A Newsletter for the Members of the Utah Chapter - Winter 2025
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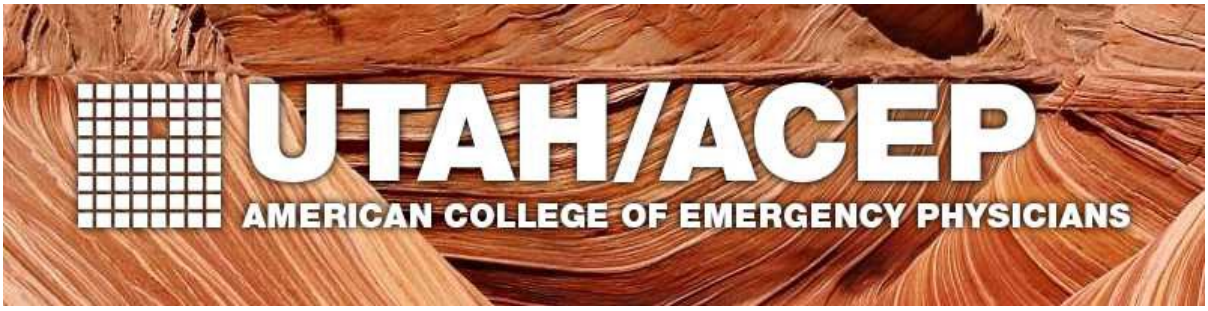


In this edition:

News from ACEP:

President's Update

Alison Smith, MD, MPH, FACEP

ACEP Council and Scientific Assembly Coming to Salt Lake City this Fall!
Salt Lake City will be the host of ACEP Council and Scientific Assembly in September 2025! Council will be September 5-6th and SA will be September 7-10th at the Salt Palace Convention Center. Watch your email inboxes for registration information.

Utah EM Physician Summit
SAVE THE DATE! The Utah ACEP annual EM Physician Summit is approaching quickly! The summit, free for members and $75 for non-members, will be on Wednesday, April 2nd at LDS Auditorium and feature national ACEP President Alison Haddock, White Coat Investor Jim Dahle, and award-winning speakers Christine Shenvi and Lisa McQueen. There will also be an ultrasound skills lab in the afternoon. The summit provides free CME and valuable learning opportunities right at your doorstep! A meet n' greet with many of our speakers will be at Wasatch Brew Pub in Sugarhouse on April 1st from 6:30 - 8:30 pm and apps and dinner will be provided. You'll be receiving registration information soon so put it on your calendar!

We will also be giving out awards again at this year's summit. If you would like to nominate yourself or someone else for the Educator or Innovator of the Year Awards, please send an email explaining who is deserving and why to paige@utahmed.org.

Educator Award:
Presented to an emergency medicine physician who demonstrates outstanding commitment to educating the next generation of emergency medicine leaders, colleagues, and/or the community.

Innovator Award:
Presented to an emergency medicine physician who pioneers new ideas and drives innovative solutions in the emergency department and/or community.

Leadership and Advocacy Conference - 2025 Scholarship
For the first time ever, UCEP would like to sponsor one of our members to go to ACEP's Leadership and Advocacy Conference (LAC) in Washington, D.C., April 27-29th, 2025. UCEP will cover the cost of one member's lodging and meeting registration, a scholarship valued at approximately $1500. If selected, you will be responsible for covering meals, transportation, and airfare. This is an amazing opportunity to network with EM colleagues from around the country and interact directly with and hear from members of Congress and political pundits in a conference format filled with interesting lectures and panels. On the last day of the conference, you will go to Capitol Hill with representatives from the UCEP board to lobby and meet with congressional representatives about some of the timeliest and most pressing issues in emergency medicine today. You can find more information about the conference at https://www.acep.org/lac.

If interested in the scholarship, please send an email to alisonsmith01@gmail.com by February 19th about why you would like to attend the conference. The UCEP board will decide on a recipient and that person will be notified by the following week so travel plans can be made.

