American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2026 Council Meeting

Preliminary Report of REFERENCE COMMITTEE C

Presented by: Hilary Fairbrother, MD, FACEP, Chair

Mr. Speaker and Councillors:

Reference Committee C gave careful consideration to the asynchronous testimony of the resolutions assigned to it and submits the following report for consideration:

Recommended for Adoption:

1. RESOLUTION 42(26): Clarification and Revision of ACEP Policy on Medical Cannabis in the Era of Emerging Psychoactive Cannabinoids
2. RESOLUTION 43(26): ED-Initiated Pharmacotherapy Pathways for Alcohol Use Disorder
3. RESOLUTION 47(26): ED of the Future
4. RESOLUTION 49(26): Ensuring Transparency and Accountability in Emergency Department Staffing Proposals
5. RESOLUTION 53(26) Protecting Emergency Physician Privacy in Hospital Identification and Directories

Recommended for Adoption as Amended or Substituted:

6. AMENDED RESOLUTION 44(26): Contraceptive Provision is Within the Scope of Emergency Medicine Practice
7. AMENDED RESOLUTION 45(26): Medical Management of Early Pregnancy Loss in the Emergency Department
8. AMENDED RESOLUTION 46(26): Strengthening ACEP Educational Resources and Guidelines on the Ultrasonographic Diagnosis of Early Pregnancy Loss
9. AMENDED RESOLUTION 50(26): Law Enforcement Presence in the Emergency Department
10. AMENDED RESOLUTION 51(26): Physician Staffing Requirements for Pediatric Ready Designation
11. AMENDED RESOLUTION 56(26): Strengthening ACEP Policy on the Appropriate Use of ED Patient Experience Surveys

Recommended NOT for Adoption:

12. RESOLUTION 48(26): No-Cost Solutions to ED Boarding
13. RESOLUTION 52(26): Prioritizing Inpatient Medical Admission for Geriatric Psychiatric Patients When Psychiatric Beds Are Unavailable
14. RESOLUTION 54(26): Radiology Turn-Around Time

Recommended for Referral:

15. RESOLUTION 55(26) Responsible Use of AI in Emergency Medicine Documentation

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Recommended for Adoption

1. **RESOLUTION 42(26): Clarification and Revision of ACEP Policy on Medical Cannabis in the Era of Emerging Psychoactive Cannabinoids**

RESOLVED, That ACEP revise its policy statement “Medical Cannabis” to include a clear and explicit definition of “medical cannabis,” distinguishing between FDA-approved cannabinoid medications, state-regulated cannabis products, and non–FDA-approved hemp-derived psychoactive cannabinoids; and be it further

RESOLVED, That ACEP update its policy statement “Medical Cannabis” to specifically acknowledge the

emergence of hemp-derived psychoactive cannabinoids (including but not limited to delta-8 THC and similar compounds) and their associated clinical and public health risks; and be it further

RESOLVED, That ACEP incorporate language in the policy statement "Medical Cannabis" to address the risks of unintentional pediatric exposures to cannabinoid-containing products and support measures to reduce such exposures, including improved labeling, packaging, and public education; and be it further

RESOLVED, That ACEP advocate for standardized nomenclature, regulation, and research regarding emerging cannabinoid products to better inform emergency physicians and protect public health.

Summary of Asynchronous Testimony

Asynchronous testimony was primarily in support. Testimony in support highlighted the critical gap in ACEP's medical cannabis policy statement caused by the proliferation of unregulated, hemp-derived psychoactive cannabinoids like delta-8 THC and increasing pediatric exposure risks. Testimony both in support and against the resolution supported the intent but highlighted fulfillment of the resolution could be accomplished through the existing ACEP policy and the usual committee-based revision process and did not necessitate a new initiative. Further testimony emphasized the need to incorporate existing state statutes and federal regulatory frameworks to prevent duplicating work during the revision process.

