Emergency Department," Emergency Department Design: A Practical Guide to Planning for the Future, Second Edition, American College of Emergency Physicians, April 2106, p289-292

"Optimizing Patient Throughput from Physician Contact to Disposition Decision", Emergency Department Management, McGraw Hill 2014, Section 3, Chapter 35, p235-241

"Measuring the Opportunity Loss of Time Spent Boarding Admitted Patients in the Emergency Department: A Multihospital Analysis", Journal of Healthcare Management, Vol. 54, No. 2, March/April 2009 p117-124

Curriculum Vitae

Curriculum Vitae

"Emergency Department Overcrowding, Patient Flow, and Safety," Patient Safety In Emergency Medicine, Lippincott, Williams, and Wilkins, 2009, Chapter 22, p149-157

"The Five Stages of Patient Satisfaction Survey Scores", Physician Executive, October, 2006. Vol. 32, Issue #5, p28-31

"When Overcrowding Paralyzes an Emergency Department", Managed Care, June 2006, p54-59

"Triage Bypass to Improve Door-to-Bed Times", Urgent Matters E-Newsletter, Volume 2, Issue 5, October 5, 2005

"Going to the Dogs", Maryland EPIC, Summer Issue, 2005

"The Seven Stages of Press-Ganey", Maryland EPIC, Spring Issue, 2004

"Eye Injuries", Emedicine.com, 2000, 2002

"Incidence of Apnea in Siblings of Sudden Infant Death Syndrome Studied at Home", (Kelly, Twanmoh, and Shannon), Pediatrics, Vol. 70, No. 1 July 1982

PRESENTATIONS:

"Still Crowded After All These Years"
"Eliminating ED Bottlenecks: An Introduction to Queuing Theory, Theory of Constraints, and Critical Servers"
"Making Change Happen: A Change Management Checklist"
ED Management Solutions Conference, Virtual Format, January 12-14, 2021

"Are Advanced Practice Practitioners a Disruptive Innovation?" ED Management Solutions Conference, Academy of Emergency Medicine, New Orleans, Louisiana, September 5-6, 2019

"All You Need to Know About Lean," ED Management Solutions Conference, Academy of Emergency Medicine, New Orleans, Louisiana, September 5-6, 2019

"Making It Happen! Change Management," ED Management Solutions Conference, Academy of Emergency Medicine, New Orleans, Louisiana, September 5-6, 2019

"Eliminating ED Bottlenecks: An Intro to Queuing Theory, Theory of Constraints, and Critical Servers," ED Management Solutions Conference, Academy of Emergency Medicine, New Orleans, Louisiana, September 5-6, 2019

Curriculum Vitae

Curriculum Vitae

"The ESI 3 ED: Addressing the changing emergency department population," American Academy of Emergency Medicine Scientific Assembly, Las Vegas, Nevada, March 12, 2019

"Let It Flow: Eliminating Bottlenecks in the Emergency Department", ED Management Solutions Conference, American Academy of Emergency Medicine, Austin, Texas, September 6-7, 2018

"All You Need to Know About Lean", ED Management Solutions Conference, American Academy of Emergency Medicine, Austin, Texas, September 6-7, 2018

"Do You Have the Right Intake System", ED Management Solutions Conference, American Academy of Emergency Medicine, Austin, Texas, September 6-7, 2018

"Making it Happen! Change Management", ED Management Solutions Conference, American Academy of Emergency Medicine, Austin, Texas, September 6-7, 2018

"Let It Flow: Eliminating Bottlenecks in the Emergency Department", American Academy of Emergency Medicine Scientific Assembly, San Diego, California, April 11, 2018

"Getting the Results You Want", New Jersey Chapter, American College of Healthcare Executives, Atlantic City, New Jersey, September 13, 2017

"Let It Flow: Eliminating Bottlenecks in the Emergency Department," Grand Rounds, Windsor Regional Hospital, Windsor, Ontario, Canada Feb. 20, 2018

"Getting Rid of Bottlenecks in your Emergency Department," American Academy of Emergency Medicine Scientific Assembly, San Diego, California April 11, 2018

"Do You Have the Right Intake System," American Academy of Emergency Medicine Scientific Assembly, Orlando, Florida March 19, 2107

"Getting People to Change: A Change Management Checklist," American Academy of Emergency Medicine Scientific Assembly, Orlando, Florida March 19, 2107

"ED Flow Models," New Jersey Chapter, American College of Physician Executives Conference, Atlantic City, New Jersey September 21, 2017

"Myths and Barriers to ED Patient Flow," American Academy of Emergency Medicine Scientific Assembly, Las Vegas, Nevada February 18, 2016

"Myths and Barriers to ED Patient Flow," New Jersey Chapter, American College of Physician Executives Conference, Atlantic City, New Jersey September 30, 2015

Curriculum Vitae

Curriculum Vitae

"Turning Function Into Form: The ESI 3 ED," The Center for Healthcare Design Conference, San Francisco, California June 18, 2015

"Myths and Barriers to Optimizing Patient Flow," Urgent Matters Webinar
January 13, 2015

"Why Lean Won't Fix Healthcare and What You Need for Transformational Change,"
EmCare 28th Annual Leadership Conference, Orlando, Florida March 31, 2105

"Myths and Barriers to Optimizing Patient Flow," Urgent Matters Webinar
January 13, 2015

"Direct to Bed and other Myths of Patient Flow, " Emcare National Medical Directors Meeting, Las Vegas, Nevada, April 23, 2013

"ED Efficiencies, Defining Benchmarks, and How to Meet Them," Emergency Medicine Grand Rounds, Mount Sinai School of Medicine, New York, March 28, 2012

"The Five Stages of Low Patient Satisfaction Scores", Community Health Network of Washington, Lake Chelan, Washington, June 28, 2006

"Retail Based Medical Clinics: A Disruptive Innovation?" 2006 Fall Primary Care Conference, Community Health Association of Mountain/Plains States and Northwest Regional Primary Care Association, Denver,
Oct. 24, 2006

Maryland Patient Safety Center ED Collaborative Workshop II, Ellicott City, MD
June 9, 2006

The ICU, The ED, and Hospital Transformation, Maryland Patient Safety Center Annual Meeting, Baltimore Convention Center, Baltimore MD, March 30, 2006

Proliferation of Retail based medical clinics, National Association of Community Health Centers National meeting, Washington, DC, March 29, 2006

"The Five Stages of Press-Ganey," Grand Rounds Emergency Medicine, University of Maryland Medical Center, Baltimore, Maryland March 1, 2006

Patient Care Teams, Poster Presentation, Urgent Matters 2005 Regional Conference: Perfecting Patient Flow, Proven Solutions to ED Crowding, Atlanta Oct. 13-14, 2005, and Las Vegas Oct. 27-28, 2005

Curriculum Vitae

Curriculum Vitae

The Hospital Emergency Department: What It Takes to Fix It, Course Director and Faculty, Crystal City, Virginia (2000)

Lessons in Liability: Risk Management Course in Emergency Medicine, Course Director and Faculty, Dearborn, Michigan (1993)

American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

Council Officer Candidates

Scientific Assembly

BOSTON 21

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2021 Council Officer Candidates

Speaker

Kelly Gray-Eurom, MD, MMM, FACEP

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer
- CV

Vice-Speaker

Melissa W. Costello, MD, MS, FACEP

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer
- CV

Kurtis A. Mayz, JD, MD, MBA, FACEP

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer
- CV

2021 COUNCIL SPEAKER CANDIDATE WRITTEN QUESTIONS

Kelly Gray-Eurom, MD, MMM, FACEP

Question #1: How do you see yourself advocating for the College as a non-voting participant at ACEP Board meetings?

I am a reserved person, but I am not a quiet person. For the past 2 years, I have used my voice as the Vice-speaker to advocate for Council and the College at the ACEP BOD meetings. Although I couldn't raise my hand to be counted when the vote was called, my comments – and more importantly Council's comments – were given the opportunity to impact each and every one of those votes.

Council Officers are included in every BOD meeting and session. The Speaker is part of the Executive Committee of the BOD. The Vice-speaker is part of the Finance Committee. We contribute to ACEP strategic planning and high-level deliberations. We are guests of the Board given the opportunity to actively participate in different facets of the College because we represent the voice and actions of Council. That is a privilege and responsibility I value very much.

The Speaker and Vice-speaker, with the assistance of the Council Steering Committee, work to enhance the impact of their 2 seats at the BOD table through preparation, knowledge and balance.

Council deliberations help form the framework of College evolution. As a Council Officer, I have to be prepared to discuss, advocate and at times defend Council's thoughts and actions on resolutions. The BOD determines the final action items around each resolution, but they are held accountable to the Council process through the Council Standing Rules (CSR) and the ACEP bylaws. Knowledge of those documents (and an easily accessed copy of both) help ensure the correct steps are followed during complex decisions. Sometimes the thoughts at the core of those decisions get tricky. The fiduciary responsibility of the ACEP BOD is to ACEP the College. The fiduciary responsibility of the Council Officers is to the members of Council. That difference is subtle but very important because it promotes balance. The difference empowers your Council Officers to encourage the balance of BOD opinions with thoughts from Council during the BOD meetings.

Voting privilege aside, the BOD listens to the voices of the Speaker and Vice-speaker because our two voices bring the entirety of Council to the conversation. I hope to promote and increase those conversations over the next 2 years.

Question #2: **Do you think governance changes need to be made within ACEP? Why or why not?**

ACEP needs to continue refining leadership processes as it grows, but I do not believe major governance changes are needed.

Council elects the ACEP President to lead the College. Council has 3 separate opportunities to determine who is selected to fill that role and 3 separate opportunities to gather information on the communication skills, leadership style and preparedness of that person.

The first opportunity to impact who is ultimately selected as the President of ACEP is the initial BOD elections. Council determines which talented members are best suited to help represent and govern ACEP. The second opportunity is the BOD re-elections. Directors spend their first 3 years becoming familiar with the internal mechanisms of the College. They usually work exceptionally hard and are re-elected to a second term by Council. The third opportunity is the President-Elect (P-E) election itself. The P-E nominees are selected from Board of Director candidates who have spent 5-6 years gaining the additional knowledge and skills essential to becoming the most effective outward-facing leader of the College.

Although I believe the process we have in place now helps ensure Council elects the right person at the right time with the right talents to the role of President, refinements to the traditional BOD leadership training base could potentially even better prepare future P-E candidates.

Presidents and the BOD need to possess an understanding of core functions within the College. Gaining knowledge of the complexity of College finances (Secretary / Treasurer), insights into the relationships with external partners (VP) and the

journeyman's or journeywoman's advanced preparations in advocacy, media and College dynamics (P-E) are all needed to be an effective ACEP President. But the depth and scope of College has changed dramatically over the past 50 years.

Social media, in-depth knowledge of workforce issues, ACGME factors and scope of practice are substantially important issues for emergency physicians. Tweaks to the traditional pillars of P-E preparation by adding learning pathways around these high-priority topics could give future ACEP leaders additional foundations of success.

Question #3: **What have you learned that would improve the councillor experience and improve the Council meeting operations?**

Virtual Council 2020 was an eye-opening event for us all.

The COVID mandated virtual format for the 2020 October meeting created time limitations for usual reference committee deliberations. Asynchronous testimony was created to help fill that gap. Using technology borrowed from EMRA, the platform was created on the fly and launched within the engagED online community. This default platform had challenges and bumps, but even in its infancy, the value of asynchronous testimony was clear.

Asynchronous testimony is a functionality Council has long needed. Members from Council and across the membership submitted their thoughts. Debate was at times spirited, but the resolution-specific online chats helped shape the resolutions in meaningful ways and allowed a full book of business during Virtual Council. The Council Officers are working with ACEP staff to launch a more robust platform so Council can better leverage this resource for future Councils.

The 2020 reference committees used the asynchronous testimony to create draft discussion documents as guides during the abbreviated reference committee forums. The draft documents helped decrease duplicative testimony and enabled members to more fully participate in all reference committees. Many believed it enhanced the quality of the reference committee recommendations presented on Day 2 of the Council meeting. Nothing can replace actual in-person testimony but augmenting the in-person event with asynchronous testimony and Ref. Com. discussion guides will make more effective use of Councillor and Council time.

Broadcasting Council meeting is a complex topic of legalities, location, finance, production capabilities and a frank assessment of value. Hybrid models are extremely difficult and costly. The 2020 mini model with only the Council Officers on screen in Dallas cost in excess of $50,000. Unless Council elects to cease in-person meetings (***which I sincerely hope it does not***), a video-accessible, full Council meeting would likely have double or triple that production cost added to the annual meeting budget.

I doubt a majority would have raised a "yes we can" orange voting card to asynchronous online testimony 5 years ago; however, COVID driven necessity forced the decision and proved its efficacy. I know there are other mediums yet to be considered that can enhance Council. I would like us to continue asking questions and investigating better ways to engage more members in the Council process – including realistic ways to make virtual access possible.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DATA SHEET

Kelly Gray-Eurom, MD, MMM, FACEP

Contact Information

4228 Fairway Drive
Jacksonville, FL 32210
Phone: 904.389.9692 (h)
904.352.6379 (c)
E-Mail: Kelly.grayeurom@jax.ufl.edu

Current and Past Professional Position(s)

University of Florida / UF Health Science Center - Jacksonville

- Chief Quality Officer / Assistant Dean of Quality and Safety
- Associate Chair, Director of Business Operations, Director of PA Services Department of EM
- Administrative Director of Emergency Services at Winter Haven Hospital
- Chairman & Medical Director Division of EM at Orange Park Medical Center
- Assistant Medical Director & Vice-Chairman Division of EM at Orange Park Medical Center
- Assistant Medical Director, Clay County Fire and Rescue
- Professor, Associate Professor, Assistant Professor, Clinical Instructor

Education (include internships and residency information)

Masters of Medical Management (MMM) – Tulane School of Public Health (2008-2010)

Residency – University of Florida Health Science Center

- Chief Resident, Department of Emergency Medicine (1995-1996)
- Residency, Department of Emergency Medicine (1993-1995)
- Internship, Department of Internal Medicine (1992-1993)

University of Vermont College of Medicine – MD (1988-1992)

Iowa State University – BS (1985-1988)

Specialty Board Certifications(e.g., ABEM, AOBEM, AAP, etc.)

American Board of Emergency Medicine (1997, 2007, 2017)
Just Culture Champion Certification (2015)

Professional Societies

American College of Emergency Physicians
Florida College of Emergency Physicians
American College of Physician Executives
Emergency Department Practice Management Association
Society of Academic Emergency Medicine
American Medical Association
Florida Medical Association

National ACEP Activities – List your most significant accomplishments

- ACEP Council Vice-speaker 2019 - 2021
- ACEP Council Meritorious Service Award 2017
- Council Tellers, Credentials & Elections Committee
    - Chair 2011 – 2013
    - Member 2010 – 2018
- ACEP Nominating Committee 2010-2013; 2017
- Council Reference Committee
    - Chair 2016, 2009
    - Member 2008
- ACEP 50th Jubilee Task Force 2015 – 2018
- ACEP Steering Committee 2008 – 2010
- Councilor
    - Florida College of Emergency Medicine 2008 – 2019
    - AAWEP 2006 – 2007
    - AAWEP (alternate) 2005 – 2006
    - Young Physicians Section 2003 – 2004

- Membership Committee
    - Chair 2013 – 2016
    - Member 2008 - present
- Section Affairs Task Force / Grant Reviews
    - Chair 2007-2013
    - Member 2005-2007
- Outstanding Service to Section Award
    - Chair, Young Physicians Section 2006
- Outstanding Section Newsletter Award
    - Editor, Young Physicians Section 2006

- Fellow, American College of Emergency Physicians 1997

ACEP Chapter Activities – List your most significant accomplishments

Florida College of Emergency Physicians

William T. Haeck, Member of the Year Award	2014
Immediate Past-President	2013 – 2014
President	2012 – 2013
Delegate to the FMA	2012 - 2013
President Elect	2011 – 2012
Vice-President	2010 – 2011
Member, Executive Committee	2009 - 2014
Secretary / Treasurer	2009 – 2010
Councilor	2008 - 2019
Chair, Bylaws Review	2008 - 2009
Member, Board of Directors	2006 – 2014
Member, Government Affairs Committee	2004 - 2015
Member, Professional Development Committee	2004 - 2015
Chair, Academic Affairs Committee	2004 – 2008
Member, Medical Economics Committee	1999 – 2015
Member	1992 - 2015

Practice Profile

Total hours devoted to emergency medicine practice per year: **2021** Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.

Direct Patient Care **10** % Research **0** % Teaching **10** % Administration **80** %

Other: _____ ____%

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

I am a full-time Professor of Emergency Medicine for the University of Florida COM-Jacksonville. The Emergency Department (ED) at UFHealth-Jacksonville is an urban safety-net providing care to nearly 90,000 adult and pediatric patients presenting for acute medical, surgical, obstetrical and critical care. It is made-up of 6 different care units including a Critical Care Area, a separate ED Observation Area, level-1Trauma Center and dedicated Pediatric ED. We train emergency medicine residents, pediatric emergency medicine fellows, ultra-sound fellows, toxicology fellows and patient safety fellows.

I have served as the medical director of the academic ED, the administrative director of emergency services at a 60,000-volume community ED and the medical director of a 45,000-volume community ED. I have been the Director of Business Operations since 2001 overseeing EM billing, coding and compliance. In 2015, I became Chief Quality Officer and Assistant Dean of Quality & Safety for the organization. I coordinate a division of quality, safety, risk, accreditation, infection prevention & control and performance improvement. I remain an active part of the Department of EM and work clinically in the ED.

Expert Witness Experience

If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony.