Why LAC is More Important Now than Ever
By Joshua Berko, DO

I am a PGY-2 in emergency medicine at the University of Utah and I will be attending ACEP's Leadership and Advocacy Conference (LAC) from April 27-29th this year. As emergency physicians, we practice in a rapidly evolving landscape shaped by policymakers in Washington, D.C. Unfortunately, the disconnect between politicians and the realities of our work in the trenches is stark. They often don't see the true implications of their decisions—unless we show up to advocate for change.
I understand this firsthand. In medical school, I served as both a national delegate to our medical association and a state delegate for our Florida chapter. I've written multiple resolutions, spoken directly with members of Congress, and even met with the U.S. Surgeon General to push for change. I firmly believe that showing up is half the battle. When we stand together as a unified voice, our impact is far greater. Given the current political climate—one that thrives on chaos and change—this is an unprecedented opportunity for advocacy. Now more than ever, physicians must

be the loudest voices in the room, defending our patients and shaping the future of our profession. Attending LAC this year means advocating at a pivotal moment in history, when our presence and engagement can make a lasting difference.
“One of the penalties of refusing to participate in politics is that you end up being governed by your inferiors.”
— Plato

Alta Medical Clinic
Tim Jahn, MD, FACEP

Alta at night (credit: Alta Ski Area)

The town of Alta (Spanish for “upper” or “higher”) was formed in 1865 to house miners from several of the nearby silver mines. Originally called Central City, the population soon thereafter was in the thousands. After the silver mine operations closed, much of the town’s land was subsequently donated to the US Forest Service. The town was incorporated in 1970. Now known as a high-altitude ski town, Alta’s most recent population was 220 in 2020, although this number varies widely depending upon the season, growing into the thousands during ski season. Alta has many characteristics that make it unique, with a small town feel where everyone knows everyone, people rely on one another to meet needs and there is a great sense of community.

Alta is located nine miles up Little Cottonwood Canyon (LCC). Lying within the Wasatch National Forest and located 15 miles from Salt Lake City, it provides much of the drinking water for the Salt Lake Valley. LCC is one of the most avalanche prone canyons in the world--in the 2022-2023 winter, 98 avalanches hit the road that travels up LCC. It is threatened by 64 different avalanche paths with 76% of Alta/Snowbird roads at risk. Over 80% of the town’s structures are situated within avalanche run out areas. Little Cottonwood Canyon has one of the highest

avalanche indexes anywhere in the world. https://cottonwoodcanyons.udot.utah.gov/avalanche-information/. Avalanche injuries tend to be very serious, are frequently life-threatening, and often require transport by ambulance or helicopter to Salt Lake City.

LCC is thus subject to “interlodge”, a requirement for all individuals to remain indoors either because of avalanche threat or due to avalanche mitigation effort activity. It is a legal directive issued by the town of Alta through the marshal’s office. Although interlodges frequently last only several hours, the 2021 interlodge of 60 hours was the longest in history--during that storm 103” of snow and 6.2” of water content were recorded. Transportation considerations for medical conditions thus become challenging-- options typically include POV, ambulance or helicopter, but are extremely limited during interlodge. People are notified as early as possible that interlodge may go into effect, anyone having any reason to be out of the canyon are strongly encouraged to do so prior.

Alta Ski Area opened for its 87th season 22 Nov 2024. The base altitude is 8530 ft; there are 119 runs of which 55% are black diamond. Considered one of the resorts with the most snowfall in North America, Alta averages nearly 550 inches of snow yearly.