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2. **RESOLUTION 43(26): ED-Initiated Pharmacotherapy Pathways for Alcohol Use Disorder**

RESOLVED, That ACEP create a policy statement for emergency department-initiated treatment of moderate-severe alcohol use disorder, including the use of anti-craving medications; and be it further

RESOLVED, That ACEP promote multidisciplinary care models, analogous to emergency department medication assisted treatment (MAT) programs for opiate use disorder, that integrate medication initiation, patient education, and coordinated follow-up for individuals with alcohol use disorder.

Summary of Asynchronous Testimony

Asynchronous testimony was largely in support. Testimony highlighted that EDs currently do very little for patients with alcohol use disorder once discharged from the ED and research has shown success with ED-initiated medication for opioid use disorder. Testimony also reflected that the anticipated cost of fulfilling the request of the resolution appeared to be high and much of the groundwork for this resolution has been initiated with Amended Resolution 73(25) Promoting Comprehensive Treatment of Substance Use Disorders Across the Nation. Further testimony suggested the work to fulfill this resolution could be appended to the work being done to complete Amended Resolution 73(25).

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3. **RESOLUTION 47(26): ED of the Future**

RESOLVED, That ACEP appoint a task force to define the ED of the present and near future, including scope of practice, structural and functional needs, anticipating future changes in medicine, such that patients are assured the best care possible.

Summary of Asynchronous Testimony

Asynchronous testimony was mixed. Testimony in support stressed that ACEP must shape the specialty's future standards proactively rather than letting external organizations such as the ACGME define them retroactively. Further testimony in support added that ED operational flow and physical design have stagnated for over a decade, necessitating stronger institutional drive to modernize. Testimony opposed suggested that a separate task force is redundant with existing resources, including ED architecture literature, current accreditation programs, and that ACEP

lacks regulatory enforcement power over hospital systems. Clarification was requested as to what this resolution is asking, what value it would add, and how it would benefit the College, members, and patients.

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4. **RESOLUTION 49(26): Ensuring Transparency and Accountability in Emergency Department Staffing Proposals**

RESOLVED, That ACEP develop and disseminate best practice guidelines for emergency department Request for Proposal (RFP) processes that promote transparency by encouraging:

- objective disclosure of the clinician workforce and operational resources available to support implementation of the proposed contract at the time of award;
- clear distinction between existing resources and projected future recruitment or expansion;
- transparent description of implementation plans, assumptions, and anticipated timelines; and
- disclosure, upon request by interested parties and consistent with applicable law and contractual obligations, of the evaluation criteria and materials used during the contract selection process, including scoring methodologies and other documentation supporting the award decision; and be it further

RESOLVED, That ACEP advocate for emergency department Request for Proposal (RFP) processes that promote objective evaluation of proposals using transparent criteria and accurate representations of organizational capabilities, while recognizing the diversity of emergency medicine practice structures and employment models; and be it further

RESOLVED, That ACEP support transparency regarding implementation outcomes following emergency department contract transitions by encouraging reporting, upon request by interested stakeholders and consistent with applicable law and contractual obligations, comparing key elements of proposed implementation plans with actual implementation one year following transition.

Summary of Asynchronous Testimony

Asynchronous testimony was almost exclusively in support. Testimony highlighted that despite ACEP's limited direct control over hospital decisions, establishing transparent hospital RFP guidelines through a low-cost, accessible white paper would be beneficial to the membership. Further testimony suggested that since hospitals control the RFP process, any endeavor should emphasize that success relies on actively disseminating these best practices to hospital leaders and external health organizations. Testimony cautioned that engaging hospitals on RFP practices could inadvertently encourage them to employ individual physicians rather than contracting with independent groups.

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5. **RESOLUTION 53(26): Protecting Emergency Physician Privacy in Hospital Identification and Directories**

RESOLVED, That ACEP develop a policy statement supporting emergency physicians' discretion over the extent of personally identifying information displayed on hospital identification badges, attire, and public-facing directories.