Defense Expert 0 Cases **Plaintiff Expert 0 Cases**

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DISCLOSURE STATEMENT

Kelly Gray-Eurom, MD, MMM, FACEP

1. Employment – *List current employers with addresses, position held and type of organization.*

Employer: University of Florida COM

Address: 655 W. 8th St.

Jacksonville, FL 32209

Position Held: Professor of EM / Chief Quality Officer / Assistant Dean of Quality & Safety

Type of Organization: Academic, Urban, Safety-Net Hospital / Multi-disciplinary physician practice

Employer: University of Florida COM

Address: 655 W. 8th St.

Jacksonville, FL 32209

Positions Held: Associate Chair, Director of Business Operations, Director of PA Services
Associate Chair, Director of Business Operations, Director of PA Services
Administrative Director of Emergency Services at Winter Haven Hospital
Chairman & Medical Director Division of EM at Orange Park Medical Center
Assistant Medical Director & Vice-Chairman Division of EM at Orange Park Medical Center
Assistant Medical Director, Clay County Fire and Rescue
Professor, Associate Professor, Assistant Professor, Clinical Instructor

Type of Organization: Academic, Urban, Safety-Net Hospital / Multi-disciplinary physician practice

2. Board of Directors Positions Held – *List all organizations and addresses for which you have served as a board member – including ACEP chapter Board of Directors. Include type of organization and duration of term on the board.*

Organization: Shands Jacksonville BOD

Address: 655 W 8th St.

Jacksonville, FL 322209

Type of Organization: Academic, Urban, Safety-Net Hospital; not-for-profit

Duration on the Board: 2013-2014

Organization: Winter Haven Hospital

Address: 200 Ave F NE

Winter Haven, FL 33881

Type of Organization: Community Hospital – non affiliated; not-for-profit

Duration on the Board: 2006-2012

Organization: Florida College of Emergency Physicians

Address: 3717 S Conway Rd

Orlando, FL 32812

Type of Organization: Not-for-profit

Duration on the Board: 2006-2014

I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

☒ NONE
☐ If YES, Please Describe:

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) a an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☒ NONE
☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☒ NONE
☐ If YES, Please Describe:

5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE
☐ If YES, Please Describe:

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO
☐ If YES, Please Describe:

I certify that the above is true and accurate to the best of my knowledge:

Kelly Gray-Eurom, MD,MMM, FACEP 5/25/21

Florida College of Emergency Physicians

A CHAPTER OF THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS
3717 South Conway Road • Orlando, FL 32812
(407) 281-7396 • FAX (407) 281-4407
(800) 766-6335 • www.fcep.org

August 18, 2021

Dear Councillors,

The Florida College of Emergency Physicians (FCEP) is proud to unequivocally endorse our colleague Kelly Gray-Eurom MD, MMM, FACEP for the position of Council Speaker of the American College of Emergency Physicians (ACEP).

Dr. Gray-Eurom's leadership as Vice Speaker and the accomplishment of her insightful goals helped ACEP during a critical period of leadership and transition. Her emphasis on inclusivity and engagement through enhanced communication was ideally timed as the global pandemic brought challenges and changes to all member communications. By focusing on the member and leveraging technology for involvement, she has found new and necessary ways to listen to and include members. From asynchronous testimony to a more effective committee process and the Council EngageED platform, all members now see what FCEP members have always known. That, innovative, dynamic and inclusive is great for ACEP and a hallmark of Dr. Gray-Eurom's leadership and service.

From the early days of her residency 22 years ago through her current position, she has been active with FCEP and ACEP. She has dedicated countless hours toward the advancement of emergency medicine in the state of Florida, Washington DC, on ACEP Committees and during her 17-year tenure as an ACEP Councillor. She has been a member and chaired many different committees including Membership, Section Affairs, Bylaws, Quality and CEDR. Council has also benefited from her time as a Councillor for AAWEP, YPS and for the last decade, as a member of the Florida Delegation. She has served on the Council Steering Committee, Nominating Committee and Awards Committee. Her leadership skills have been put to work as a Reference Committee Chair and for many years (3 as Chair) serving on the Council Tellers, Credentials & Elections Committee. In 2017, in recognition for her outstanding service to Council, Dr. Gray-Eurom was awarded the Council Meritorious Service Award.

Dr. Gray-Eurom has spent her career with the University of Florida "Shands" Jacksonville, but her career spans much more than traditional academics. Her areas of expertise include ED management, ED flow, billing, coding, compliance and quality. Her collaborative leadership style and attention to detail has led her to enhance system development with a focus on quality improvement. In her career, she has been a medical and business director of a 45,000 volume community ED, the Administrative Director of a 60,000 volume community ED in central Florida and became the Medical Director of the 90,000 volume academic ED in Jacksonville. She has continued her successful career as the Business Director for the Department of Emergency Medicine, is currently a Professor of Emergency Medicine and Chief Quality Officer for UF Health Jacksonville. She continues the clinical practice of emergency medicine and enjoys working with

the emergency medicine residents as her passion remains teaching young physicians how to transition from residency into a successful EM career.

Dr. Gray-Eurom has developed strong leadership skills over the years and they are exhibited in her daily work and years of service to others. As a Past President of FCEP, former ED Director, ACEP committee chair and in her current role, she has the experience and skill needed to guide diverse teams through difficult scenarios to reach meaningful and successful outcomes. Her continued leadership as ACEP Council Speaker will enhance ACEP and the specialty through working with, listening to and leading all Councillors.

FCEP is pleased to support Kelly Gray-Eurom, MD, MMM, FACEP as Council Speaker. If you would like to learn more about her outstanding abilities or why we unanimously support her election, please contact me, our Chapter Executive, or any of the Florida Councillors.

Respectfully,

Sanjay Pattani, MD, MHSA, FACEP
President

Kelly Gray-Eurom, MD, MMM, FACEP

To the 2021 Councillors:

My name is Kelly Gray-Eurom and I am asking for your vote for Council Speaker.

Two years ago, my campaign platform for vice-speaker was *Your Voice – Before, During and After Council.* My goals were to better leverage existing technology, create new platforms so more members could interact during reference committee testimony and find ways to better engage the College in Council deliberations. The virtual nature of Council 2020 allowed many of these initiatives to come into fruition.

Asynchronous testimony proved to be a valuable thought-exchange vehicle. It allowed the reference committees to create working draft documents that added efficiency and effectiveness to reference committee deliberations. It decreased duplicative testimony without curtailing the open vetting of ideas.

Throughout the year, the Speaker and I shared information from the Board of Directors meetings, Steering Committee and other venues using Council engagED. The ability to share information and receive feedback from you was much appreciated by your Council Officers. It helped ensure we were representing and advocating your thoughts and your desired actions to the ACEP BOD.

We are moving down the road to more enhanced Council communications and increased councillor involvement but there is more work to be done. I am committed to that journey and hope you will entrust me to continue the work with you.

Thank you! With much appreciation –

Kelly

Kelly Gray-Eurom MD MMM FACEP

FOR ACEP COUNCIL SPEAKER

Advocating Your Council Voice

Proudly Endorsed By The Florida College Of Emergency Physicians

SMALL TOWN ROOTS
URBAN TRAINING
ACADEMIC & COMMUNITY PRACTICE

Professional Experience

Professor of Emergency Medicine

Chief Quality Officer

Assistant Dean for Quality and Safety

Director of EM Billing, Coding & Compliance

Director of Business & Clinical Operations
- 90K academic ED

Administrative Director of Emergency Services
- 60K community ED

ED Medical Director
- 45k community ED

Masters in Medical Management

Advisory Workgroup for CMS Hospital Star Rankings

Sr Lead for Strategic Planning University of Florida

Redefining How Council Does Business

Virtual Council 2020
Yes We Did!

Asynchronous Reference Committee Testimony
A greater collection of voices

Council EngagED
Moving communication forward

The Future of EM
Defining what you want/desire/need/envision

Kelly Gray-Eurom, MD, MMM, FACEP

kelly.grayeurom@jax.ufl.edu

Professional Address
UFHealth-Jacksonville
655 West 8th Street
Jacksonville, FL 32209
(904) 244-4433

Residential Address
4228 Fairway Drive
Jacksonville, FL 32210
(904) 389-9692

Date of Birth: January 4, 1966
Place of Birth: Oskaloosa, Iowa

Marital status: married (spouse Douglas)
2 children – Jessica & Rebecca

Education

Masters:	Masters of Medical Management (MMM) Tulane School of Public Health and Tropical Medicine New Orleans, Louisiana August 2008 – May 2010
Residency:	University of Florida Health Science Center/Jacksonville Department of Emergency Medicine Jacksonville, Florida July 1993 - June 1996
Internship:	University of Florida Health Science Center/Jacksonville Department of Internal Medicine Jacksonville, Florida July 1992 - June 1993
Medical School:	University of Vermont College of Medicine Burlington, Vermont August 1988 - May 1992
Undergraduate:	Iowa State University Ames, Iowa January 1985 - May 1988 Major - Zoology Minor – English

Professional Employment

July 2015 – present	Professor of Emergency Medicine Department of Emergency Medicine University of Florida Health Science Center/Jacksonville
December 2014 – present	Chief Quality Officer UFHealth-Jacksonville
December 2014 - present	Assistant Dean for Quality and Safety University of Florida Health Science Center/Jacksonville
August 2015- present	Associate Chair, Director of Business Operations Department of Emergency Medicine University of Florida Health Science Center/Jacksonville
July 2008 – June 2015	Associate Professor of Emergency Medicine Department of Emergency Medicine University of Florida Health Science Center/Jacksonville
May 2008 – August 2015	Associate Chair, Director of Business & Clinical Operations Department of Emergency Medicine University of Florida Health Science Center/Jacksonville
May 2008 – May 2015	Director of PA Services, Department of Emergency Medicine University of Florida Health Science Center/Jacksonville
July 2003 – September 2015	Administrative Director of Emergency Services Department of Emergency Medicine Winter Haven Hospital
November 2001 – June 2008	Assistant Professor of Emergency Medicine, Department of Emergency Medicine University of Florida Health Science Center/Jacksonville
November 2001 – present	Director of Business Operations Department of Emergency Medicine University of Florida Health Science Center/Jacksonville
October 2000 – June 2001	Assistant Medical Director Clay County Fire and Rescue, University of Florida Division of Emergency Medicine at Orange Park Orange Park Medical Center
April 1999 – November 2001	Medical Director and Chairman University of Florida Division of Emergency Medicine at Orange Park Orange Park Medical Center
June 1997 - November 2001	Clinical Assistant Professor of Emergency Medicine Division of Emergency Medicine at Orange Park University of Florida

Professional Employment (con't)

July 1997 – March 1999	Assistant Medical Director and Vice-chairman University of Florida Division of Emergency Medicine at Orange Park Orange Park Medical Center
July 1996 – June 1997	Clinical Instructor of Emergency Medicine University of Florida Division of Emergency Medicine at Orange Park Orange Park Medical Center

Medical Staff Privileges:

Shands Jacksonville
Department of Emergency Medicine
655 W. 8th St.
Jacksonville, FL 32209
July 1996 - present (904) 244-3134

Professional Certification

- American's Essential Hospitals Fellowship Program, June 2018
- HRO Certified Champion, December 2016
- Certified Just Culture Champion, April 2015
- Fellow of the American College of Emergency Physicians – November 1997 (current)
- Diplomate of the American Board of Emergency Medicine - June 23, 1997; recertification 2007
- Diplomate of the National Board of Medical Examiners - March 3, 1993
- Licensure by the Florida Board of Medicine - March 8, 1994 (current)
- DEA Licensure - May 19, 1994 (current)
- Advanced Cardiac Life Support (ACLS)
- Pediatric Advanced Life Support (PALS)
- Advanced Trauma Life Support (ATLS)
- Privileges in Critical Care Medicine Shands Jacksonville – July 24, 2006 (current)

Professional Societies

American College of Emergency Physicians
Florida College of Emergency Physicians
American College of Physician Executives
Emergency Department Practice Management Association
Society of Academic Emergency Medicine
American Medical Association
Florida Medical Association
Alpha Omega Alpha

Professional Honors and Awards

- ACEP Council Meritorious Service Award 2017
  American College of Emergency Physicians Scientific Assembly 2017

- Distinguished Preceptor Award 2017
  UNF Health Administration Program

- 2016 Vizient Innovation Excellence Award
  https://youtu.be/bXgD18f9MQY

- William T. Haeck, MD Member of the Year Award - 2014
  Florida College of Emergency Physicians

- Distinguished Faculty Member Award, 2013-2014
  Department of Emergency Medicine
  University of Florida College of Medicine – Jacksonville

- Healthcare Hero
  HPC Annual Meeting & JBJ Health Care Heroes Honorees
  Jacksonville Business Journal Oct 21, 2013

- Service Excellence Award, 2011-2012
  Department of Emergency Medicine
  University of Florida College of Medicine – Jacksonville

- Distinguished Faculty Member of the Year, 2010-2011
  Department of Emergency Medicine
  University of Florida College of Medicine – Jacksonville

- Compliance Advocate of the Year 2010
  University of Florida College of Medicine – Jacksonville

- First Place Poster Presentation - ED Documentation Training in the Face of ED Overcrowding. American College of Emergency Physicians Scientific Assembly Research Forum. Boston, MA. October 5, 2009

- American College of Emergency Physicians Heroes of Emergency Medicine Award; awarded at ACEP Scientific Assembly October 2008

- Top Doc Award
  Jacksonville Magazine June 2008

- Fellow of the American College of Emergency Physicians November 1997 (recertification 2007)

- American College of Emergency Physicians Outstanding Service to Section Award; awarded at ACEP Scientific Assembly October 2006 (Chair)

- American College of Emergency Physicians Outstanding Section Newsletter Award; awarded at ACEP Scientific Assembly October 2006 (Editor)

Professional Honors and Awards (con't)

- Outstanding Faculty Member of the Year 1999–2000
  Department of Emergency Medicine
  University of Florida College of Medicine – Jacksonville

Residency:

- Jelks Award - Outstanding resident clinician of the year 1996
  College of Medicine UFHSC/Jacksonville

- Chief Resident 1995-96 Department of Emergency Medicine
  Intern of the Year 1992-93 Department of Internal Medicine UFHSC/Jacksonville

Medical School:

- Alpha Omega Alpha (AOA)
- Achievement Citation
- American Medical Women's Association Award

Publications – professional manuscripts

- Guirgis F, Jones, Esma R, Webb KL, **Gray-Eurom K**: Innovative, Data-driven Care for Sepsis: the UF Health Jacksonville Experience. *Northeast Florida Medicine*. Summer 2017:

- **Gray-Eurom K**, Berk, ES, Webb KL, Berk AS, Hendry P. Life after residency workshop: a statewide workforce preparation day for emergency medicine residents and pediatric emergency fellows. Academic Emergency Medicine April 2012;19(4, Supp 1):S395.

- Lenhart B, **Gray-Eurom K**, Caro D: ED Documentation Training in the Face of ED Overcrowding. *Northeast Florida Medicine.* Summer 2010;61(2):12-13.

- Hinshelwood H, **Gray-Eurom** K: His Voice. *J Em Med.* Nov 2008;35(4):459-60.
  Epub 2008 Jun 5

- **Gray-Eurom, K**, Deitte L: Imaging in Abdominal Pain. *Emergency Medicine Practice*. February 2007;9(2):1-32.

- **Gray-Eurom, K**: Creating Conflict Resolution in the Emergency Department. *Emergency Medicine & Critical Care Review 2006.* June 2006:12-13.

- **Gray-Eurom, K**: Emergency Physicians and the victim of sexual assault - correspondence. *Ann of Emerg Med.* 2002;40(4):438-39.

- **Gray-Eurom, K**: The Sexual Assault Examination: do we make a difference. *Emergency Medicine News.* June 2002;24(6):3&40.

- **Gray-Eurom K**, Seaberg D, Wears R: The Prosecution of Sexual Assault Cases: correlation with forensic evidence. *Ann of Emerg Med.* 2002;39:39-46.

- **Gray-Eurom K**: The Crime of Power. *Jacksonville Medicine* 1996;47(8):334-38.
- Misselbeck W, **Gray K**, Uphold R: Latex Induced Anaphylaxis: a case report. *Am J Em Med.* 1994;12(4):445-47.
- Deaton LE, **Gray KR**: Excitation of the clam heart by phorbol esters. *Comp Biochem Physiol*. 1990;95C:155-57.

Publications – Books, Co-authored

- 2003. *Preparing for the Real World: An Interviewing Guide for the EM Resident 2nd Edition.* **Gray-Eurom K** (Ed.). Florida College of Emergency Physicians and the American College of Emergency Physicians.
- 1998. *Preparing for the Real World: An Interviewing Guide for the EM Resident.* **Gray-Eurom K** (Ed.). Florida College of Emergency Physicians and the American College of Emergency Physicians

Publications – Books, Contributor of chapters

- **Gray-Eurom K**. 2020. *ACEP COVID-19 Field Guide.* Chapter 1 Preparing for Work. American College of Emergency Physicians. https://www.acep.org/corona/covid-19-field-guide/cover-page/
- **Gray-Eurom K**. 2020. *ACEP COVID-19 Field Guide.* Chapter 2 Returning from Work. American College of Emergency Physicians. https://www.acep.org/corona/covid-19-field-guide/cover-page/
- **Gray-Eurom K**. 2003. *Preparing for the Real World: An Interviewing Guide for EM Resident 2nd Edition.* Introduction. Florida College of Emergency Physicians and the American College of Emergency Physicians
- **Gray-Eurom K**. 2003. *Preparing for the Real World: An Interviewing Guide for the EM Resident" 2nd Edition.* The Interview - questions the employer may ask. Florida College of Emergency Physicians and the American College of Emergency Physicians. 7-13.
- **Gray-Eurom K**. 1998. *Preparing for the Real World: An Interviewing Guide for the EM Resident.* Introduction. Florida College of Emergency Physicians and the American College of Emergency Physicians.
- **Gray-Eurom K**. 1998. *Preparing for the Real World: An Interviewing Guide for the EM Resident.* The Final Decision. Florida College of Emergency Physicians and the American College of Emergency Physicians. 51-53.
- **Gray-Eurom K,** and Perry S. 1998. *Preparing for the Real World: An Interviewing Guide for the EM Resident.* Prospecting and Interviewing. Florida College of Emergency Physicians and the American College of Emergency Physicians. 25-33.