Dr. Ken outside Clinic (Credit: Stio)

Located behind Goldminer’s Daughter Lodge at the base of the Collins Lift, the Alta Medical Clinic was established in 2004 and still operated by founder Dr. Ken Libre--board certified Family Physician (featured in Ski Magazine (1/2021)). Known locally as Dr. Ken, he began working in the Alta area after receiving his medical school training at Dartmouth, residency at University of Utah and employed briefly at Snowbird Ski Resort. His wife, Dr. Carolyn Anctil, is a FACEP boarded emergency physician who works at Intermountain Health in Salt Lake City. Dr. Ken carries a radio which is on at all times and connects the entire Alta team including staff, ski patrollers, lift personnel, and EMS. A champion cross country skier, he lives in Alta and will often ski to/from work following significant snow. Emergency physician and

fellow UCEP Board member Dr Sean Slack has worked at the clinic and on a prn basis for the past seven years.

The clinic is open daily during ski season and can be accessed on an as needed basis in the off season. There is fantastic hiking with numerous mountains nearby (for hiking and climbing), mountain biking and wildlife including moose, mountain goats, cougar, multiple snake species and occasional black bear. All of these can lead to outdoor related injuries.

Over the decades he's practiced at Alta, Dr. Ken has noted a number of changes to ski injury patterns, including:

1. More collisions as a result of higher speed- probably multifactorial including improved ski gear, increased distractions such as listening to music.
2. Fewer head injuries, including scalp lacerations, since ski helmets began being used routinely
3. More tibial plateau fractures

Alta Medical Clinic specific info
On its website (www.altaclinic.com) the clinic advertises: "Specializing in the management of all ski injuries, including lacerations, fractures, dislocations and altitude sickness. We also treat acute and chronic illnesses in kids and adults."

Dr. Ken, ofc mar Elyse Clancy, RN Tessa Searle (Credit: Tim Jahn)

The clinic sees approximately 1200 patients annually, has 5 beds and on-site X-ray capability. The clinic is open daily during ski season and on an “as needed” basis at other times. Dr. Ken also provides the majority of primary care services for full time residents of Alta. The age breakdown of clinic patients is- 0-11 yrs 4%, 12-17 yrs 5.9%, 18-34 yrs 44%, 35-59 yrs 27%, 60-74 yrs 15%, 75-84 yrs 2%, >85 yrs 0.8%. A local practice-based electronic health record (EHR), Practice Fusion, is used for all patient visits. Epic EHR which is used by large health systems in the Salt Lake valley, is also available to access for review of pertinent patient histories. Sophisticated fracture management, including anesthesia with sedation as needed, fracture reduction, splinting can be performed.

7% of patients seen at the clinic are transported to a higher level of care. Of these, 38% are transported by privately owned vehicle (POV), 58% by ambulance and 2% helicopter. Depending upon their condition, patients are most frequently referred to Level 1 trauma centers for Intermountain Health Care or the University of Utah in Salt Lake City.

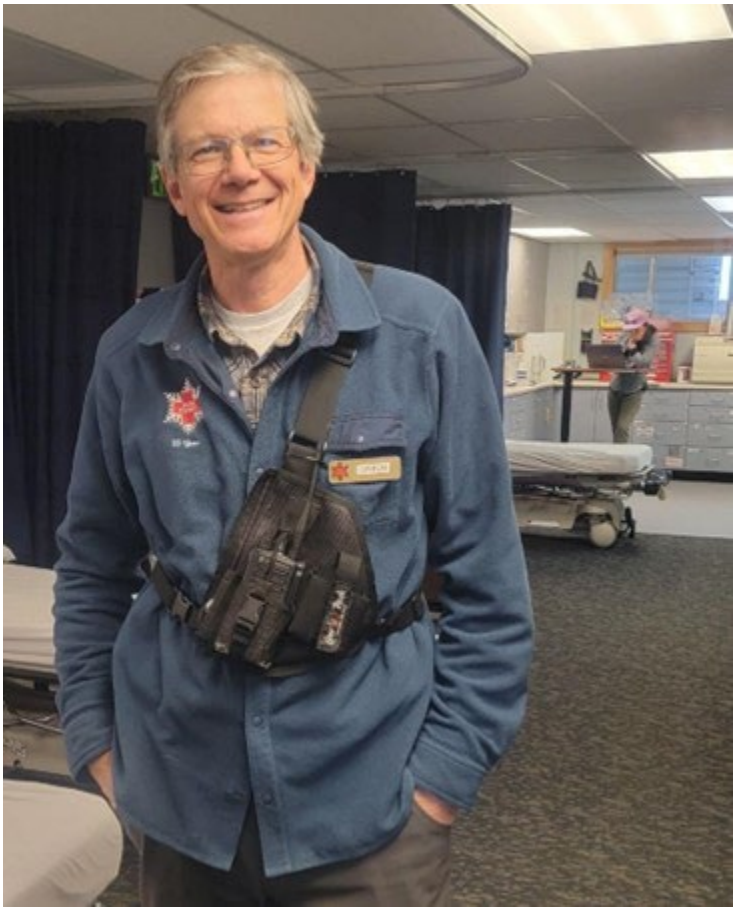
The Clinic is a popular site for residents training in Emergency Medicine, Family Practice and Sports Medicine to rotate through. These are typically 2-week rotations during ski season- 6-8 providers come through annually. The opportunity to receive