Summary of Asynchronous Testimony

Asynchronous testimony was largely in support. Testimony in support highlighted that reducing public identifiers provides a critical safeguard against workplace violence, stalking, and online harassment. Testimony also emphasized that patient transparency can be maintained since physician identities remain readily available in medical records, discharge paperwork, and secure portals. Testimony in opposition questioned the practical feasibility of withholding names, arguing that limiting public identification could impede care coordination, reduce accountability, and infringe on a patient's right to know who is directing their care.

Recommended for Adoption as Amended or Substituted

6. **AMENDED RESOLUTION 44(26): Contraceptive Provision is Within the Scope of Emergency Medicine Practice**

RESOLVED, That ~~the~~ ACEP ~~Board of Directors~~ assign an appropriate committee or task force to collaborate with the Reproductive Health Section and other relevant committees and sections as needed to develop and publish an educational resource and model residency curriculum to equip emergency physicians with the knowledge and skills necessary to provide contraceptive care (including contraception counseling, prescribing and initiation) in the ED; and be it further

RESOLVED, That ~~the~~ ACEP ~~Board of Directors advocate for~~ **support** the removal of systemic barriers to ED-based contraception provision, including formulary restrictions, insurance and reimbursement barriers, and regulatory obstacles that limit patient access to contraceptive services in the emergency care setting.

ORIGINAL RESOLUTION LANGUAGE AS SUBMITTED

RESOLVED, That the ACEP Board of Directors assign an appropriate committee or task force to collaborate with the Reproductive Health Section and other relevant committees and sections as needed to develop and publish an educational resource and model residency curriculum to equip emergency physicians with the knowledge and skills necessary to provide contraceptive care (including contraception counseling, prescribing and initiation) in the ED; and be it further

RESOLVED, That the ACEP Board of Directors advocate for the removal of systemic barriers to ED-based contraception provision, including formulary restrictions, insurance and reimbursement barriers, and regulatory obstacles that limit patient access to contraceptive services in the emergency care setting.

Summary of Asynchronous Testimony

Asynchronous testimony was almost exclusively in support. Proponents of the resolution supported the development of optional resources for contraceptive counseling and initiation citing that it is a vital safety-net service for patients lacking primary care. Proponents also supported the reduction of systematic and regulatory barriers as well as insurance obstacles but cautioned against the ever-expanding expectations of emergency care that can strain limited resources. Concerns highlighted continuation of care after ED-initiated contraception. It was suggested the first resolved be amended to assign the resolution directly to the Reproductive Health Section to save costs and prevent duplicate staff work. Additionally, it was suggested changing "ACEP Board of Directors" to "ACEP" in the second resolved to reflect the entity responsible more accurately for fulfilling the resolution. Another amendment was suggested for the second resolved requesting "advocate" be changed to "support" to reflect the language typically used when collaborating with partner organizations such as the American College of Obstetricians and Gynecologists.

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7. **AMENDED RESOLUTION 45(26): Medical Management of Early Pregnancy Loss in the Emergency Department**

RESOLVED, That ACEP, supporting clinical practice ~~in line with the American College of Obstetricians and Gynecologists Practice Bulletin~~ and clinical guidelines for medication management of early pregnancy loss, update the existing policy statement "Emergency Physicians' Role in the Medical and Procedural Management of Early Pregnancy Loss" to include the medication management ~~regimens~~ that can be offered to patients with early pregnancy loss in the ED; and be it further

RESOLVED, That ACEP expand on the miscarriage management resources available on the website by collaborating with Council of Residency Directors in Emergency Medicine and other relevant groups to develop a curriculum for emergency medicine clinicians for diagnosis and treatment of early pregnancy loss in the emergency department, highlighting medication management regimens~~, as standard~~ in emergency medicine.