Refereed Publications

- Padro T, Smotherman C., Gautam S., Gerkik C, **Gray-Eurom K,** Guirgis F.W.. June 2019. Admission characteristics predictive of in-hospital death from hospital acquired sepsis: A comparison to community-acquired sepsis. *Journal of Critical Care*. 51 (2019): 145–148

- Guirgis F.W., Jones L., Esma R., Weiss A., McCurdy K., Ferreira J., Cannon C., McLauchlin L., Smotherman C., Kraemer D.F., Gerdik C., Webb K., Ra J., Moore F.A., **Gray-Eurom K.** : Managing sepsis: Electronic recognition, rapid response teams, and standardized care save lives. *J Crit Care.* 2017 Apr 8. pii: S0883-9441(16)31007-3. doi: 10.1016/j.jcrc.2017.04.005. [Epub ahead of print]

- McAllister M.W., Aaronson P., Spillane J., Schreiber M., Baroso G., Kraemer D., Smotherman C., **Gray-Eurom K.** : Impact of prescription drug-monitoring program on controlled substance prescribing in the ED. *American Journal of Emergency Medicine.* March 2015. Article in Press.

- **Gray-Eurom K.,** Hale M., Thomas M., Kalynch C. March 2015. The CARE 2 Committee: Improving efficient use of the ED through a review of high-use patients. *American Journal of Emergency Medicine.* Vol. 33, Issue 3, p465-467.

- Guirgis F.W., **Gray-Eurom K.**, Mayfield T.L.(r), Imbt D.M.(r), Kalynych C.J.(p), Kraemer D.F.(p), Godwin S.A. : 2014. Impact of an abbreviated cardiac enzyme protocol to aid rapid discharge of patients with cocaine-associated chest pain in the clinical decision unit. *Western Journal of Emergency Medicine.* 15/2: 180-3.

- **Gray-Eurom K.**, Berk E.S., Webb K.L., Berk A.S., and Hendry P. 2012. Life after residency workshop: A statewide workforce preparation day for emergency medicine residents and pediatric emergency fellows. *Academic Emergency Medicine.* 19/4S1: S395.

- 2011. High Risk Scenarios in Blunt Trauma. **Gray-Eurom K** (Ed.). *EM Critical Care.* 1/3:

- 2011. ED Overcrowding: An Evidence Based Approach to the Problem and Its Solutions. **Gray-Eurom K.** (Ed.). *Emergency Medicine Practice.* April:

- 2009. Fixing Faces Painlessly: Facial Anesthesia in Emergency Medicine. **Gray-Eurom K** (Ed.). *Emergency Medicine Practice.* 11/12: 1-28.

- **Gray-Eurom K**, and Hinshelwood H. 2008. His Voice. *Journal Emergency Medicine.* 35/4: 459-60.

- **Gray-Eurom K**, and Deitte L. 2007. Imaging in Abdominal Pain. *Emergency Medicine Practice.* 9/2: 1-32.

- **Gray-Eurom K**. 2006. Creating Conflict Resolution in the Emergency Department. *Emergency Medicine & Critical Care Review 2006.* June 2006: 12-13.

- 2003. Violence against Women. **Gray-Eurom K** (Ed.). www.healthywomen.org

- **Gray-Eurom K**. 2002. The Sexual Assault Examination: Do We Make A Difference. *Emergency Medicine News.* 24/6: 3, 40.

- **Gray-Eurom K**, Seaberg D, and Wears R. 2002. The prosecution of sexual assault cases: correlation with forensic evidence. *Annals of Emergency Medicine.* 39: 39-46.

- **Gray-Eurom K** 1996. The Crime of Power. *Jacksonville Medicine.* 47/8: 334-38.

- Misselbeck W, **Gray-Eurom K** and Uphold R. 1994. Latex Induced Anaphylaxis: A case report. *American Journal of Emergency Medicine.* 12/4: 445-447.

Non-refereed Publications

- **Gray-Eurom K**. Academic Matters https://hscj.ufl.edu/news/ Quarterly e-publication August 2018; November 2018

- **Gray-Eurom K**. Academic Matters https://hscj.ufl.edu/news/ Quarterly e-publication February 2017; June 2017; August 2017; November 2017; February 2018; June 2018

- **Gray-Eurom K**. 2013. The Prescription Problem. *EmPulse Summer 2013.* 19/1:

- **Gray-Eurom K** 2013. Passing the Torch. *EmPulse Spring 2013.* 12/2:

- **Gray-Eurom K**. 2012. Saying Goodbye to Things We have Known. *EmPulse Winter 2012.* 18/1:

- **Gray-Eurom K**. 2012. Where we are going – and where we have been. *EmPulse Fall 2012.* 18/4:

- **Gray-Eurom K**, Lenhart B, and Caro D. 2010. ED documentation training in the face of ED overcrowding. *Northeast Florida Medicine.* 61/2: 12-13.

- 2009. If Coders Ruled the World: what coders wished every emergency physician knew. **Gray-Eurom K** (Ed.). *Online educational module.* Part 1: www.acep.org

- 2009. Talking with your Legislator. **Gray-Eurom K** (Ed.). *Online educational module.* www.acep.org

- 2009. Preparing for your Deposition. **Gray-Eurom K** (Ed.). *Online educational module.* www.acep.org

- 2009. Common Medico-legal Chart Traps. **Gray-Eurom K** (Ed.). *Online educational module.* www.acep.org

- 2009. The History of E&Ms. **Gray-Eurom K** (Ed.). *Online educational module.* www.acep.org

- 2009. Show Me the Money; how a patient encounter translates into your paycheck. **Gray-Eurom K** (Ed.). *Online educational module.* Part II: www.acep.org

- 2009. Show Me the Money; how a patient encounter translates into your paycheck. **Gray-Eurom K** (Ed.). *Online educational module.* Part 1: www.acep.org

- 2009. If Coders Ruled the World; what coders wished every emergency physician knew. **Gray-Eurom K** (Ed.). *Online educational module.* Part II: www.acep.org

- **Gray-Eurom K**. 2007. A Council Summary Report. *AAWEP Section Newsletter.* 8/1:
- 2005. Young Physicians Newsletter. **Gray-Eurom K** (Ed.). *American College of Emergency Medicine.* 10/4: 1-12.

- 2005. Young Physicians Newsletter. **Gray-Eurom K** (Ed.). *American College of Emergency Medicine.* 10/3: 1-12.

- 2004. Young Physicians Newsletter. **Gray-Eurom K** (Ed.). *American College of Emergency Medicine.* 10/1: 1-12.

- **Gray-Eurom K**. 2002. Emergency Physicians and the Victim of Sexual Assault. *Annals of Emergency Medicine.* 40/4: 438-439.

Book Manuscripts Reviewed

- 2020*. New Resident EPIC ASAP Documentation Guide.* **Gray-Eurom K** (Ed.). University of Florida Health Science Center/Jacksonville.

- **Gray-Eurom**. 2014. *Clinical Decision Unit Manual: Guidelines, policies and protocols for patient care in the clinical decision unit.* University of Florida Health Science Center/Jacksonville

- **Gray-Eurom K**. 2013. *Department of Emergency Medicine Nursing Triage Criteria Manual.* University of Florida Health Science Center/Jacksonville

- 2012*. EPIC ASAP Quick Start Guide.* **Gray-Eurom K** (Ed.). University of Florida Health Science Center/Jacksonville.

- **Gray-Eurom K**. 2011. *Clinical Decision Unit Manual: Guidelines, policies and protocols for patient care in the clinical decision unit.* University of Florida Health Science Center/Jacksonville

- **Gray-Eurom K**. 2011. *Department of Emergency Medicine Nursing Triage Criteria Manual.* University of Florida Health Science Center/Jacksonville

- 2003. *Preparing for the Real World: An Interviewing Guide for the EM Resident 2nd Edition.* **Gray-Eurom K** (Ed.). Florida College of Emergency Physicians and the American College of Emergency Physicians.

- 1998. *Preparing for the Real World: An Interviewing Guide for the EM Resident.* **Gray-Eurom K** (Ed.). Florida College of Emergency Physicians and the American College of Emergency Physicians.

Lectures, Speeches, Posters Presented at Professional Conferences

Lectures/Oral Presentations

Things You Should Know About Charting & Revenue
Department of Emergency Medicine
University of Florida HSC/Jacksonville — January 23, 2020

Quality Overview for Orthopedics
Faculty Development Series – Orthopedics
University of Florida Jacksonville — July 17, 2019

Strategic Planning: How to Develop a Strategic Direction/Plan and Why it's Important
American College of Emergency Physicians Leadership and Advocacy Conference
Washington, DC — May 5, 2019
Invited, Peer Reviewed

Incorporating Quality
University of Florida Faculty Development Series
Jacksonville, FL — April 24, 2019

Educate, Innovate and Empower to Reduce CAUTIs & CLABSIs
Vital2018 America's Essential Hospitals Annual Meeting
San Francisco, CA — June 21, 2018
Invited, Peer Reviewed

Billing Reminders
Department of Emergency Medicine
University of Florida HSC/Jacksonville — May 3, 2018

Improving Patient Safety at an AMC
2018 Patient Safety Forum QSEN Institute
Jacksonville University, Jacksonville, FL — March 2, 2018
Invited Oral Presentation

EHR Documentation – Part II
Department of Emergency Medicine
University of Florida HSC/Jacksonville — February 1, 2018

EHR Documentation – Part I
Department of Emergency Medicine
University of Florida HSC/Jacksonville — December 7, 2017

Quality & Patient Safety
New Faculty Orientation
University of Florida HSC/Jacksonville — October 20, 2017

The EM Job Search – preparing for success
Department of Emergency Medicine
University of Florida HSC/Jacksonville — March 23, 2017

Why, What & How for EPIC ASAP
Department of Emergency Medicine
University of Florida HSC/Jacksonville — February 2, 2017

Just Culture for Residents
Department of Anesthesia
University of Florida HSC/Jacksonville — November 30, 2016

A Physician's Perspective on Quality in Healthcare
UNF MHA program
University of North Florida /Jacksonville — October 26, 2016

Quality and Safety
GMEC Orientation
University of Florida HSC/Jacksonville — July 1, 2016

Creating a Just Culture: a program director tool kit
GMEC Program Director Retreat
University of Florida HSC/Jacksonville — April 20, 2016

QI & Patient Safety: the basics
Faculty Development Lecture Series
University of Florida HSC/Jacksonville — February 10, 2016

The WHYs behind the How in EPIC documentation
Department of Emergency Medicine
University of Florida HSC/Jacksonville — September 3, 2015

What is Quality?
The Employee Forum
UF Health - Jacksonville — September 2, 2015

ACGME CLER Quality and Patient Safety
CLER Site Visit Preparation
University of Florida HSC/Jacksonville — July 21/22, 2015

Quality on this Campus
New Resident Orientation
University of Florida HSC/Jacksonville — June 23, 2015

The Quality Question
Department of Emergency Medicine
University of Florida HSC/Jacksonville — June 11, 2015

Introduction to the ABEM Boards
Department of Emergency Medicine
University of Florida HSC/Jacksonville — November 7, 2013

Keynote Address - Interfacing with the Safety Net
Academy of Pain Management Annual Clinical Meeting
Orlando, FL — September 27, 2013
Invited Oral Presentation – Keynote Speaker

Leadership Skills for the Leadership Academy
FCEP Symposium by the Sea
Clearwater, FL — August 2, 2013
Invited Oral Presentation

Taking the Lead: Essential Skills for Becoming a Highly Effective Chapter Leader
ACEP Leadership and Advocacy Conference
Washington, DC — May 19, 2013
Invited Oral Presentation

Specialist coverage of Emergency Departments and Related Reporting Requirements
AHCA State Consumer Health Information and Policy Advisory Council
Tallahassee, FL — March 15, 2013

Preparing for the ABEM Boards
Department of Emergency Medicine
University of Florida HSC/Jacksonville — November 29, 2012

Job Search Boot Camp
Life after Residency and Fellowship Statewide Workshop
Jacksonville, FL — November 8, 2012

Florida Town Hall Presentation
FCEP Symposium by the Sea
Amelia Island, Florida — August 5, 2012
Invited Oral Presentation

The Crisis in the ED
American Academy of Professional Coders
Coding on the River Conference
Jacksonville, FL — June 21, 2012
Invited Oral Presentation

The Oral Boards & You
Department of Emergency Medicine
University of Florida HSC/Jacksonville. — May 31, 2012

Life after residency workshop: a statewide workforce preparation day for emergency medicine residents and pediatric emergency fellows — May 10, 2012
Innovations in Emergency Medicine Education at 2012 Annual
SAEM Meeting - Chicago, Illinois
Refereed proceeding, selected from abstract submissions

E/M from a Physician's Perspective – clairvoyance into the physician mind
American Academy of Professional Coders
Coding on the River Conference
Jacksonville, Florida — October 1, 2011
Invited Oral Presentation

Communication & Professionalism
Clinical Decision Making in Emergency Medicine
Ponte Vedra, Florida. June 25, 2011
Invited Oral Presentation

The Clairvoyant Coder
American Academy of Professional Coders Regional Meeting
Jacksonville, FL March 15, 2011

Transitioning to Practice
FCEP State Legislative EM Days
Tallahassee, FL March 16, 2011
Invited Oral Presentation

Observation Medicine
Grand Rounds Department of Emergency Medicine
University of Florida HSC/ Jacksonville January 6, 2011

The ABEM Oral Boards from an Examiners Perspective
Grand Rounds Department of Emergency Medicine
University of Florida HSC/ Jacksonville December 2, 2010

The Basics of Survival in the ED
Grand Rounds Department of Emergency Medicine
University of Florida HSC/ Jacksonville. November 4, 2010

Promoting Leadership
ACEP Scientific Assembly
Las Vegas, NV September 30, 2010
Invited Oral Presentation

What to Expect in Your Job Search
Grand Rounds Department of Emergency Medicine
University of Florida HSC/ Jacksonville. September 23, 2010

Perspectives on the Emergency Medicine Job Search
Department of Emergency Medicine
University of Florida HSC/Jacksonville September 22, 2010
Panel Discussant

Risk Reduction and Operational Efficiencies
Clinical Decision Making in Emergency Medicine
Ponte Vedra, Florida June 26, 2010
Invited Oral Presentation

Section Leadership
ACEP Leadership and Advocacy Conference
Washington, DC May 18, 2010
Invited Oral Presentation

K. Gray-Eurom, MD, MMM, FACEP

Patient Satisfaction Scores in the ED
Grand Rounds Department of Emergency Medicine
University of Florida HSC/ Jacksonville — April 1, 2010

Public Policy Panel. ACEP Council Forum
ACEP Scientific Assembly
Boston, MA — October 2, 2009
Invited Oral Panelist

Coordinator /Candidate Forum. ACEP Council Forum
ACEP Scientific Assembly
Boston, MA — October 2, 2009
Invited Oral Presentation

Imaging in Abdominal Pain
FCEP Symposium by the Sea
Naples Florida — August 9, 2009
Invited Oral Presentation

If Coders Ruled the World Part II; what coders wished every emergency physician knew about coding. ACEP Web Page http://acep.org/ — July 2009

If Coders Ruled the World Part I; what coders wished every emergency physician knew about coding. ACEP Web Page http://acep.org/ — July 2009

Life after Residency
Grand Rounds Department of Emergency Medicine
University of Florida HSC/ Jacksonville — November 19, 2008

Where to Go From Here? Strategic Issues Forum
ACEP Scientific Assembly.
Chicago, Illinois — October 25, 2008
Invited Panelist

Top Ten Billing Errors
Grand Rounds Department of Emergency Medicine
University of Florida HSC/ Jacksonville. — November 8, 2007

Parenting, Pregnancy and Professional Careers
ACEP Scientific Assembly, AAWEP Section Meeting
Seattle, WA — October 8, 2007

Invited Panelist

Quality - what is it and what does it really accomplish?
Clinical Decision Making in Emergency Medicine
Ponte Vedra, Florida. June 24, 2016
Invited Oral Presentation

More Measures: improving care or creating chaos?
Clinical Decision Making in Emergency Medicine.
Ponte Vedra, Florida. June 23, 2007
Invited Oral Presentation

Improving ED Operations with MedTeams. Medical Directors Workshop
Clinical Decision Making in Emergency Medicine
Ponte Vedra, Florida. June 22, 2007
Invited Oral Presentation

Business vs. Education - are they really competing goals at an academic training program?
Council of Emergency Medicine Residency Directors Annual
Academic Assembly.
Orlando, Florida March 2, 2007
Invited Oral Presentation

Posters

America's Essential Hospitals
Universal MRSA Decolonization for Reduce Adult ICU MRSA Infections
Miami, FL June 20, 2019
Refereed proceeding, selected from abstract submissions

America's Essential Hospitals
2017-2018 Fellows Program
Transferring Quality North
Washington, DC March 1, 2018

Institute for Healthcare Improvement
28th Annual National Forum on Quality Improvement in Health Care
CLABSI Reduction: "Back to Basics"
Orlando, Florida December 4-7, 2016
Refereed proceeding, selected from abstract submissions

FCEP Symposium by the Sea poster presentation
The Care2 Committee; Improving Efficient Use of the ED
Through a Review of High Use Patients
Amelia Island, Florida August 7-9, 2015
Refereed proceeding, selected from abstract submissions