medical education and work with experienced medical professionals around skiing/ski injuries in a high-altitude environment at the time of injury is truly unique.

A breakdown of patient visits to the Clinic reveals 70% are orthopedic/trauma and 30% medical. Further breakdown (percentages are relative to total visits):

1. Knee- 20% (11.2% ACL, 4.5% MCL, 4% internal derangement syndrome, 3% tibial plateau fractures)
2. Overall fracture rate 14.5%
3. Shoulder- 7% (Including rotator cuff, dislocations, impingement syndrome)
4. Head- 6.5% (closed head injury w/wo LOC)
5. Lacerations 5%
6. Acute mountain sickness 1.7% (with occasional high altitude pulmonary edema (HAPE))
    a. These cases are treated with oxygen concentrators, acetazolamide, dexamethasone and descent if needed
    b. Alta visitors that are not local are frequently from the northeast US or California
7. Ulnar Collateral Ligament strain or tear 0.65% (skiers thumb)
8. Cardiac 0.6% (including both ASCVD and arrhythmias)
9. Annual influenza vaccination 8% (typically for local residents)
10. Backcountry- occasional

Having fun at work is important and this is evident at the clinic. The clinic team frequently participates in the local Alta Biathlon. Ken himself skis often around Clinic hours. Finally, Dr. Ken stresses that many of the people skiing here are from out of town on vacation. He emphasized that there are many patient presentations which can be treated with a bias towards keeping people skiing and continuing to enjoy their time at Alta.



Dr. Ken Libre (Credit: Tim Jahn)

The Real Story of EMTALA (or, how we almost went to jail)
Jim Antinori, MD, FACEP

As emergency physicians, the Emergency Medical Treatment and Labor Act (EMTALA) is a fact of everyday life in our professional practice. We all know what it means – that everyone presenting to a hospital emergency department must receive, at minimum, a medical screening exam to determine if an “emergency medical condition” is present, and if so the emergency department must provide care to stabilize that condition. All this is done regardless of the patient’s insurance status or ability to pay. It has been the law for 40 years, and (for the most part) it has been a good thing for our patients, and for the health of the nation. But its origins are interesting, to say the least, especially for emergency physicians. I was practicing in the mid 1980’s when EMTALA was first initiated, and I was involved with national ACEP to a degree where I was privy to some of the behind-the-scenes drama and negotiating that was involved. It was quite a story.

If you look up EMTALA in Wikipedia or some other similar source, it will tell you the official history of this law, how it came about, and its implications for the US healthcare system. This information is accurate, slightly sterile, but also somewhat incomplete. I will now endeavor to tell you, as Paul Harvey used to say, “the rest of

the story." (You young and mid-career physicians can Google Paul Harvey, if you wish.) Be aware that this is my personal recollection of events, and I should not be considered an unbiased historian in this matter. But I lived it, and here is the story as I remember it.

THE BACKGROUND

Prior to the mid-1980s, the vast majority of emergency departments, and emergency physicians, treated patients as we do now, regardless of their ability to pay. But there were some outliers, and they were getting more numerous. Hospitals, which had previously been mostly not-for-profit organizations run by state, county, religious or charitable institutions, were unfortunately rapidly transitioning into for-profit businesses, with an emphasis to maximize the bottom line. As a result, pressure was increasingly being brought to bear by hospital administrators on emergency departments to avoid treating and admitting patients who were uninsured, or otherwise "undesirable". Some consulting physicians, many of whom were no longer enamored with their professional responsibility to be on-call for emergency patients, were sometimes refusing to come in to see or admit patients who had no insurance or other financial resources. I EMPHASIZE AGAIN, THIS WAS RARE, BUT UNFORTUNATELY WAS BECOMING MORE COMMON.

It seems unthinkable today, but there were circumstances in which emergency physicians were "ordered" by hospital administrators to transfer uninsured patients to other facilities, usually county hospitals or university medical centers, because that was where the "charity cases" were supposed to go. A small but growing minority of consulting physicians at certain facilities had the same attitude.

It was not unusual at that time, as a receiving facility, to get a phone call from an outlying hospital only to learn that a patient was already "on the way" with a significant medical issue. Some patients, when being triaged, were asked about their insurance and financial status and if it was determined that they had no insurance, they were just told to go to the nearest county hospital (or similar facility), without ever seeing a physician. I am proud to say that this happened very rarely in Utah during those days, but it was happening. It was informally called "the new Dumping Syndrome" by medical personnel, and it was more common in other parts of the country. Like California, for example.

THE CONGRESSMAN

Fortney Hillman "Pete" Starke was a congressman from the Oakland area, a banker who first elected to Congress in 1973. Stark had a longstanding interest in health care issues and was critical of health insurance coverage in the United States, and of the health insurance industry in general. In January 1985, Stark became Chairman of the powerful House Ways and Means Health Subcommittee, with jurisdiction over Medicare and a number of other healthcare issues.

At about this time he learned that some of his poorer constituents had been turned away from Oakland area hospitals because of their lack of insurance. These were anecdotal stories and were few in number, but they were unfortunately true. So, in 1986, he decided to attach the Emergency Medical Treatment and Active Labor Act (EMTALA) to the Congressional Budget Reconciliation Act, which would require

hospitals to treat and stabilize persons presenting to emergency departments with emergency conditions or in active labor, regardless of the person's insurance status or ability to pay.

Why attach a piece of healthcare legislation to a budget bill? Because the budget bill had to pass Congress in order to keep the government from shutting down. Any legislation, no matter how unrelated, which was tagged onto the budget bill would also pass because it was an all-or-nothing package. This was unfortunately a common method by many members of Congress of both parties to get their pet legislation enacted without having to go through the normal legislative process. Also unfortunately, it persists today.

THE MISPERCEPTION

The problem was that Representative Stark had a very flawed concept of what happened in emergency departments. For example, if someone came to the ED complaining of abdominal pain, he thought that the emergency physician would evaluate the patient, diagnose appendicitis, take the patient to the OR, remove the appendix, admit the patient to the hospital, provide all the post-op care, and discharge the patient when they had sufficiently recovered from their surgery. He may have also thought that we pushed the wheelchair out to the car when they went home.

I know it sounds crazy today, but in the 1980's that was what many in Congress, and many across the country, thought we did. Pete Stark was certain that if a patient was turned away, or transferred for financial reasons, it was solely the decision and responsibility of the (greedy and unethical) emergency physician. That is why his original language for the EMTALA legislation made the emergency physician CRIMINALLY LIABLE for violations. Not only would you be subject to a $50,000 fine (equivalent to $145,000 today) which was not covered by malpractice insurance, but you could GO TO JAIL if an uninsured patient was transferred for just about any reason, financial or otherwise. Ouch.