Society for Academic Medicine Annual Meeting poster presentation
The Care2 Committee; Improving Efficient Use of the ED
Through a Review of High Use Patients
San Diego, CA May 14, 2015
Refereed proceeding, selected from abstract submissions

FCEP Symposium by the Sea poster presentation
Rapid Discharge of Patients Presenting to the Emergency Department with Cocaine Chest Pain: application of an abbreviated cardiac enzyme protocol in the clinical decision unit
Clearwater, FL August 2-4, 2013
Refereed proceeding, selected from abstract submissions

University of Florida COM Research Day
Rapid Discharge of Patients Presenting to the Emergency Department with Cocaine Chest Pain: application of an abbreviated cardiac enzyme protocol in the clinical decision unit
Jacksonville, Fl May 16, 2013
FCEP Symposium by the Sea poster presentation
Life after Residency Workshop: A Statewide Workforce Preparation Day for Emergency Medicine Residents and Pediatric Emergency Fellows
Amelia Island, Florida
August 3 -5, 2012
UF COM – Jacksonville Medical Education Day
Patient education for sexually transmitted diseases
Jacksonville, FL April 12, 2012
Refereed proceeding, selected from abstract submissions

Southeastern SAEM - poster presentation
Life after Residency Workshop: A Statewide Workforce Preparation Day for Emergency Medicine Residents and Pediatric Emergency Fellows
Jacksonville, FL February 25-26. 2012
Refereed proceeding, selected from abstract submissions

FCEP Symposium by the Sea Poster Presentation
ED Documentation Training in the Face of ED Overcrowding
Boca Raton, FL August 6, 2010
Refereed proceeding, selected from abstract submissions

ACEP Leadership & Advocacy Conference Poster Presentation
ED Documentation Training in the Face of ED Overcrowding
Emergency Medicine Residents Association Innovations in Teaching Conference
Washington, DC May 17, 2010

ED Documentation Training in the Face of ED Overcrowding
University of Florida COM-Jacksonville Medical Education Week
Jacksonville, FL April 22, 2010
Refereed proceeding, selected from abstract submissions

ED Documentation Training in the Face of ED Overcrowding
Duval County Medical Society
Jacksonville, FL January 21, 2010
Refereed proceeding, selected from abstract submissions

ACEP Scientific Assembly Research Forum Poster Presentation
ED Documentation Training in the Face of ED Overcrowding
Boston, MA October 5, 2009
Refereed proceeding, selected from abstract submissions

K. Gray-Eurom, MD, MMM, FACEP

The Business of Emergency Medicine
ACEP Educational Webinars
University of Florida HSC/ Jacksonville April 23, 2009
Refereed proceeding, selected from abstract submissions

Creative Works or Activities

SPECIAL PROJECTS

Chair, faculty search committee (Jacksonville, Winter Haven, North Campus)
- Design HR appropriate recruitment materials, advertising and brochures
- Coordinate electronic and print advertisement campaigns
- Coordinate job fair participation

Emergency Department Clinical Decision Unit (ED CDU)
- Creation and implementation of an ED observation unit
- Opened – January 12, 2011

CDU ED Observation Patient Belongings Bag
- Designed a reusable canvas tote for patient care, storage and unit advertising
- The canvas tote contains comfort care supplies for the patient (tooth brush, comb, soap, deodorant etc.) and can be used as a personal patient belonging bag. The tote is given to the patient at discharge to take home.

Lead coordinator EPIC ASAP project
Implementation of an Electronic Medical Record in the ED
University of Florida College of Medicine - Jacksonville
February 2010 - current

FCEP Media Coordinator
EMS Days 2006
Tallahassee, FL

National ACEP Survey Creator and Project Coordinator
Emergency Medicine Graduate Preparedness – an employers' perspective
September 2005

Super Bowl XXXIX (2005)
Director of Operations and Medical Coordination
University of Florida / Shands Jacksonville

G-8 Presidential Summit 2004
Regional Medical Coordination Team
University of Florida, Physician Director
Sea Island Georgia

CURRICULA

Life after Residency & Fellowship Workshop
Course Creator, Director and Curriculum Development
Jacksonville, Florida
October 16, 2014

Univerisity of Florida at UFHealth-Jacksonville
MHA Administrative Internship in Emergency Medicine Management and Business Operations
Semester II – Winter 2014

Univerisity of Florida at UFHealth-Jacksonville
MHA Administrative Internship in Emergency Medicine Management and Business Operations
Semester I – Fall 2013

Advisor
Life after Residency & Fellowship Workshop
Orlando Sept 24, 25, 2013

Life after Residency & Fellowship Workshop
Course Creator, Director and Curriculum Development
State-wide workshop with 144 resident & faculty participants
Jacksonville, Florida
November 7-8, 2012
Life after Residency & Fellowship Workshop
Course Creator, Director and Curriculum Development
State-wide workshop with 125 resident & faculty participants
Jacksonville, Florida
August 31 – September 1, 2011

Curriculum Design and Administrative Coordinator
Emergency Medicine Graduate Preparedness Lecture Series 2010
University of Florida Department of Emergency Medicine – Jacksonville

Curriculum Design and Administrative Coordinator
Emergency Medicine Graduate Preparedness Lecture Series 2009
University of Florida Department of Emergency Medicine - Jacksonville

CME Course Coordinator
EM Days Educational Programs
March 10 – 12, 2008
Tallahassee, FL

Curriculum Design and Administrative Coordinator
Emergency Medicine Graduate Preparedness Lecture Series 2008
University of Florida Department of Emergency Medicine - Jacksonville

Curriculum Design and Administrative Coordinator
Emergency Medicine Graduate Preparedness Lecture Series 2007
University of Florida Department of Emergency Medicine - Jacksonville

Curriculum Design and Administrative Coordinator
Emergency Medicine Graduate Preparedness Lecture Series 2006
University of Florida Department of Emergency Medicine - Jacksonville

Curriculum Developer – Professional Development Series
ACEP Spring Congress 2006
Las Vegas, Nevada

Curriculum Design and Administrative Coordinator
Work Force Preparation and Transition into Emergency Medicine Practice Lecture Series 2005
University of Florida Department of Emergency Medicine - Jacksonville

Curriculum Design and Administrative Coordinator
Work Force Preparation and Transition from Residency Day Lecture Series 2003
University of Florida Department of Emergency Medicine - Jacksonville

Grants and Contracts

Summary of External Grant & Contract Funding

Role	TOTAL	Direct Costs	Indirect Costs
Principle Investigator	$77,140,254	$77,140,254	$0
Co-Investigator	$0	$0	$0
Consultant	$0	$0	$0
Sponsor of Junior Faculty	$0	$0	$0
TOTALS	$**77,140,254**	$**77,140,254**	$0

Grant Reviewer

American College of Emergency Physicians
Section Affairs Task Force
Principal Reviewer 2013
Grants Reviewed: 17 / Amount Requested: $114,187
Approved Grants: 9 / Amount Awarded: $ 39,485

American College of Emergency Physicians
Section Affairs Task Force
Chair / Principal Reviewer 2007-2012
Grants Reviewed: 69 / Amount Requested: $403,953
Approved Grants: 29 / Amount Awarded: $139,225

American College of Emergency Physicians
Section Affairs Task Force
Reviewer 2005-2006
Grants Reviewed: 17 / Amount Requested: $149,220
Approved Grants: 9 / Amount Awarded: $ 46,475

UNIVERSITY GOVERNANCE AND SERVICE

University

Claims Prevention and Loss Committee University of Florida	2018 - present
Member, Dean's Search Committee Senior Associate Dean for Educational Affairs University of Florida College of Medicine - Jacksonville	2013
Faculty Senate Representative University of Florida College of Medicine - Gainesville	2008 - 2011

College

University of Florida Health Science Center / UF COM-Jacksonville

Senior Lead, 20 Year Strategic Plan UFHealth & UF COM	2018 – present
Panel Member, Annual Institutional Review	2017 - present
Member, Patient Safety Evaluation System Committee	2016 - present
Member, Value Based Funding Committee / MACRA	2016 - present
Panel Member, Annual Institutional Review	June 2016
Member, BOD Quality Committee Shands Jacksonville Board of Directors	2015 - 2020
Member, Gator Care Plan Design Committee	2013 - 2014
Immediate Past President, Faculty Council	2013 - 2014
Member, Shands Jacksonville Medical Executive Committee	2013 - 2014
President, Faculty Council	2012 - 2013
Member, Shands Jacksonville Board of Directors	2012 - 2013
Member, Search Committee Chair, Department of Anesthesiology, College of Medicine Jacksonville	2012
EPIC Implementation Coordinator	2011 - 2015
President-Elect, Faculty Council	2011 - 2012
Member, Cloned Medical Records Task Force	2010
Faculty Councilor	2008 - 2014

Chair, Vascular Center of Excellence Committee	2008 - 2009
Member, Finance Committee	2006 - present
Member, Health Ease Managed Care Specialty Committee	2006 – 2007
Member, Neurology Residency Program Internal Review Committee	2005
Member, Planning and Development Committee	2004 – 2012
Member, Emerson Task Force	2003 – 2005

Department/Center

Emergency Medicine – UF Health Health Science Center / UF COM-Jacksonville

Chair, ED Operations Committee	2008 - 2015
Chair, University of Florida Faculty Search Committee	2005 - 2015
Member, Failure Mode Effects Analysis for ED Radiology Committee	2003
Member, Resident Selection Committee	2003
XPC System Administrator	2002 - present
Member, Emergency Department Quality Management Committee	2001 - 2016
Chair, Chart flow and revenue recovery in the ED	2002 - present
Member, Shands Managed Care QI/UM & Business Committee	2002 - 2007

Medical Center / Hospital

UFHealth-Jacksonville

EPIC Operations Committee	2017 - present
Champion, IM COPD Readmission Reductions PIT	2017 – present
Member, CAUTI PIT	2017 – present
Founder & Member, Ambulatory PIC	2016 – present
Chair, Readmissions Reduction Task Force	2016 – present
Champion, Pain I.D.E.A.S. 2 PIT	2016 – 2018
Member, Deans' Task Force on Handoffs	2016 – 2018
Chair, Performance Improvement Committee	2015 – present
Chair, UHC Steering Committee	2015 – 2016
Chair, PoPS. PIT	2015 – 2016
Chair, Pain I.D.E.A.S. PIT	2015 – 2016
Member, Medical Performance Improvement Committee	2015 - present
Member, Surgical Performance Improvement Committee UFHealth-Jacksonville	2015 - present
Member, Nursing Performance Improvement Committee	2015 - present
Member, Infection Prevention & Control Committee	2015 – present
Member, TOP Steering Committee	2015 – present
Member, CLABSI PIT	2015 – present
Member, Patient Experience Committee	2015 - 2017

Winter Haven Hospital

Board Member Winter Haven Hospital Board of Directors	2006 - 2012

Orange Park Medical Center

Chair, Performance Improvement Committee Medical Necessity review of chest radiograph utilization in the ED	2000
Chair, Performance Improvement Committee Medical Necessity review of lower acuity evaluations in the ED	2000
Member, Executive Committee	1999 – 2001
Member, Credentialing Committee	1999 – 2001
Chair, Performance Improvement Committee Hospital Admission Quality Action Team	1998
Chair, Performance Improvement Committee Medical Necessity review of ED CT scans	1998
Medical Director and Coordinator Physician Medical Staff ACLS Re-certification Class	1998
Medical Director and Coordinator Physician Medical Staff ACLS Re-certification Class	1998
Chair, Emergency Department Overuse Review Panel	1997 – 2001
Member, Hospital Infectious Disease Control Committee	1996 – 1999

CONSULTATIONS OUTSIDE THE UNIVERSITY

AHCA State Consumer Health Information and Policy Advisory Council March 2013
Invited Consultant Tallahassee, FL
Topic: on-call issues in the emergency department

NE Florida Regional Prescribing of Controlled Substances Task Force 2011-2012
Center for Global Health and Medical Diplomacy Jacksonville, FL

The Centers for Disease Control and Prevention (CDC) report that "the abuse of prescription painkillers has reached epidemic proportions in the US." In April 2011, the White House Office of National Drug Control Policy (ONDCP) reported that "prescription drug abuse is the Nation's fastest-growing drug problem," and that "unprecedented increases in levels of abuse pose a serious threat to the health and safety of Florida's citizens." There has been a statewide push for reduction and more stringent prescribing of controlled substances, especially to opiate naïve patients or those with a history of substance abuse.

The task force was a multi-disciplinary group representing the majority of hospitals, medical professional societies and medical disciplines in NE Florida. The task force created voluntary guidelines intended to reduce the indiscriminant use of controlled medications for non-acute, non-malignant pain conditions, while continuing to adequately treat acute pain. The guidelines also raised awareness of a growing problem within our community and aimed to reduce chemical dependence, addiction, abuse, and drug diversion in Northeast Florida.
The health care facilities in Jacksonville adopted these guidelines and have incorporated them into patient education and suggested patient-care guidelines in the ED. A guideline example is contained in section 33.

Florida ED Collaborative – Area 4 December 2011–December 2012
Statewide Medicaid Managed Care Program
Invited participant – program objectives:

"Through a collaborative, The Agency for Healthcare Administration (AHCA) will work with key stakeholders including certain Health Maintenance Organizations (HMOs) and Provider Services Networks (PSNs), hospitals, community providers, patient advocacy organizations, and Medicaid consumers to reduce avoidable emergency department (ED) utilization. Many of the ED services utilized by Florida's Medicaid members are non-emergent and could be treated safely and effectively in an urgent or primary care setting.

AHCA is forming the ED Collaborative because there is a recognized need to address ED over-utilization at a systems level through a multifaceted approach that maximizes health care resources, encourages information sharing, and promotes community-specific solutions as essential elements in redirecting patients seeking avoidable care in the ED."

Board of Trustees Winter Haven Hospital 2006 – 2013
Winter Haven, FL

"*Winter Haven Hospital with over 2,500 employees is the largest private employer in east Polk County. The hospital is fully accredited by the Joint Commission on Accreditation for Healthcare Organizations (JCAHO) and has over 300 board-certified physicians on its medical staff representing every major specialty. With 527 licensed hospital beds, Winter Haven Hospital is*

the larger of the two main facilities in our healthcare system followed by our women's hospital, the Regency Medical Center."

"Winter Haven Hospital established in 1926 serves as the major medical center for east Polk County and the highway 27/Ridge Corridor. The hospital is a division of Mid-Florida Medical Services, a locally owned and operated501(C)(3) not-for-profit organization which is governed by an independent Board of Trustees made up of local business and civic leaders who serve without pay. "- Winter Haven Hospital http://www.winterhavenhospital.org/aboutwhh/about.html

Medic Alert Foundation's Emergency Medical Information Record 2009 - 2010
Invited Consultant / Expert Panelist Boston, MA

Electronic Medical Record Advisor March 2005 – Dec 2014
Winter Haven Hospital, Winter Haven, FL

Serves as the senior physician advisor to provide technical and systems expertise in support of the planning, implementation and performance of an electronic medical record, physician order entry system and patient tracking system with-in the emergency department. Duties include the analysis of operations, fiscal impact assessments and performance improvement activities.

Super Bowl XXXIX (2005)
Director of Operations and Medical Coordination
City of Jacksonville Super Bowl Host Committee

Coordinated logistics, staff and equipment to provide medical care at the events associated with and including Super Bowl XXXIX hosted in Jacksonville, Florida December 27, 2004 through February 6, 2005.

Required the development of a health care operations system to provide medical care services to the NFL Family which consisted of approximately 10,000 contractors providing the workforce to outfit the stadium for the Super Bowl.

Involved the creation of a fully functional, staffed and equipped healthcare clinic located at the Super Bowl hotel headquarters for the week preceding the Super Bowl. These personnel also provided physician medical services for the NFL Commissioner's Party hosted at the Equestrian Club in Jacksonville, Florida.

Staffed and equipped all medical care rooms in the stadium on super Bowl Sunday providing physician medical services to approximately 30,000 vendors, media personnel and stadium workers in addition to the nearly 80,000 fans in attendance at Super Bowl XXXIX.

G-8 Presidential Summit 2004
Regional Medical Coordination Team Physician Director
Sea Island, GA

Served as the physician liaison for UF and Shands Jacksonville for the 2004 G-8 Presidential Summit. Supervised the security and operational needs for the medical preparation of the unit which was designated as the primary receiving facility for the most senior participants in the G-8 Summit hosted at Sea Island, Georgia June 8 – 10, 2004.

Clay County Sexual Assault Task Force May 1998 – Nov 2001
Clay County Sheriff's Office

Part of a multidisciplinary team to define, assess, review and implement policy and procedures for law enforcement, medical personnel, victim service advocates, mental health professionals and County administration to better serve the victims of sexual assault in Clay County, Florida.

Duval County Adult and Adolescent Sexual Assault Program July 1996 – Nov 1997
Assistant Medical Director

Coordination of physician administrative and program development-related duties focused on the establishment, enhancement, and implementation of a comprehensive sexual assault forensic examination program for adults and adolescents in Duval County.

The program goals were to provide professional and compassionate forensic evidence collection for sexual assault victims, ensure that evidence is collected according to the highest professional standards in order to protect the interests of both the alleged victim and the accused, and avoid further trauma to victims of sexual assault in the healthcare environment. Duties included the ongoing refinement of program initiatives, policies, protocols and procedures addressing sexual assault forensic examination procedures, evidence collection, interactions with law enforcement, physician education, appropriate medical treatment and physiological care for the victims of sexual assault in Duval County.