The hospital was also liable, with the potential loss of their Medicare and Medicaid participation status, but otherwise only for a monetary fine. I guess Rep. Starke thought it would have been unseemly to put those fine hospital administrators in the slam.

THE RESCUE

Fortunately, ACEP was on the job. When their lobbyist in Washington found out about the proposed legislation and informed the College, emergency physicians were sent to DC to explain to Rep. Stark the realities of emergency medicine. He was told how emergency departments really worked, and how the ED physician did not provide every patient's entire health care from start to finish. He also had to be educated about consultants refusing to see patients, about hospitals which did not have the ability to handle certain medical conditions, and about some hospital administrators blocking admissions. It was explained to him how these were situations often out of the emergency physician's control. Pete Stark was not completely convinced – he had a deep suspicion of physicians, hospitals, and insurance which continued until his death in 2020 – but he at least agreed to eliminate the emergency physician's criminal liability for EMTALA violations in the original legislation. That was a huge win.

It would take more lobbying and future legislation to subject on-call physicians to the same rules, to make hospitals more accountable, and to legally protect emergency physicians who were only trying to do what was best for their patients. Definitions of an emergency medical condition, of a medical screening exam, of what constituted a “stabilized” patient and many other details were ultimately negotiated, all with ACEP input. Your dues dollars at work.

So, the next time you have to see that patient with the trivial complaint, or call a reluctant consultant to come in and see a patient, or transfer a patient and become irritated with the paperwork and phone calls involved, remember that it could have been worse – much worse – for the “good guys” (and girls) in the ED. We could have gone to jail.

Introducing Fit.ER.Doc
Ben Buchanan, MD, MBA, FACEP

We all know the many benefits of exercise, as well as how challenging it can be to fit it into our busy lives. Fit.ER.Doc will feature an ER Doc who has successfully "Fit-In" exercise.

This issue features Dr. Megan Fix, Assistant Dean for Student Affairs at the Spencer Fox Eccles School of Medicine and the Vice Chair of Education for Emergency Medicine at the University of Utah.

1. Tell us about yourself and your background (your training, your practice situation, etc).

My name is Megan Fix. I am an emergency physician practicing in Salt Lake City. I grew up in a small town in Michigan called Grand Haven. It was a town on the water and I have from there developed a passion for all things swimming and water-related as well as a great respect for the value of kindness and treating your

neighbors as you would wish to be treated. I attended Stanford for undergraduate and medical school and also took a year to be a course assistant where I developed a life-long love for teaching. I went to EM residency training at the Harvard Affiliated Residency program in Boston, MA and then took my first job as an emergency physician in Portland Maine. We moved to Utah in 2010 where I have been an attending physician at the University of Utah Hospital Emergency Department. I split my time between taking care of patients in the ER and teaching the medical students and residents. I've held multiple roles including Associate Residency Director, Course Director for the doctoring course and now Vice Chair of Education for the Emergency Department and Assistant Dean for Student Affairs for the School of Medicine. I am so fortunate to have a wonderful husband and three sons and we love everything about living in Utah.

2. What is your current exercise regimen?

Having been a competitive athlete for much of my life I realize the amazing value of exercise – on my mood and my approach to life and my health. Therefore I try to do some form of exercise every day. That can range from a hike with our lab-border collie mix Pepper to a yoga class to a swim workout at the pool to a trail run to a Nordic ski or alpine ski day with the family. I try to make sure to get in some cardio (bike, run, swim, Nordic ski) and some strength training and some fun social exercise as well. I've always been a fan of variety in exercise so as opposed to doing something every Monday or every Friday I try to go with my mood and needs as they come. I have a running buddy who we make sure to fit in a run together at least once per week and I make sure to ski, bike or hike with my family most weeks as well. Between that, anything goes. I think the more that time goes on I treat exercise as

something that feeds my body and soul and try to move every day as opposed to getting a certain number of miles or yards or reps.

3. How has your exercise regimen changed over the years?

I competed in swimming and track in high school then was a college athlete in Synchronized Swimming, and in medical school I was on the triathlon team. For many years my exercise regimen was focused on performance, speed, strength, and agility. For synchronized swimming we spent many hours conditioning (weights, dry land training, strengthening, stretching) and then even more hours swimming, breath work, and practicing our routines. Then while in medical school I was a member of the triathlon team where we combined group swim workouts in the morning to long bike rides on the weekends and team runs and track workouts in the afternoons. Then in residency and post residency I kept active as much as I could, mainly with running, because that was the easiest way to get exercise with a busy resident schedule. I didn't buy a car in residency so that I could bike commute in Boston so at least I was biking every day. I did a few marathons and triathlons and then after residency prior to having children I focused on triathlon training and built a community of friends who shared those goals.

Since having children, I have really focused on trying to be active, move my body and maintain strength and fitness but combining that with my love for my kids. We did a ton of hiking and biking with the kids in a trailer tow and using the run stroller. See the picture of how we rigged up a system for all three kids to be pulled by one parent! I continued to do about one race per year to help have a goal and would train with kids in tow. My husband and I love to do 12-hour mountain biking races together and camp with the kids. Living in Utah, I have made an effort to learn mountain biking and Nordic skiing better.

So, in summary my exercise has morphed to fit my family and the environment and overall fun with activities. I'm super grateful for the opportunity to be able to be active and fit in life.

4. What are some of your fitness high points and low points?

My fitness high points are numerous, and some are personal (running along a beautiful trail or beach and reflecting on my life as fortunate and taking in nature) or team oriented (college national championship to share with teammates or competing in a swim-run race while tethered to my friend Leah in Maine) or just feeling good in my body (competing in a world triathlon in Nice). If you know me, you know that one of my most favorite things to do is to jump into bodies of water and swim – anywhere. Cold, warm, cliffs, beach, you name it. Wherever we are traveling I get our three boys to jump in with me and recently that has involved dips in Alaska, Norway, Montana, and two of my sons just did an open water non wetsuit swim with me in San Francisco bay where we were able to swim with sea lions!

The low points involve largely myself being my own critic – you are not fast enough, you are not good enough, you are not training enough. I have had a long struggle with my personal mental health over the years and I'm fortunate to have been able to work though my own self doubt and loathing over years of therapy and reflection. I have had some injuries that have set me back, but overall the trajectory has been full of joy, growth, and understanding that being good to my body and my soul helps me be a better physician, spouse, mother and colleague.

5. What are your current short-term and long-term fitness goals?

In the short term, I have a goal to move my body in some way every day – aside from my recent bout with Influenza A where I was flat in bed for 2 – and be inspired by exercise as mental and physical therapy. My long term fitness goals have changed, now that I'm in my late 40s I am trying to do more strengthening and yoga in addition to cardio in the hopes that I can keep being active well into my late decades of life. Another long term fitness goal of mine is to keep being active for my kids and hopefully grandkids. I am inspired by many of the folks I see in Utah in their 70s and 80s outside doing all of the things. I hope to be able to share this with the younger generations, and even do a few 5Ks or swim races.

6. Any fitness tips or mottos you would like to share?

When things get rough, just think, "one foot in front of the other or one arm at a time," sooner than you expect, you will be through it.

7. Who is your favorite or most inspiring athlete?

I have always been inspired by the female distance athletes Janet Evans and Joan Benoit. It gives me joy to know that I have swum in the same pool as Janet Evans in California and run on the same roads in Maine as Joan Benoit.

8. How do you fit in fitness?

I make it a priority to move every day. Its part of my mental and physical well being so I make it happen. Some days more than others, but I do what works.