Professional Activities / Committees

National

Advisory Work Group for CMS Hospital Star Ratings	2017-2019
American College of Emergency Physicians (ACEP)	
Member, (non-voting) Board of Directors	2019-present
CoChair, Council Steering Committee	2019-present
Member, Council Awards Committee	2019-present
Member, Finance Committee	2019-present
Member, Quality Strategic Planning Task Force	2018
Member, ACEP Nominating Committee	2020, 2017, 2010-2013
Chair, Council Reference Committee C	2016
Member, CEDR Task Force	2015 - 2019
Member, Quality & Safety Committee	2015 - 2019
Member, ACEP 50th Jubilee Task Force	2015 - 2018
Member, ACEP Residency Visit Ambassador	2014 - 2019
Member, ACEP Council Tellers, Credentials & Elections Committee	2010 - 2018
- Chair, ACEP Council Tellers, Credentials & Elections Committee	2011 - 2013
Member, Membership Committee	2008 - 2019
- Chair, Membership Committee	2013 - 2016
- Chair, Subcommittee for Membership Committee	2010 - 2012
- Chair, Subcommittee for Membership Committee	2008 - 2009
Member, National Chapter Relations Committee	2013 - 2017
Chair, Membership Task Force	2013 - 2014
Member, Residency Visit Task Force	2013 - 2014
Member, Membership Bylaws Restructuring Task Force	2013 - 2014
Member, Section Affairs Task Force	2012 - 2013
National Task Force, Medic Alert Foundation EMIR	2009 - 2010
Chair, Council Reference Committee B	2009
Chair, Academic Business Development Task Force	2008 - 2010
Steering Committee	2008 – 2010
- Chair, Subcommittee for Steering Committee	2009 - 2010
- Member, Subcommittee for Steering Committee	2008 - 2009
Member, Council Reference Committee B	2008
Chair, Section Affairs Task Force	2007 - 2012
Chair, Subcommittee for Section Affairs Committee	2006 - 2007
Chair, YPS Graduate Preparedness Task Force	2006 - 2007
Steering Committee Young Physicians Section	2006 - 2007
Immediate Past Chairman, Young Physicians Section	2005 - 2006
Member, Section Affairs Committee	2004 - 2007
Chair, Young Physicians Section	2004 - 2005
Members, Young Physicians Section	2003 - present
Member, Wellness Section	2003 - present
Member, AAWEP	2003 - present

ACEP Council

Vice Speaker	2019 - 2021
Councilor, Florida College of Emergency Medicine (FCEP)	2008 - 2019
Councilor, AAWEP	2006 - 2007
Alternate Councilor, AAWEP	2005 - 2006
Councilor, Young Physicians Section (YPS)	2003 - 2004

American Board of Emergency Medicine

ABEM Oral Board Examiner	2008 - present

Vizient (UHC)

Patient Populations Network	2018 - present
CQO Council	2015 - present

State

Florida College of Emergency Physicians

Immediate Past-President	2013 - 2014
President	2012 - 2013
Delegate to the FMA	2012 - 2013
President Elect	2011 - 2012
Vice-President	2010 - 2011
Member, Executive Committee	2009 - 2014
Secretary / Treasurer	2009 - 2010
Councilor	2008 - 2019
Chair, Bylaws Review	2008 - 2009
Member, Board of Directors	2006 - 2015
Member, Government Affairs Committee	2004 - 2015
Member, Professional Development Committee	2004 - 2015
Chair, Academic Affairs Committee	2004 - 2008
Member, Medical Economics Committee	1999 - present

Local

Member, Duval County Medical Society	2001 - present

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2021 COUNCIL VICE SPEAKER CANDIDATE WRITTEN QUESTIONS

Melissa W. Costello, MD, MS, FACEP, FAEMS

Question #1: How do you see yourself advocating for the College as a non-voting participant at ACEP Board meetings?

To address this question, it is important to understand the role of the vice-speaker and speaker within the context of the Board of Directors specifically and the College as a whole. The elected, voting Board of Directors members are charged with representing all of the members of the College. The speaker and vice-speaker are not elected representatives of the *College*, but of the *Council*. The distinction is especially important in situations where the general membership (the College) and the Council may disagree. The Speaker and Vice-Speaker bring the voice of the Council to the Board, channeling the insights of persons intimately involved in the deliberations on the Council floor. They must convey the dynamics of the debate on the various issues and resolutions to ensure that the spirit of a resolution is not lost in policy-making. I served on many boards and committees over the course of my career (as a voting and non-voting member) and never shy away from contributing to a discussion on behalf of those I represent. This is true even when the position of my organization does not align with my personal opinion. Being able to set aside my personal views while advocating for the Council's position is a challenge that lies at the heart of the Vice-Speaker role. I am fully prepared to meet this challenge after four years as the Chair of the Tellers, Elections and Credentials Committee. The Speaker and Vice-Speaker serve other roles in addition to their advocacy for the Council. Oversight of new Councilor orientation, steering committee, nominating committee and reference committees entails a broad scope of responsibility and influence. It is vital that the Council officers apply this influence in a manner that drives balanced and diverse representation, fair and impartial decision-making, and deliberate identification and mentorship of future leaders. I have been blessed throughout my path to this nomination with outstanding role-models. Ultimately, the Speaker and Vice-Speaker spend the better part of two days leading the Council meeting. My goal is to guide the Council through the issues in a manner that is efficient, collaborative and inclusive, making the most of the limited time we have as a Council to do "the work of the College".

Question #2: **Do you think governance changes need to be made within ACEP? Why or why not?**

Not yet. The current governance structure has served the College well for many years and has evolved as the College's size and influence has grown. Particularly over the last 10 years our College, like our country, has become more divided. We are united in our identity as Emergency Physicians. Yet, our College is comprised of members from a variety of backgrounds, ages, genders, identities, races, political ideologies and practice structures. We are, at our core, a membership organization. Often, an important issue to one segment of our members can be incredibly divisive within the membership as a whole. The risk of alienating certain groups while ostensibly advocating on behalf of "all" Emergency Physicians is a challenge that will likely grow immensely over the next several years. Unfortunately, our governance structure, particularly on the staff professional side, lacks sufficient transparency. In the end, the governance structure of the organization is guided by the Board of Directors--not the Council officers. When and if the Council decides to push for a change in governance, I will advocate its position to the Board.

Question #3: **What do you think works well for the Council meeting operations and how would you improve the councillor experience?**

The Council has been well served over many years by its consistency and predictability. Very little has changed in the basic structure and agenda in my twenty years of participation. I have spent my time in the Council either as the lone Councillor from a section or as one of two or three councillors from a small state. Over the last few years, there has been robust discussion and task force work regarding the size of the Council as we approach the limits of hotel capacity to accommodate an organization of our size. As we continue to grow, the representation ratios, Councillor allocations and in-person attendance requirements will need to be revisited so that everyone from the largest states to the solo councilor believes that they have equal standing in our deliberative process. Last year, COVID forced us to more fully utilize asynchronous testimony and

remote participation in the annual meeting. These are innovations that allowed for more efficient use of the reference committees members' time, single Councillors to contribute to all three reference committees, and a consent agenda from minute one of the "floor" debate. I am convinced that these innovations engender greater focus on pivotal issues that benefit from live debate. While there are some kinks to be worked out, I was inspired by the degree of engagement and participation in asynchronous testimony. Although we are returning to the "pre-COVID" way of conducting the Council this year, it is my hope that some hybrid of these new tools will remain in place in order to engage a wider swath of members in the Council process.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DATA SHEET

Melissa Wysong Costello, MD, MS, FACEP, FAEMS

Contact Information

109 Myrtlewood Lane
Mobile, AL 36608
Phone: 251-753-2698
E-Mail: emsdoc1@gmail.com

Current and Past Professional Position(s)

Mobile Infirmary Medical Center, Mobile, Alabama	
Staff Emergency Physician: Baldwin Emergency Group, PC	12/2018-present
Facility Medical Director-Emergency Medicine: TeamHealth	7/2014-11/2018
Singing River Hospital System, Pascagoula, Mississippi	
Staff Emergency Physician - Emergency Room Group, LLC	1/2019-present
Ascension Sacred Heart Hospital, Nine Mile Free Standing ED, Pensacola, FL	
Staff Emergency Physician – Envision Healthcare	12/2020-present
AirMethods Corporation, Denver, CO	
Clinical Appeals Consultant/Utilization Review	1/2017-present
EMS Medical Director Positions:	
Mobile Fire &Rescue, Urban Search and Rescue	6/2006-present
Federal Bureau of Investigation, Mobile Division, SWAT Medical	9/2007-present
Baptist LifeFlight/Alabama Lifesaver/AirMethods	11/2008-present
Mobile Police Department, Police Surgeon	2/2016-present
US Department of Health and Human Services: NDMS	
Medical Officer – Trauma Critical Care Team -South (TCCT-S)	10/2018-present
Supervisory Medical Officer: AL-3 DMAT	10/2003-10/2018

Education (include internships and residency information)

Education:

Arizona State University, Tempe, AZ
Master of Science, Science of Health Care Delivery, Dec 2019
University of Alabama School of Medicine, Birmingham, AL
Doctor of Medicine, May 2000
Georgetown University, Washington, DC
Bachelor of Science in Biology, May 1995

Internship/Residency Training:

Johns Hopkins University School of Medicine, Baltimore, MD
Emergency Medicine: 2000-2003

Specialty Board Certifications(e.g., ABEM, AOBEM, AAP, etc.) and dates certified and recertified)

American Board of Emergency Medicine
Emergency Medicine – 2004, 2014, 2020 current including MOC through 12/31/2024
Emergency Medical Services – 2013, current including MOC through 12/31/2023

Professional Societies

American College of Emergency Physicians – 1998-present
National Association of EMS Physicians – 2003-present
American Medical Association – 1996-2010
Alabama Chapter – American College of Emergency Physicians – 1998-2000, 2003-present
Mississippi Chapter – American College of Emergency Physicians – 2010-present
American Academy of Women Emergency Physicians – 2000-present
Medical Association of the State of Alabama – 1996-2000, 2003-present
Mobile County Medical Society – 2003-present
Society for Academic Emergency Medicine – 2003-2010

National ACEP Activities – List your most significant accomplishments

Nominee to ABEM Board of Directors 2019, 2020
Education Committee-EMS Subcommittee: 2015-21
Tellers, Elections and Credentials Committee: 2012-2019 **Chair 2014-18**
EMS Committee: 2008-2015, **Chair: 2011-2014**
EMS Section: Councilor: 2009, Sec-Treas: 2012 Chair-elect: 2014 **Chair: 2016-18**

ACEP Chapter Activities – List your most significant accomplishments

Alabama Chapter:
Board of Directors 2008-2016
President-Elect 2013-14, President 2014-15

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 **80** % Research **0** % Teaching **5** % Administration **5** %
Other: **Medical Direction for EMS** **10** %

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

I work full-time clinical, community-based, emergency medicine through a blend of part-time positions. ~100 hrs/mo is with Baldwin Emergency Group, PC, a private, democratic group covering 2 hospital EDs and 2 free-standing EDs in the Mobile, AL. ~16-24 hrs/mo is with Emergency Physicians Group, LLC (priv/dem) in Pascagoula, MS. ~16-24 hr/mo is with Envision affiliated EDs at Ascension Sacred Heart Health System in Pensacola, Florida

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.) **-- Staff 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 2 Cases **Plaintiff Expert 0 Cases**

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DISCLOSURE STATEMENT

Melissa W. Costello, MD, MS, FACEP, FAEMS

1. Employment – *List current employers with addresses, position held and type of organization.*

Employer: Mobile Infirmary Medical Center with Baldwin Emergency Physicians, PC
Address: 5 Mobile Infirmary Circle
Mobile, AL 36602
Position Held: Emergency Physician
Type of Organization: Private Group – W2

Employer: Singing River Health System with Emergency Physicians Group, LLC
Address: 2809 Denny Avenue
Pascagoula, MS 39581
Position Held: Emergency Physician
Type of Organization: Hospital Employee, PRN with democratic Group – W2

Employer: Ascension Sacred Heart Health System with Envision Health
Address: 5151 N 9th Avenue
Pensacola, FL 32504
Position Held: Emergency Physician
Type of Organization: CMG employee – W2

2. Board of Directors Positions Held – *List all organizations and addresses for which you have served as a board member – including ACEP chapter Board of Directors. Include type of organization and duration of term on the board.*

Organization: Alabama ACEP
Address: 2323 West Main Street, Ste 223
Dothan, AL 36301
Type of Organization: ACEP Chapter Board
Duration on the Board: 2008-2016

Organization: Mobile County EMS System, Board of Directors

Address: 10392 Moffett Rd

Semmes, AL 36575

Type of Organization: 501c(3) non-profit organization providing 911 service to Mobile County, AL

Duration on the Board: 2007-present

I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

☒ NONE
☐ If YES, Please Describe:

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) a an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☒ NONE
☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☒ NONE
☐ If YES, Please Describe:

5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE
☐ If YES, Please Describe:

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO
☐ If YES, Please Describe:

I certify that the above is true and accurate to the best of my knowledge:

Melissa W. Costello, MD Date 7/8/21

ALABAMA CHAPTER
AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

POST OFFICE BOX 1265
DOTHAN, AL 36302

(334) 793-7270
1-877-2AL-ACEP
FAX (334) 671-1685

Dear Fellow Councillors:

It is with great pleasure that the Alabama College of Emergency Physicians endorse Melissa Costello, MD, FACEP for ACEP Vice Speaker. Melissa served with distinction as a member of ALACEP's Board of Directors for eight years including a term as president. She has been a strong supporter of ALACEP Leadership and our annual education program, the EMerald Coast Conference. In addition to her work at the state level, Melissa has been a tremendous asset to national ACEP. She has been active in ACEP leadership, Chapter support, as well as the ACEP Council, where she has served as a Councillor since 2009. At the ACEP Council, she has actively served on the Tellers Committee and the Council Steering Committee which has allowed her to cultivate successful relationships with current and past leaders. She also represented the Tactical Medicine Section as Councillor as well. She led or served in various committees including Wellness and EMS.

With each endeavor, Melissa has built upon and proven her ability to lead by determination and dedication to strengthening the future of ACEP. In addition to these activities, she is a full-time active clinician in Alabama, Mississippi, and Florida and leads four different agencies as EMS Medical Director. I would respectfully ask that you join our Chapter in support of the election of Melissa Costello, MD, FACEP, as Vice Speaker of the American College of Emergency Physicians.

Bryan Balentine, MD, FACEP

Bryan Balentine, MD, FACEP
President
ALACEP

Melissa Wysong Costello, MD, MS, FACEP, FAEMS

Dear Colleagues/Friends,

Shakespeare said that "brevity is the soul of wit," so I hope that you will all find this message terribly witty indeed. As I write (in August) it is still unclear whether Council will meet in person or remotely. Either way, the elections will move forward and it is my hope that all of you will have the opportunity to vote for me as your new Council Vice-Speaker.

My goals are simple: I want to work with the Council leadership, the Board of Directors and the ACEP staff to help us run our Council meetings as efficiently and effectively as possible. I want to make the most of the limited time that we all have together. Traditional Council format compresses the entirety of our formal policy-making into just eleven hours per year and limits testimony to those in the room. Last year's addition of asynchronous testimony was an innovation that gave a voice to many more members. I feel strongly that more input leads us to better policy and that, in addition to keeping the asynchronous testimony necessitated by COVID, we need to look for new ways to engage more members in the Council business. This year will have the largest number of resolutions ever handled by our deliberative body, and as the volume of our business grows, we will need to have efficient and effective leadership from the Speaker and Vice-Speaker to keep business moving while ensuring fair, diverse and representative testimony.

The role of the Speaker and Vice-Speaker changes after the meeting from facilitator to advocate. They become the impartial voice of the Council for the subsequent year of Board business. They ensure that the policy-making at the Board does not lose sight of the original intent of the Council. Communication about these meetings and solicitation of Council input when there are debates is a year-round commitment. I have been fortunate to have some amazing role models to follow into this responsibility and I look forward to the opportunity to serve in this role. I ask for your vote and support to become the newest ACEP Vice-Speaker.

Effective, efficient & collaborative meetings

* * *

An impartial voice for the Council

* * *

Tradition with technology

* * *

Connection between the Board and Council

Melissa Costello

MD, MS, FACEP, FAEMS

Vice Speaker

Candidate

Sponsored by the Alabama Chapter of ACEP

Melissa Wysong Costello, M.D., M.S., FACEP, FAEMS

emsdoc1@gmail.com
109 Myrtlewood Lane, Mobile, Alabama 36608
*251-753-2698 (cell) 251-202-9110 (google voice) 251-652-3133 (home)

Education:

Arizona State University, Tempe, AZ
Master of Science, Science of Health Care Delivery, Dec 2019
University of Alabama School of Medicine, Birmingham, AL
Doctor of Medicine, May 2000
Georgetown University, Washington, DC
Bachelor of Science in Biology, May 1995

Internship/Residency Training:

Johns Hopkins University School of Medicine, Baltimore, MD
Emergency Medicine: 2000-2003

Board Certifications:

American Board of Emergency Medicine
Emergency Medicine – 2004, current including MOC through 12/31/2024
Emergency Medical Services – 2013, current including MOC through 12/31/2023

Current Clinical Appointments:

Singing River Hospital System, Pascagoula, Mississippi
Staff Emergency Physician - Emergency Room Group, LLC 1/2019-present

Mobile Infirmary Medical Center, Mobile, Alabama
Staff Emergency Physician: Baldwin Emergency Group 12/2018-present
Facility Medical Director-Emergency Medicine: TeamHealth 7/2014-11/2018

AirMethods Corporation, Denver, CO
Clinical Appeals Consultant/Utilization Review 1/2017-present

EMS Medical Director Positions:
Mobile Fire &Rescue, Urban Search and Rescue 6/2006-present
Federal Bureau of Investigation, Mobile Division, SWAT Medical 9/2007-present
Baptist LifeFlight/Alabama Lifesaver/AirMethods 11/2008-present
Mobile Police Department, Police Surgeon 2/2016-present

US Department of Health and Human Services: NDMS
Medical Officer – Trauma Critical Care Team -South (TCCT-S) 10/2018-present
Supervisory Medical Officer: AL-3 DMAT 10/2003-10/2018

Credentials:

Licenses:

Alabama: exp. 12/31/21 with unrestricted DEA/ACSC
Mississippi: exp. 06/30/2021
Georgia: exp. 7/31/2021
Florida: exp. 1/31/2023
DEA X-Waiver with MAT training 6/2020

Fellow, American College of Emergency Physicians (FACEP), 2006
Fellow, National Association of EMS Physicians (FAEMS), 2016
Epic: Physician Builder Certified 11/2016
Lean Six Sigma: Green Belt: April 2018
Biocontainment Training: November 2019
Specialized immersive training in the University of Nebraska Biocontainment Unit via the NDMS Isolation, Simulation and Quarantine Program for highly infectious diseases.
COVID-19 Experience:
Full-time EM employment throughout COVID-19 beginning in March 2020. Hospital census at COVID peak was 110 with 20+ on vents.
Vaccine – Pfizer 12/16/2020 and 1/6/2021

Previous Positions:

Singing River Hospital System, Pascagoula, MS 10/2010-8/2014
Emergency Physician/Partner, Emergency Room Group, LLC
Acadian Ambulance 6/2011-5/2014
EMS Medical Director, Mississippi Operations
University of South Alabama College of Medicine, Mobile, Alabama 7/2003-9/2010
Associate Professor of Emergency Medicine (adjunct 2010-2019)
Adjunct Assoc. Professor of EMS Studies
Joint Associate Professor of Physician Assistant Studies
Clinical Instructor – Pediatric Emergency Medicine
Providence Hospital, Mobile, Alabama 2/2008-12/2010
Emergency Physician-Department of Emergency Medicine
Gulf Coast MedEvac, Helicopter EMS, Mobile, Alabama 3/2006-9/2008
Medical Director, AirMethods Corporation
South Baldwin Regional Medical Center 10/2005-9/2007
Emergency Physician- Emerald Healthcare Group, LLC

Consulting:

Subject Matter Expert for Emergency Medicine and EMS:
Independent Review Panel Aurora, CO: 2020-2021
Expert Witness Consulting for Emergency Medicine and EMS – since 2007

Awards and Appointments:

American Board of Emergency Medicine
- Oral Board Examiner: 2008-present

American College of Emergency Physicians
- Wellness Committee: 2020-2022
- Steering Committee: 2017-2019
- Education-EMS Subcommittee: 2015-21
- Tellers, Elections and Credentials Committee: 2012-2019 Chair 2014-18
- EMS Committee: 2008-2015, Chair: 2011-2014
- EMS Section: Councilor: 2009, Sec-Treas: 2012 Chair-elect: 2014 Chair: 2016-18
- Tactical Medicine Section: Councilor 2007-2012
- Excited Delirium Task Force: 2008-2009
- EMS Subspecialty Board Review: Course Committee 2012-2014
- ACEP/Emergency Medicine Foundation Teaching Fellowship: 2006

Alabama ACEP
- Board of Directors 2008-2016
- President 2014-15
- Councilor/Alt Councilor 2012-present

Mobile Infirmary Medical Center
- Chair, Critical Care Committee: 2016-2018
- Medical Executive Committee: Division Representative 2016-2018
- Electronic Health Record Committee: 2015-present

TeamHealth
- Nomination for Medical Director of the Year for Southeast Group: 2017

American Medical Association
- 2008 Excellence in Medicine Leadership Award

Alabama Office of EMS and Trauma
- EMS Advisory Committee Chair 2009-2011, HEMS subcommittee

Mississippi Office of EMS
- EMS Performance Improvement Committee 2012-2015

Mississippi Department of Public Health:
- Trauma System Surveyor 2015-present

Mobile County EMS Systems
- Board of Directors, 2007-present

University of South Alabama College of Medicine
- Faculty Senator: 2004-2006
- Admissions Committee: 2005-2008
- Red Sash Teaching Award: 2004, 2005, 2007, 2008, 2009

Medical Association of the State of Alabama
- Vice-President 2010-2011
- Chair, Young Physician Section, 2006-2009
- Council on Medical Education 2005

Residency and Student Activities:

United States Secret Service
- Clinical Instructor- Paramedic Refresher Courses 2001-2003
- Medical Support- 2002 Olympic Winter Games, Salt Lake City, UT
- Instructor- USSS Rescue Swimmer Certification Course

Medical Association of the State of Alabama (MASA)
- State Chair: MASA-MSS 1999-2000

University of Alabama School of Medicine
- Class President, Tuscaloosa Class of 2000,
- Honor Court, 1998-2000

Personal:

Spouse: Sean P. Costello, United States Attorney Southern District of Alabama, Criminal Chief
Children: Catherine (18), Ashley (16), Reagan (14)

Publications:

Refereed/Peer Reviewed

- Vilke GM, Debard ML, Chan TC, Ho JD, Costello MW, et al. "Excited Delirium Syndrome (ExDS): Defining Based on a Review of the Literature". *J Emerg Med.* 2011 Mar 24.
- Costello MW, Bolling R., Gonzalez R. "Colon Perforation with High Pressure Water Injection – a Case Report". *Journal of Trauma: Injury Infection and Critical Care*. 65(1):222-224, July 2008.
- Costello MW, Heins A, Zirkin D. "North American Snake and Scorpion Envenomation: Diagnosis and Treatment". *Emergency Medicine Practice*. September 2006.
- Heins A, Grammas M, Heins JK, Costello M, Huang K, Mishra S. Determinants of variation in analgesic and opioid prescribing practice in an emergency department. *Journal of Opioid Management*. 2006;2(6):335-340.
- Heins JK, Heins A, Grammas M, Costello M, Huang K, Mishra S. Disparities in Analgesia and Opioid Prescribing Practices for Patients with Musculoskeletal Pain in the Emergency Department. *J Emerg Nurs*. 2006:32:219-24.
- Costello MW. "Images in Emergency Medicine: Atlanto-occipital dislocation (AOD)". *Annals of Emergency Medicine*. 44(3): 277, 2004 Sep.

Other Publications

- Smith J, Costello MW, Villasenor R. Investigation Report and Recommendations, City or Aurora, Colorado February 22, 2021. Available at: https://www.auroragov.org/news/whats_new/independent_report_released_in_mc_clain_case
- Costello MW. 5 chapters in Mattu A, Chanmugam A et al (Eds) Avoiding Common Errors in the Emergency Department. Lippincott 2010.
- AAOS, ACEP, UMBC Authors (Costello MW - Reviewer) Critical Care Transport. Jones & Bartlett 2009.
- Costello MW. EMRA Top 30 Clinical Problems in Emergency Medicine. 2nd edition. Editors: Katz G, Moseley M. June 2008.
- Costello MW, McNair WS. Intussusception. Chpt 34 In Cline D, Stead L Abdominal Emergencies. McGraw Hill 2007.
- Costello MW. "Ultrasound Guided Vascular Access". ACEP News. 2005 Dec.
- Costello MW. "Tissue Plasminogen Activator in Advanced Cardiac Life Support". Practical Reviews in Emergency Medicine. 2003.
- Wysong MH. "P31 NMR Spectroscopy in Highly Trained Athletes"; Georgetown University Senior Thesis 1995
- Ward KM, Rajan SS, Wysong M, Radulovic D, Clauw DJ. Phosphorus nuclear magnetic resonance spectroscopy: in vivo magnesium measurements in the skeletal muscle of normal subjects. [Journal Article] Magnetic Resonance in Medicine. 36(3):475-80, 1996 Sep.

Poster Presentations

- Heins A, Grammas M, Heins JK, Costello M. Disparities in Emergency Department (ED) Pain Management. SAEM Annual Meeting, New York, NY. May 2005.

Significant Lectures/Presentations/Speaking Engagements:

- Air Methods: New Hire Orientation Cadaver Lab instructor (quarterly 12/2017-12/2018)
- ACEP Scientific Assembly 2017: Weed Wars and Gun Battles 10/2017
- Air Methods: Case Reviews in Airway and Vent Management 8/2016
- Pinnacle EMS Conference: Understanding Current EMS Research 7/2016
- TeamHealth: 2-day High Fidelity Simulation Education for Emergency Medicine 6/2016
- Assoc. for Prof in Infection Control and Epidemiology: Sepsis Care for EMS/ED 4/2016
- Mobile Infirmary Stroke Symposium: Golden Hour of Stroke Care 3/2015
- Surviving Trauma Conference: 10 Commandments of EMS 11/2014
- Mississippi Trauma Symposium: Ketamine and Tourniquets 5/2014
- Gathering of Eagles: Ketamine: Another Way to Break the Ache 2/2014
- ACEP/NAEMSP EMS Board Review Course Faculty: 8/2012,9/2013, 10/2013
- Mississippi Trauma Symposium 5/2013
- Surviving Trauma Conference: Bomb and Blast Injury 11/2012
- Mississippi Stroke Symposium: Golden Hour of Stroke Care 6/2012
- Surviving Trauma Conference: EMS and Law Enforcement 11/2011
- Tactical Medicine 3-day Course Faculty: 8/2011
- Gulf Coast Regional Trauma Symposium: Tactical Emergency Medicine 11/2010
- Homeland Security Professionals Conference: Tactical EMS for Law Enforcement, 10/2010
- Gulf Coast Regional Trauma Symposium: Pediatric Trauma, 8/2010
- Orthopedics Grand Rounds, Procedural Sedation and Regional Anesthesia, 12/2009
- AMEC, Difficult Airway Management for EMS, 2/08, 11/08, 7/09, 8/09, 5/10, 8/10
- NDMS Training Summit, The Use of Real-time Ultrasound in DMAT: 3/08, 4/09
- Surgery Grand Rounds, Post-Disaster Medical Care 2/2009
- Gulf Coast Regional Trauma Symp., Disaster Preparedness for Medical Providers, 9/2008
- FBI, Buddy Aid and Basic First Aid for the SWAT operator, 11/2007
- NDMS Conference, The Use of Real-time Ultrasound in DMAT 3/2007
- ACEP New Speakers Bureau, Cocaine Overdose: An Unexpected Source, 10/2006
- Gulf Coast Regional Trauma Symposium, Post-Disaster Medical Care, 4/2006
- Teaching Fellowship, Ultrasound Curriculum for EM Faculty, 3/2006
- American Medical Women's Association, Balancing Life and Medicine, 3/2005

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2021 COUNCIL VICE SPEAKER CANDIDATE WRITTEN QUESTIONS

Kurtis A. Mayz JD, MD, MBA, FACEP, FACLM

Question #1: How do you see yourself advocating for the College as a non-voting participant at ACEP Board meetings?

As Vice Speaker the job of advocacy as a non-voting member of the Board starts long before seated in the boardroom. Effective advocacy involves establishing relationships and a friendly rapport with both members of the Council and the Board, as well as members of the College. That process leads to the sense of mutual trust which helps the Vice Speaker effectively advocate for the Council. If I have the honor of becoming Vice Speaker, I will work with the Speaker to cultivate these relationships in order to help the Council reach its goals and objectives. Discussing issues in both a personal as well as group setting is instrumental in guiding the Board in the direction that the Council has intended to go. This is instrumental in achieving what is most important to me, the will of the Council.

As Vice Speaker, I will work with the Speaker to keep the Council informed of current events. I will engage the membership, soliciting their valuable input so I can strongly advocate for them when I meet with the Board. I will synthesize and distill the Council meeting testimony and directives from the Council resolutions and use that information to formulate and support arguments which uphold the principles set forth by the Council.

As an advocate for the Council and membership at large, I see the Vice Speaker role as at times a partner and other times the loyal opposition to the Board. Sometimes partnering, and sometimes challenging them to consider issues from the broader perspective of the entire College. As a skilled advocate, my job is to understand the position of the Council, understand what is important to the Board, and why those ideas are important. That way, when you graciously cast your vote for me as Vice Speaker, I am convinced that I can help craft solutions that create the win/win scenarios which ultimately benefit all of us.

Question #2: **Do you think governance changes need to be made within ACEP? Why or why not?**

I view the governance structure of ACEP in four component parts: the Executive and non-physician leadership team, the Board, the Council, and the administrative and procedural rules governing the College.

I believe that we have an outstanding Executive Director and non-physician leadership team and our leadership structure in this area should remain intact.

Ultimately, management and control of ACEP is vested in the Board of Directors. This responsibility requires a fluid diversity of expertise that changes over time, meeting whatever challenges arise. This requires the flexibility to choose leaders that best meet the needs of the Board without artificially limiting its composition. However, as a young, Hispanic physician leader, I believe that diversity and inclusion are also important and grown organically from our wealth of talent. We must continue creating a diverse group of leaders with exceptional expertise. National and state chapter leadership development programs should be used to identify a diverse leadership base, identify particular areas of professional interest, and develop these interests. As we do this, I remain confident in the members of the Council to help identify the needs of the College and best select the right candidate for the times. This process will ultimately lead to better governance.

As the College continues to grow, the size of the Council will need to be addressed. As a representative body we need to balance that representation with the need to be able to effectively and efficiently conduct business. As our College grows I do believe we will need to limit the size of the Council to be able to conduct our business, but I am not in favor of decreasing the current size of the Council. I am in favor of having a conversation as a Council about where that critical mass of Councillors lies and believe that now would be a reasonable time to do so. Once we reach that critical point we will need to re-apportion our representative formula accordingly. However, this change should not alter the current forms of representation (chapters, sections, component bodies), as I believe each of these serve a specific diversity of interests and ideas that is important to the College.

As a member of the Bylaws committee, I feel the pain that individual chapters endure with the never ending cycle of regulatory review. This process is harder on smaller chapters. I would advocate for a longer, 5 year cycle of review which allows for timely review while providing chapter relief from the arduous task of perpetual rule making. We should continue to explore avenues through which smaller chapters can use already built ACEP resources or share burdens with other small chapters. This could help them to continue to have their own independent voice while maintaining the structural standards of an effective ACEP chapter.

Question #3: **What do you think works well for the Council meeting operations and how would you improve the councillor experience?**

I want every Councillor's voice heard. One lesson learned from our 2020 meeting was a more longitudinal Council timeline is beneficial to that process. The use of asynchronous testimony was instrumental in the success of the meeting and we should continue to develop that process further. The development of Council work-groups on "hot button" issues could help facilitate the creation of resolutions as well as limiting the sometimes duplicative nature of resolutions. In doing so, we create a more contemplative environment during which ideas can be more thoroughly vetted and refined prior to the Council meeting, with the goal of making the meeting more streamlined and efficient. 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.

Council and Council meeting procedure education would help enhance the efficiency of meetings. Approximately one-third of our Councillors are new each year. We currently rely on new Councillor orientation to introduce the Council and its procedures. As the Council work becomes longer in scope and timeline, it would help to have 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 so we are ready to work when the gavel hits. As chair of the Council meeting subcommittee, I advocated 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 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.

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. 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, FACEP, FACLM

Contact Information

1 E Main
Suite 404
Champaign, IL 61820
Phone: 914-420-7927
E-Mail: drmayzesq@gmail.com

Current and Past Professional Position(s)

Chairman and Medical Director, Vice Chair and Associate Medical Director, Assistant Medical Director- Presence Saint Joseph Medical Center, Joliet, IL

Emergency Medicine Physician- Genesys Regional Medical Center, Grand Blanc, MI

Emergency Medicine Physician- Heart of Mary Medical Center Urbana, IL

Traveling Emergency Medicine Physician- United States Acute Care Solutions

Education (include internships and residency information)

BA: Political Science; BA: Biology
Certificate in Lobbying: Center for Congressional and Presidential Studies
The American University, Washington, DC

Masters of Business Administration: Medical Scholars Program
University of Illinois, Champaign-Urbana, Illinois

Juris Doctor: Medical Scholars Program
University of Illinois, Champaign-Urbana, Illinois

Medical Doctor: Medical Scholars Program
University of Illinois, Champaign-Urbana, Illinois

Emergency Medicine Resident
Stony Brook University Medical Center, Stony Brook, New York

Chief Resident, Emergency Medicine, Patient Safety and Quality Improvement
Stony Brook University Medical Center, Stony Brook, New York

Pediatric Emergency Medicine Fellowship
University of Michigan Health System, Ann Arbor, Michigan

GME Scholars Program: Healthcare Administration Certificate
University of Michigan Health System, Ann Arbor, Michigan

Specialty Board Certifications(e.g., ABEM, AOBEM, AAP, etc.) and dates certified and recertified)

American Board of Emergency Medicine- Emergency Medicine

American Board of Emergency Medicine-Pediatric Emergency Medicine

Professional Societies

National Association of Parliamentarians
American Academy of Emergency Medicine
American Academy of Pediatrics
American Bar Association
American College of Emergency Physicians
American College of Legal Medicine
American Health Lawyers Association
American Medical Association
Emergency Medicine Resident Association
Illinois College of Emergency Physician
New York State Bar Association

National ACEP Activities – List your most significant accomplishments

Council Steering Committee- (Chair of Council Meeting Subcommitee)

Council Reference Committee

Council Tellers Committee

Council Special Task Force on Elections

ACEP Bylaws Committee

ACEP Medical Legal Committee

ACEP Pediatric Emergency Medicine Committee

ACEP Educational Faculty

ACEP Chapter Activities – List your most significant accomplishments

Illinois ACEP Councilor
Legislative Advocacy

Practice Profile

Total hours devoted to emergency medicine practice per year: **1600** Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.