9. How has exercise benefited you?

So many ways!!!! I have found physical joy, personal joy, emotional joy, and social joy through exercise. Even in my work, I have been able to run or ski or bike with our residents and faculty and have benefited from connection and being able to talk thorough things while in the beautiful outdoors together. (see photos above)

For volunteers or suggestions for a Fit.ER.Doc in an upcoming newsletter, please contact Ben Buchanan at bdb3@comcast.net or 801-209-5935.

FROM NATIONAL ACEP

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

ACEP Resources & Latest News

ACEP Calls for Administration to Ensure Robust Federal Health Infrastructure
The American College of Emergency Physicians (ACEP) respectfully calls on the Administration to recognize the critical importance of a robust federal health infrastructure in safeguarding the prosperity and security of our nation, and the health and well-being of our people. Read more.

Act Now to Reverse the Medicare Cuts
With ACEP's strong support, new bipartisan legislation has been introduced to reverse the harmful Medicare Physician Fee Schedule (PFS) cuts. Read more.

Change is Happening Fast: ACEP is Your Voice in Washington When it Matters Most
The first days of the Trump Administration include seismic policy shifts with significant implications for emergency physicians and patients. Read more.

ACEP Strongly Applauds Senate Bill Supporting Physician Mental Health
Bipartisan legislation introduced in the Senate this week would reauthorize funding for the law named in honor of the life and legacy of Dr. Lorna Breen, an emergency physician who died by suicide during the pandemic. Read more.

Ohio ACEP is Protecting Emergency Physicians from Violence
A new Ohio law will help protect the state's emergency physicians and health care workers from violence. Ohio ACEP advocacy supported the effort from start to finish. Read more.

ACEP Applauds HHS for Raising Corporatization Concerns, Continues to Press for Change

ACEP strongly applauds the new report from the Dept of Health and Human Services (HHS) regarding consolidation in health care. Read more.

AHRQ Announces 'Special Emphasis' on Research to Reduce Boarding
The Agency for Healthcare Research and Quality (AHRQ) is doubling down on efforts to address boarding in the emergency department, building on ACEP-generated momentum. Read more.

Connecticut ACEP Leads Efforts to Boost Hospital Transparency Around Boarding Crisis - UPDATE
With the state legislative session now underway, ACEP members are leading the call for changes to alleviate the boarding crisis. Read the report prepared for legislators by Dr. Christopher Moore and the committee of physicians. Read more.

ACEP Applauds Reauthorization of Emergency Medical Services for Children Law
The ACEP-supported bipartisan Emergency Medical Services for Children (EMSC) Reauthorization Act of 2024 was signed into law December 23, 2024. Read more.

Upcoming ACEP Events and Deadlines

- **ACEP Council 101**
  April 10, 2025
  2:00 PM - 3:00 PM Central time
  Join ACEP Council Speaker Melissa W. Costello, MD, FACEP, and ACEP Council Vice Speaker Michael J. McCrea, MD, FACEP, to learn about how the ACEP Council works and how even a single member can make a big impact on the policy and direction of the College. The ACEP Council is a deliberative body that meets once a year for two days in conjunction with the College's annual Scientific Assembly. The Council votes on resolutions that guide the activities of the College. Learn how to craft your resolution and weigh in on the pressing issues in emergency medicine.

- **ACEP Leadership & Advocacy Conference**
  April 27-29, 2025
  Join your colleagues in Washington, DC, and make your collective voices heard to inspire change for your patients and your specialty. Both chambers of Congress are expected to be in session. Together, we'll:

  - tackle problems facing EM such as the current boarding crisis,
  - develop tools to advocate at all levels, and
  - build relationships with policymakers and fellow advocates.
    Register today!

- **ACEP25 Scientific Assembly**
  September 7-10, 2025
  For the first time, ACEP's annual meeting will be in the beautiful city of Salt Lake City, UT. The world's largest emergency medicine educational conference bringing together the global EM community.

Contact Utah ACEP

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