Direct Patient Care **100** % Research **0** % Teaching **0** % Administration **0** %

Other: _____ ____%

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

Corporate Medical Group- Traveling physician licensed in 10 states, pediatric and general emergency medicine, rural, suburban, urban, academic and non-academic settings.

Provide specific title(s) or position(s) within your group, hospital, department, system (e.g., Medical Director, Regional Director, Director of Quality, Vice President, Chief of Staff, etc.)

No Current Title- Previously Medical Director, Associate Medical Director and Assistant Medical Director

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

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DISCLOSURE STATEMENT

Kurtis A. Mayz JD, MD, MBA, FACEP, FACLM

1. Employment – *List current employers with addresses, position held and type of organization.*

Employer: United States Acute Care Solutions

Address: 4335 Dressler Ave NW

Canton, OH 44718

Position Held: Traveling Physician (Firefighter)

Type of Organization: Corporate Medical Group

Employer: Envision Physician Services

Address: 1A Burton Hills Blvd

Nashville, TN 37215

Position Held: Staff Physician- Heart of Mary Medical Center, Urbana, IL

Type of Organization: Corporate Medical Group

2. Board of Directors Positions Held – *List all organizations and addresses for which you have served as a board member – including ACEP chapter Board of Directors. Include type of organization and duration of term on the board.*

Organization: _____

Address: _____

_____

Type of Organization: _____

Duration on the Board: _____

Organization: _____

Address: _____

_____

Type of Organization: _____

Duration on the Board: _____

I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

X NONE

☐ If YES, Please Describe:

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) a an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

X NONE

☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

X NONE

☐ If YES, Please Describe:

5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

X NONE

☐ If YES, Please Describe:

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

X NO

☐ If YES, Please Describe:

I certify that the above is true and accurate to the best of my knowledge:

Date 6/17/2021

Illinois College
of Emergency Physicians
ADVANCING EMERGENCY CARE ICEP.org
3000 Woodcreek Drive, Suite 200, Downers Grove, IL 60515 phone: 630.495.6400 toll-free: 888.495.ICEP fax: 630.495.6404

Dear Councillors,

It is with great excitement and enthusiasm that the Illinois College of Emergency Physicians endorses Kurtis A Mayz, JD, MD, MBA, FACEP, for Vice Speaker of the Council of the American College of Emergency Physicians. Dr. Mayz first joined the College as a medical student at the University of Illinois and later returned to Illinois to become a full and active member of our chapter after residency and fellowship training.

While a member of ICEP, Dr. Mayz has continued to lend his expertise and engagement to our Council delegation and our chapter. Dr. Mayz consistently reviews resolutions and provides cogent and constructive feedback which has been helpful to our Council delegation as we prepare for the annual meeting. As a member of the National Association of Parliamentarians and a candidate for the Registered Parliamentarian credential, Dr. Mayz is versed in parliamentary procedure and has helped our delegation work through the procedural aspects of the Council. As a member of the ACEP Bylaws Committee, Dr. Mayz has a working knowledge of the College rules and can be counted on to provide guidance consistent with those rules to our chapter. In addition to his Council service, Dr. Mayz has been an active voice and participant in our legislative advocacy efforts.

Dr. Mayz has also continued to contribute valuable expertise to the ACEP Council at large. He has served on reference committees and has consistently worked to synthesize the testimony given and work with the committee to frame resolutions and provide recommendations in ways that aim to build consensus on the floor of the Council. In addition, Dr. Mayz has served on the Steering Committee of the Council, where he has also chaired the subcommittee on the Council meeting, working to ensure that the agenda for the Council meeting continues to provide for an efficient forum with which to conduct business. Most recently he has also served on the Council Tellers and Credentials Committee.

As a former medical director, Dr Mayz understands what it means to lead a team of physicians. As a traveling physician, Dr. Mayz's clinical practice has taken him to several states across the country working in many different practice environments in 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 and will undoubtedly bring these skills to bear as Vice Speaker and advocate for the Council. He has already demonstrated this through his service on the ACEP Bylaws and Medical-Legal Committees and as ACEP faculty, teaching in the areas of medical-legal and risk management.

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. His diverse training and practice experience make him uniquely qualified to serve as an effective Vice Speaker, a 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 Illinois College of Emergency Physicians unequivocally endorses Dr. Kurtis A Mayz JD, MD, MBA, FACEP for Vice Speaker of the Council of the American College of Emergency Physicians and looks forward to his dedicated service.

Sincerely,

Chrissy Babcock, MD, FACEP
President

Kurtis A. Mayz, JD, MD, MBA, FACEP, FACLM

Fellow Councillors:

Thank you for your efforts to advance emergency medicine during this challenging time, 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 has taught us that we must continue to keep pace with the changing flow of information and be nimble in the way we conduct business. I will work to improve processes by leveraging technology and resources to create an effective environment to conduct Council business.

As a first generation Venezuelan-American I recognize the importance of diversity and inclusion. I am the product of leadership that believed in me as a resident physician and continued to encourage me and provide opportunities for me to engage in the College. Ultimately this led to the opportunity to lead. We need to continue to work towards a leadership that is as diverse as our membership and our patients. We need to create and foster opportunities for leadership development amongst our diverse group of members. I will work to create opportunities to develop Council leaders that embody this goal.

As Vice Speaker I will listen as effectively as I speak, guide as effectively as I lead, and encourage as effectively as I advocate. Thank you for this opportunity to serve you, as I work to ensure ***your voice is heard***.

Respectfully,

Kurtis

ELECT MAYZ
VICE SPEAKER

ELECT

KURTIS A MAYZ

JD,MD,MBA,FAAP,FCLM,FAAEM,FACEP

ACEP
VICE SPEAKER

"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

Council

- Steering, Reference, and Tellers Committees
- Chair- Steering sub-comittee on Council Meeting
- Member- Special task force on elections

Clininical

- Emergency Medicine and Pediatric Emergency Medicine
- Former Medical Director- Experience leading a team of physicians
- Traveling Physician- licensed in 10 states, academic, non-academic, urban, suburban, and rural settings, has a broad understanding of what it is like to practice EM across the country
- Telemedicine physician

Professional

- National Association of Parliamentarians- Member and Registered Parliamentarian candidate. Experience with parliamentary procedure and meeting facilitation.
- 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 my 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

Illinois College of Emergency Physicians

Kurtis A Mayz, JD, MD, MBA, FAAP, FAAEM, FACEP, FACLM

1 East Main St
Unit 404
Champaign, IL 61820
drmayzesq@gmail.com
914-420-7927

Education

08/2008-05/2011	Masters of Business Administration: Medical Scholars Program University of Illinois, Champaign-Urbana, Illinois
08/2006-05/2011	Medical Doctor: Medical Scholars Program University of Illinois, Champaign-Urbana, Illinois
08/2004-12/2006	Juris Doctor: Medical Scholars Program University of Illinois, Champaign-Urbana, Illinois
08/2000-05/2004	BA: Political Science; BA: Biology Certificate in Lobbying: Center for Congressional and Presidential Studies The American University, Washington, DC

Post Graduate Training

07/2014-06/2016	Pediatric Emergency Medicine Fellowship University of Michigan Health System, Ann Arbor, Michigan
07/2013-06/2014	Chief Resident, Emergency Medicine, Patient Safety and Quality Improvement Stony Brook University Medical Center, Stony Brook, New York
07/2011-06/2014	Emergency Medicine Resident Stony Brook University Medical Center, Stony Brook, New York

Post Graduate Certifications

06/2019	National Association of Parliamentarians- Member (Registered Parliamentarian Candidate- In Progress)
09/2014-04/2016	GME Scholars Program: Healthcare Administration Certificate University of Michigan Health System, Ann Arbor, Michigan
2013	ACEP Emergency Department Director's Academy: Phase 1 American College of Emergency Physicians, Dallas, TX
08/2004-05/2006	Graduate Teaching Certificate University of Illinois, Champaign-Urbana, Illinois

Board Certifications

2019	American Board of Emergency Medicine-Pediatric Emergency Medicine
2016	American Board of Emergency Medicine

Medical Licensure

California
Connecticut
Florida
Illinois
Maryland
Michigan
Ohio
Oklahoma
New York
Pennsylvania

Legal Licensure

2008-Present	New York State Bar
2007-Present	New Jersey State Bar
2007-Present	Federal District Court of New Jersey Bar
2005-Present	Notary Public: State of New York

Certifications

2011-Present	Advanced Cardiac Life Support (ACLS)
2011- Present	Advanced Trauma Life Support (ATLS)
2011-Present	Pediatric Advanced Life Support (PALS)
2014	Neonatal Resuscitation Program (NRP)
2013	Difficult Airway Course

Work Experience-Medical

11/2018- Present	Emergency Medicine Physician Envision Physician Services Heart of Mary Hospital, Urbana, IL
1/2017-Present	Firefighter (Traveling Physician) United States Acute Care Solutions
11/2017-09/2018	Emergency Medicine Physician CEP America Presence Saint Joseph Medical Center, Joliet, IL
9/2017-10/2017	Associate Director and Vice Chairman-Department of Emergency Medicine United States Acute Care Solutions (USACS) Presence Saint Joseph Medical Center, Joliet, Illinois
5/2017-8/2017	Interim Medical Director and Chairman- Department of Emergency Medicine United States Acute Care Solutions (USACS) Presence Saint Joseph Medical Center, Joliet, Illinois
7/2016-4/2017	Assistant Director-Department of Emergency Medicine United States Acute Care Solutions (USACS) Presence Saint Joseph Medical Center, Joliet, Illinois
11/2014-6/2016	Attending Physician- United States Acute Care Solutions (USACS) Genesys Regional Medical Center, Grand Blanc, Michigan

Work Experience-Legal

2/2020-Present	Medical Legal Mayz Consulting, LLC Champaign, IL
5/2005-8/2005	Law Intern-Hon. William K Nelson New York State Supreme Court, New City, New York

Research Interests

1. Risk Management and Medical Legal Review
2. Patient Safety and Quality Improvement
3. Operations

Committee Appointments

National

2020-21	ACEP Council Steering Committee American College of Emergency Physicians, Dallas, TX
2020-21	ACEP Council Tellers and Credentials Committee American College of Emergency Physicians, Dallas, TX
2019-20	ACEP Council Reference Committee American College of Emergency Physicians, Dallas, TX
2020	Risk-Underwriting Committee United States Acute Care Solutions, Canton, OH
2019-Present	Bylaws Committee American College of Emergency Physicians, Dallas, TX
2017-Present	Claims Committee United States Acute Care Solutions
2016-Present	Risk Management Committee United States Acute Care Solutions, Canton, OH
2015-Present	Medical Legal Committee Sub-committee Chair: Criminal vs Civil Testimony for ED Physicians (2016) American College of Emergency Physicians, Dallas, TX
2016-2020	Political Action Committee: Board of Directors United States Acute Care Solutions, Canton, OH
2014-2018	Pediatric Emergency Medicine Committee American College of Emergency Physicians, Dallas, TX
2012-2014	Health Policy Committee Emergency Medicine Residents Association, Dallas, TX

Local

2015-2016	Medical Legal Review Committee University of Michigan Health System, Ann Arbor, MI
2013-2014	Hospital Quality Assurance Review Committee Stony Brook University Medical Center, Stony Brook, NY
2013-2014	Emergency Medicine Quality Improvement Committee Stony Brook University Medical Center, Stony Brook, NY

2012-2014	Hospital Patient Safety Committee Stony Brook University Medical Center, Stony Brook, NY
2011-2014	Graduate Medical Education Committee Stony Brook University Medical Center, Stony Brook, NY
2009-2011	Progress and Promotions Committee University of Illinois, Champaign-Urbana, Illinois
2004-2011	Medical Scholars Program Advisory Committee University of Illinois, Champaign-Urbana, Illinois

Honors and Awards

2019	Finalist: Firefighter-Physician of the Year United States Acute Care Solutions
2015	Emeriquiz Best Case Discussant American Academy of Pediatrics Annual Meeting
2013	Emergency Department Directors Academy Scholarship Emergency Medicine Residents Association, Dallas, TX
2012	Leadership and Advocacy Scholarship Emergency Medicine Residents Association, Dallas, TX
2009	Beta Gamma Sigma Business Honor Society University of Illinois, Champaign-Urbana, Illinois
2008	NSHMBA Foundation Scholar National Society of Hispanic MBAs, Irving, TX
2006-2010	List of Teachers Rated as Excellent (9 semesters) University of Illinois, Champaign-Urbana, Illinois
2004	Land of Lincoln Legal Scholarship University of Illinois, Champaign-Urbana, Illinois

Professional Societies

2014-Present	American College of Emergency Physicians
2008-Present	Emergency Medicine Resident Association American College of Emergency Physicians
2008-Present	American Academy of Pediatrics
2008-Present	American College of Legal Medicine

2004-Present	American Bar Association
2004-Present	American Health Lawyers Association
2004-Present	American Medical Association
2011-2016	Society for Academic Emergency Medicine

Community and Professional Service

2016-Present	Litigation Stress Support Team: United States Acute Care Solutions
2012-Present	Leadership and Advocacy- Legislative Advocacy American College of Emergency Medicine
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)
2007-2011	Competition Judge: Moot Court, Client Counseling, Negotiations University of Illinois College of Law, Champaign-Urbana Illinois

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

10/2021 *Little Plaintiffs, Big Lawsuits*
ACEP21: ACEP National Conference, Boston, MA (invited)

10/2021 *Liability Concerns & Controversies Working with Non-Physician Providers*
ACEP21: ACEP National Conference, Boston, MA (invited)

10/2021 *Top 5 Legal Risks in 5 minutes or Less*
ACEP21: ACEP National Conference, Boston, MA (invited)

10/2020 *Little Plaintiffs, Big Lawsuits*
ACEP20: ACEP National Conference, Dallas, TX (virtual)

10/2019 *Double Jeopardy: Risk in Psychiatry*
ACEP19: ACEP National Conference, Denver, CO

10/2019 *Smile: You're on Candid Camera: Invasions of Privacy in the ED*
ACEP19: ACEP National Conference, Denver, CO

10/2018 *Double Jeopardy: Risk in Cardiology*
ACEP18: ACEP National Conference, San Diego, CA

10/2018 *Can I Get A Witness? Tricks and Tips for Being an Effective Witness*
ACEP18: ACEP National Conference, San Diego, CA

10/2017 *Can I Get A Witness? Tricks and Tips for Being an Effective Witness*
ACEP17: ACEP National Conference, Washington, DC

10/2015 *Can I Get A Witness? Tricks and Tips for Being an Effective Witness*
ACEP15: ACEP National Conference, Boston, MA

10/2015 *16 year old Male with Altered Mental Status*
Discussant: *And that's when I thought I had died*
Emergiquiz: 2015 American Academy of Pediatrics, Washington, DC

State/Local

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
04/2008, 10/2008 Rockland County Fire Training Center, Pomona, NY

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

ACEP HONORS 2021 LEADERSHIP & EXCELLENCE AWARD RECIPIENTS

The 2021 American College of Emergency Physicians Awards Program honors leadership and excellence.

The program provides an opportunity to recognize all members for significant professional contributions as well as service to the College. All members of ACEP are eligible to participate in one or more of the College's award programs.

John G. Wiegenstein Leadership Award

Jay A. Kaplan, MD, FACEP

Presented to a current or past national ACEP leader for outstanding contribution to the College. The award honors the late John G. Wiegenstein, MD, a founding member and the first president of ACEP.

James D. Mills Outstanding Contribution to Emergency Medicine Award

James J. Augustine, 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

Susan M. Nedza, MD, MBA, FACEP

Presented to a member who has made a significant contribution to achieving the College's health policy objectives, or who has demonstrated outstanding skills, talent and commitment as an administrative or political leader. The award is named after Colin C. Rorrie, Jr., PhD, who served as ACEP's Executive Director from 1982 to 2003.

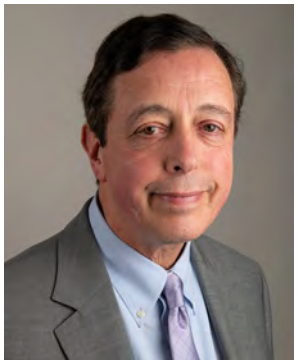
Judith E. Tintinalli Award for Outstanding Contribution in Education

Michael S. Beeson, MD, FACEP

Michael A. Granovsky, MD, FACEP

Recognizes a member who has made a significant contribution to the educational aspects of emergency medicine.

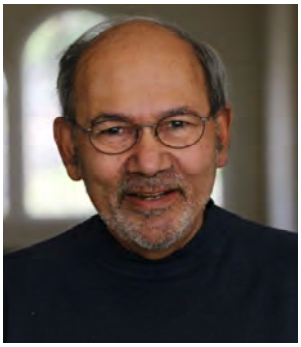
ACEP HONORS 2021 LEADERSHIP & EXCELLENCE AWARD RECIPIENTS



John A. Rupke Legacy Award

Jeffrey D. Bettinger, MD, FACEP

Presented to a current College member for outstanding lifetime contributions to the College. The award honors John A. Rupke, MD, one of the initial founding members of the College.



Award for Outstanding Contribution in Research

Ahamed H. Idris, MD, FACEP

Presented to a member who has made a significant contribution to research in emergency medicine.

Award for Outstanding Contribution in EMS

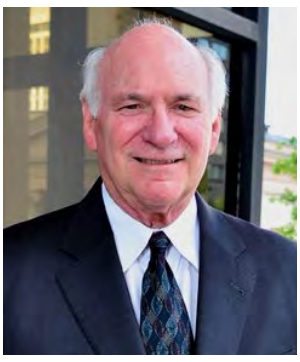
Craig A. Manifold, DO, FACEP (posthumously)

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

Joseph A. Barbera, MD

Recognizes individuals who have made outstanding contributions of national/ international significance or impact to the field of disaster medicine.



Council Meritorious Service Award

Sanford H. Herman, MD, FACEP

Recognizes consistent contributions to the growth and maturation of the ACEP Council.

ACEP HONORS 2021 LEADERSHIP & EXCELLENCE AWARD RECIPIENTS

Community Emergency Medicine Excellence Award

Michael A. McGee, MD, MPH, FACEP

Recognizes individuals who have made a significant contribution in advancing emergency care and/or health care within the community in which they practice.

Innovative Change in Practice Management Award

Matthew Rill, MD, FACEP

This annual award is given to an emergency physician who has developed an innovative process, solution, technology or product to solve a significant problem in the practice of emergency medicine.

Pamela P. Bensen Trailblazer Award

Rita Manfredi-Shutler, MD, FACEP

The Pamela P. Bensen Trailblazer Award is presented to a current College member for seminal contributions over time to the growth of the College and to the specialty of emergency medicine. The award is named after Pamela P. Bensen, MD, a charter member of ACEP and the first woman resident in emergency medicine (1971).

Diane K. Bollman Chapter Advocate Award

Stephanie Butler

The Diane K. Bollman Chapter Advocate Award is presented to a current or recent (within the past 12 months) ACEP chapter executive or chapter staff member who has made a significant contribution to advancing emergency care and the objectives of an ACEP chapter and the College. The award is named after Diane K. Bollman, who served as the executive director of the Michigan College of Emergency Physicians for 25 years and was an honorary member of ACEP.

ACEP HONORS 2021 LEADERSHIP & EXCELLENCE AWARD RECIPIENTS

Honorary Membership Award

Sally Winkelman

Presented to individuals who have rendered outstanding service to the College or the medical profession.

Policy Pioneer Award

Jordan GR Celeste, MD, FACEP

The Policy Pioneer Award is presented to early- and mid-career members who have made outstanding contributions to the College's health policy and advocacy initiatives.

2021 ACEP COUNCIL AWARDS

Council Service Milestone Award

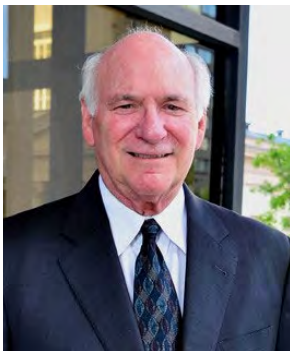
(Staff will identify all who qualify)

Purpose: To commemorate accumulated years of service as a Councillor or Alternate Councillor.

Award: The Award is a pin indicating years of service given at 5-year service intervals.

Criteria: Any member who has served as a Councillor or Alternate councillor. Recipients will be automatically recognized by ACEP staff via the Councillor database.

Presentation: The award is given to individuals at council registration. Recipients will be briefly recognized at the Council luncheon.



Council Meritorious Service Award

Sanford, H. Herman, 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

Hilary E Fairbrother, MD, 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 Champion in Diversity & Inclusion Award

Rebecca B. Parker, MD, FACEP

Purpose: The award celebrates and promotes diversity of experience and thought, the merit of inclusivity, and the value of equity. It is presented to a councillor, group of councillors, or component body that has demonstrated a sustained commitment to fostering a diversity of contributions and an environment of inclusivity that directly enhances the work of the Council and provides excellence to ACEP.

Criteria: The nominee should exemplify service to the College through the promotion of diversity and inclusion. The nominee must demonstrate evidence of having a commitment to the promotion of a diverse leadership and/or membership and/or initiatives related to diversity and inclusion through mentorship, programmatic activities, professional development, and other contributions specifically purposed to promote the mission, support the policies, and enhance the work of the Council and the specialty of emergency medicine.

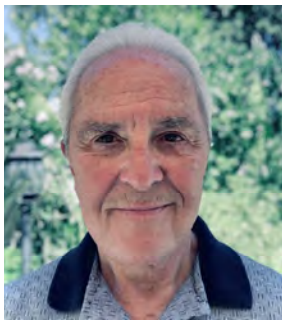
2021 ACEP COUNCIL AWARDS

Council Teamwork Award

Purpose: Presented to a component body or group of councillors to recognize outstanding contributions and participation in Council activities.

Criteria: Contributions to be recognized may include development of important resolutions, significant contributions to Council discussions, etc.

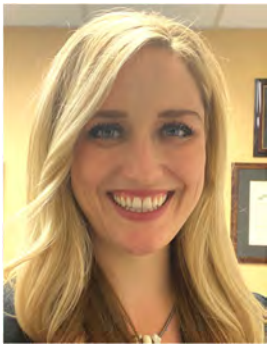
John D. Bibb, MD, FACEP



Fred Dennis, MD, MBA, FACEP

Donald E Stader III, MD, FACEP

Eric Ketcham, MD, MBA, FACEP



Alexis LaPietra, DO, FACEP

Council Curmudgeon Award

David T Overton, 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.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

ACEP Strategic Plan for 2021-2022

Goal 1 –Improve the Delivery System for Acute Care

Objective A Promote and advocate for efficient, sustainable, and fulfilling clinical practice environments.

Objective B Develop and promote sustainable models that leverage technology and ensure patient access to equivalence in unscheduled acute patient care regardless of location.

Objective C Promote the value of emergency medicine and emergency physicians as essential components of the health care system.

Objective D Promote quality and patient safety, including continued development and refinement of quality measures and resources.

Objective E Pursue strategies for fair payment and practice sustainability to ensure patient access to care.

Objective F Develop and implement solutions for workforce issues that promote physician-led teams and sustain quality and patient safety.

Objective G Pursue meaningful medical liability reform and other initiatives at the state and federal levels.

Objective H Position ACEP as a leader in emergency preparedness and response.

Objective I Play a defining role in addressing health care equity in emergency medicine.

Goal 2 – Enhance Membership Value and Member Engagement

Objective A Improve the practice environment and member well-being.

Objective B Increase total membership and retain graduating residents.

Objective C Provide robust communications and educational offerings, including novel delivery methods.

Objective D Increase ACEP brand awareness, growth, and impact internationally in a cost-effective manner.

Objective E Ensure optimal organizational infrastructure and governance to support membership, including increased resources from non-dues revenue.

Objective F Provide and enhance leadership development and recognition and strengthen liaison relationships with other emergency medicine organizations.

Objective G Promote and facilitate diversity and inclusion and cultural sensitivity within emergency medicine.

Objective H Strengthen job security and opportunity for individual members at all stages of their career.

GIVE TO EMF SO WE CAN GIVE BACK TO YOU

ACEP COUNCIL 25 YEARS EMF CHALLENGE

Research That Impacts Your Practice

YOUR SAFETY

Finding strategies to reduce physical, verbal, and emotional abuse on ED professionals

YOUR LEADERSHIP

The effect residency-trained, board-certified emergency physician-led care teams have on care quality in the ED.

YOUR IMPACT

Analyzing the logistical and financial efficiencies of EM in the rapid evaluation and diagnosis of undifferentiated acute illness and injury.

GIVING LEVELS

LEADERSHIP CIRCLE	$5,000
1972 CLUB	$1,972
FRIEND OF EMF	$1,200
WILCOX CHALLENGE	$600
LOYAL SUPPORTER	$100-$599

DONATE NOW
emfoundation.org/donate
416-499-0296

EMF Emergency Medicine Foundation®
research → education → patient care

Council Report

- 21 new research grants were awarded totaling **$ 1,067,818.** Learn more about the new grantees.

- COVID-19 grantee recipients completed research on pandemic related physician stress, pediatric care, social determinants, and prognosis value of point-of-care cardiac and lung ultrasound. Learn more about the grant recipients. New emerging grant topics were also supported through the Dr. Auerbach Climate Change Grant and EMF Health Disparities Grant.

- EMF and HKS, a recognized leader in health care design, partnered to award a $40,000 grant to help reimagine how EM departments are designed to reduce physician burnout. Learn more.

- The EMF/410 Medical LifeFlow Resuscitation Research Grant, totaling $239,789 was awarded to evaluate the effectiveness of LifeFlow compared to usual care for early fluid delivery of septic patients in the prehospital setting. Learn more.

- EMF partnered with the Emergency Medicine Policy Institute (EMPI) to award a Health Policy Research Scholar Award, totaling $99,089, which will examine the cost of boarding patients in the emergency department through time-driven activity-based costing.

- EMF supported the National Institute of Aging (NIA) in the creation of a collaborative network to optimize emergency care of older adults with dementia and will partially fund four grants related to geriatric research. These grants will offer $360,000 in available funding.

- Looking forward to the 22-23 grant cycle, **$847,500** will be awarded to address the urgent need to fund research related to critical issues facing EM and emergency physicians through the following grants:

    - **Emergency Medicine Workforce:** This grant will support research on the impact residency-trained, board-certified emergency physician-led care teams have on care quality in the ED.

    - **The "Value" of Emergency Medicine:** This grant will support research focused on the value of the specialty of emergency medicine and its logistical and financial efficiencies in the rapid evaluation and diagnosis of undifferentiated acute illness and/or injury in the emergency department or other EM-run settings that deliver acute, unscheduled care.

    - **Evidence-Based Safety Measures for ED-Based Professionals:** This grant will support research that evaluates strategies to reduce harm to ED personnel from physical, verbal, or emotional abuse. Strategies being evaluated may be physical measures taken in the ED, or educational or training programs for staff.

- EMF received the Charity Navigator 4-star rating for fifth consecutive year, the highest rating a non-profit can receive. Learn more.

FY 2021 Annual Report

Membership: 19,984

>95%
of EM Residents are EMRA members

228
programs with 100% membership

>$2.25M
annually invested into members

4.8%
revenue growth

EMRA helps you become the BEST DOCTOR you can be.

9 new or newly revised EMRA guides and EMRA reference cards

36 *on-shift clinical resources free for EMRA members*

104,921 EMRA CAST
downloads since July 2018

85,000 EM Resident
average monthly online views and print distribution of **18,000**

>500,000 EMRA Match
searches of EMRA Match for:

- *Residencies*
- *Fellowships*
- *Clerkships*
- *Jobs*

EMRA helps you become the BEST LEADER you can be.

20 committees

200+ *meetings, webinars, publications*

>8,000
members of EMRA's 20 Committees

- *Medical students*
- *Residents*
- *Fellows*

104 funded national leadership opportunities for members

92 Leadership Academy fellows
EMRA and ACEP Leadership Academy

43 categories of awards, scholarships, and grants

- *Scholarship*
- *Leadership*
- *Professional excellence*

EMRA helps EM become the BEST SPECIALTY we can be.

Workforce

EMRA helped fund research into the workforce issues facing EM and continues to take part in task force actions to **protect and shape** the future of the specialty

23 Webinars, vides, and online resources developed in response to the pandemic

19 Resolutions proposed and debated by EMRA members and the Representative Council

- *Fair compensation*
- *Injury/illness consideration*
- *Parental leave policies*
- *On-shift nutrition/hydration*
- *Protection against program closures*

3 EMRA and ACEP Health Policy Academy Fellows

10 partnerships to advance our mission (ACEP, EMF, EMAF, NEMPAC, EDPMA, AFFIRM, FemInEM, PolicyRx, AMA, Essentials of EM, AEROS)

EMRA Annual Report to ACEP Council

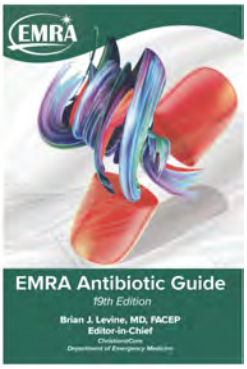
RJ Sontag, MD | EMRA President | October 2021

EMRA is the largest and oldest independent resident organization in the world. Founded in 1974, today the EMRA family includes nearly 20,000 residents, medical students, fellows, and alumni. We are proud to be ACEP's oldest and strongest strategic partner, and we appreciate the opportunity to share how we are achieving our mission to be the voice of emergency medicine physicians-in-training and the future of our specialty.

We help EM physicians-in-training become the **best doctors** they can be, the **best leaders** they can be, and we do our part to help EM become the **best specialty** we can be.

> The nearly 20,000 people who call EMRA home want the best education possible. **EMRA helps you become the best doctor you can be.**

EMRA offers 36 on-shift clinical resources FREE for EMRA members. In the past year alone, we released 10 guides and reference cards, including the all-new Emergency ECGs, PEM Fundamentals, and Urgent Care Guide, along with new editions of EM Fundamentals, Basics of Emergency Medicine, and Basics of Emergency Medicine: Pediatrics. In fact, next time you are on duty in your emergency department, we bet you can find a copy of our EMRA Antibiotic Guide, a longtime EM staple. (Get ready for our *20th edition* in the spring - free to EMRA Alumni members, btw!)



EMRA resources fit in your pocket, and **our most powerful resource is MobilEM**. Our comprehensive app features automatically updated versions of our most popular on-shift clinical resources, including EMRA's guides for

Antibiotics, EKGs, Ortho, Trauma, Pain Management, Toxicology, and more. Fully searchable, with bookmarking and annotation functions, this app is available on your favorite app store and has been downloaded tens of thousands of times. (And by the way, it's a **FREE** download with great free content alongside our subscription-based modules.)

EMRA tries to meet our members wherever they are, and that includes video and web resources. Just this week, in fact, we've introduced two new videos designed to offer key tips for telemedicine: the do's and don'ts of a virtual visit (complete with a downloadable checklist), plus pearls and pitfalls of performing physical exams in a virtual setting.

Also in the past year, we have added a high-yield feature to our already high-yield EMRA Match: **EMRA Match for Fellowships**. Much like the original EMRA Match, Fellowship Match helps you find opportunities that are a good fit for *you*. We have more than 400 fellowship programs in the database, and that number is growing.

EM Resident, the world's best resident magazine, reaches more than 18,000 homes with every issue. The web version continues to grow, with more than 1 million page views annually. Notably, we are also a starting point for the profession's newest authors. In the past year, we helped more than 300 physicians in training - and medical students - learn the ropes of publishing and feel the pride of seeing their work and their name in print.

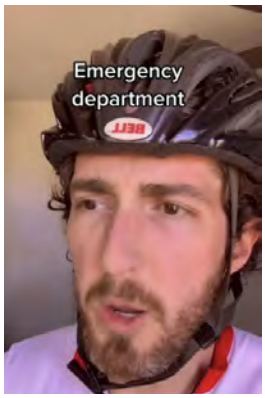
EMRA*Cast continues to grow with more than 100,000 podcast downloads. Check out some of our most popular episodes, including conversations featuring guests such as Dr. Jess Mason and Congressman Dr. Raul Ruiz, and topics ranging from law enforcement to homelessness to entrepreneurship.

Tomorrow's leaders are today's EMRA members. **EMRA helps you become the best leader you can be.**

EMRA helps create the leaders who will shape the specialty we love. EMRA's leadership development pipeline includes 20 committees with 8,000 members and more than 100 funded national leadership opportunities. In the past year, their 200+ meetings, webinars, and publications reached thousands of members.

ACEP remains a strong partner in helping EMRA create the leaders of tomorrow, and we're proud to co-brand opportunities like the EMRA/ACEP Medical Student Elective in Health Policy, the EMRA/ACEP Resident Fellow Health Policy Elective, the EMRA/ACEP Health Policy Academy, the EMRA/ACEP Congressional Health Policy Fellowship, and the EMRA/ACEP Leadership Academy, a 12-month longitudinal course that develops leadership skills and fosters networking. In addition, EMRA provides our representatives to nearly 50 ACEP Committees and Sections, powering our members' ability to build relationships and become the leaders our speciality needs.

Conference events at ACEP20 included virtual versions of our wildly popular competition events like 20 in 6, MedWAR, SimWars, CaseCon, and Quiz Show. Marquee guests covered the most pressing issues in our field, including Dr. Sadiqa Kendi's discussion of antiracism in medicine and Dr. Glaucomflecken's focus on eye emergencies.



EMRA has a strong and growing partnership with ACEP's Young Physician Section, including our signature event: the Health Policy Primer at ACEP's LAC in July. Hundreds of members engaged in this high-yield event that included Drop the Mic: Advocacy to help kick-start the advocacy and lecture careers of our young members as well as impromptu special guests and elected officials. **EMRA helps members actively engage with ACEP Chapters** by maintaining detailed opportunities for residents to connect locally.

> EMRA's powerful voice is heard at every table where issues are discussed that affect our members. **EMRA helps emergency medicine be the best specialty we can be.**

Shaping our specialty necessitates that our members and leaders represent the patients who come through our doors. To that end, **diversity, equity, and inclusion remain strong foci for EMRA**. EMRA is a steadfast partner on the ACEP Diversity Mentorship Initiative, fostering meaningful connections between leaders in our field and trainees seeking guidance and mentorship.

Highlights of our intentional internal recruitment efforts include record-breaking diversity in our committee leadership and board members.

EMRA's strong partnerships with organizations like ABEM, ACGME, CDEM, and CORD help ensure students and residents thrive. Our members debated and crafted policies that create fair compensation, parental leave policies, on-shift nutrition, and protections for residents who lose their job, either through residency closures or contract rescissions.

EMRA recognizes the importance of advocacy at the national level. EMF and NEMPAC are regularly highlighted and promoted for our members. EMRA's Board of Directors is proud to lead in this realm, and year after year, 100% of our board members donate to EMF and NEMPAC.

EMRA was an early partner with ACEP to fund the research that led to the Workforce Report. There is no doubt: **the future looks different.** The urgency of these changes give us an opportunity. It gives us – the young, scrappy emergency medicine physicians-in-training of today – the power to design our future: a future where we lead, with new solutions for safe and effective patient care. And just like the founders of this specialty, we believe in emergency medicine.

EMRA is proud to lead, to grow our specialty to new horizons, and to continue to work together for a better future.

This report will be provided as soon as it is available.