ORIGINAL RESOLUTION LANGUAGE AS SUBMITTED

RESOLVED, That ACEP, supporting clinical practice in line with the American College of Obstetricians and Gynecologists Practice Bulletin and clinical guidelines for medication management of early pregnancy loss, update the existing policy statement "Emergency Physicians' Role in the Medical and Procedural Management of Earl Pregnancy Loss" to include the medication management regimens that can be offered to patients with early pregnancy loss in the ED; and be it further

RESOLVED, That ACEP expand on the miscarriage management resources available on the website by collaborating with Council of Residency Directors in Emergency Medicine and other relevant groups to develop a curriculum for emergency medicine clinicians for diagnosis and treatment of early pregnancy loss in the emergency department, highlighting medication management regimens, as standard in emergency medicine.

Summary of Asynchronous Testimony

Asynchronous testimony was primarily in support. Testimony highlighted the need for education resources on the legal barriers and proper treatment of early pregnancy loss. Consensus among those providing testimony recommended deleting "regimens" from the first resolved since specific dosing is not provided in policy statements. In addition, it was suggested that the phrase "as standard" be deleted or replaced in the second resolved since using "standard" implies a legal "standard of care," creating severe medical-legal liability for emergency physicians operating in restricted states or religious hospital systems. Additional testimony cautioned against directly anchoring ACEP policy to external American College of Obstetricians and Gynecologists guidelines to ensure the College is not automatically bound to future policy changes made by outside organizations.

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8. **AMENDED RESOLUTION 46(26): Strengthening ACEP Educational Resources and Guidelines on the Ultrasonographic Diagnosis of Early Pregnancy Loss**

RESOLVED, That ~~the Board of Directors~~ **ACEP** request the Emergency Ultrasound Section to explore including early pregnancy loss into the evaluation of first trimester pregnancy during the next revision cycle of the ACEP Ultrasound Guidelines; and be it further

RESOLVED, That ~~the Board of Directors~~ **ACEP** assign an appropriate committee to collaborate with the Emergency Ultrasound Section, the Reproductive Health Section, and other relevant committees and sections as needed to develop and publish a clinical resource on the ultrasonographic diagnosis of early pregnancy loss in the emergency department.

ORIGINAL RESOLUTION LANGUAGE AS SUBMITTED

RESOLVED, That the Board of Directors request the Emergency Ultrasound Section to explore including early pregnancy loss into the evaluation of first trimester pregnancy during the next revision cycle of the ACEP Ultrasound Guidelines; and be it further

RESOLVED, That the Board of Directors assign an appropriate committee to collaborate with the Emergency Ultrasound Section, the Reproductive Health Section, and other relevant committees and sections as needed to develop and publish a clinical resource on the ultrasonographic diagnosis of early pregnancy loss in the emergency department.

Summary of Asynchronous Testimony

Asynchronous testimony was primarily in support. Testimony in support indicated that a guideline addressing early pregnancy loss would fill a critical clinical gap in the prevention of misdiagnosing viable pregnancies. Proponents emphasized that the development of any new material should include collaboration with radiologists and OB/GYN stakeholders and must clearly define the scope and limitations of point-of-care ultrasound (POCUS) while offering management pathways for indeterminate findings. Testimony against the resolution expressed caution

regarding medical liability, operator-dependent measurements, and whether emergency physicians possess sufficient training repetitions for definitive diagnostic calls. Further testimony recommended a virtual workgroup in place of the suggested in-person meeting to reduce anticipated costs. The Reference Committee recommended changing "Board of Directors" to "ACEP" in the resolveds to reflect the entity responsible more accurately for fulfilling the resolution.

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9. **AMENDED RESOLUTION 50(26): Law Enforcement Presence in the Emergency Department**

~~RESOLVED, That ACEP recognize the impact of federal law enforcement in hospital spaces and how it may deter vulnerable populations, regardless of immigration status, from seeking care, or providing pertinent health information during visits due to fear of confidentially breaches, in emergency departments leading to worsening disparities in health outcomes of an already marginalized population; and be it further~~

~~RESOLVED, That ACEP affirm that emergency departments are spaces dedicated to unbiased, nondiscriminatory emergency medical care, and supports policies that protect safe access to emergency care regardless of immigration status; and be it further~~

~~RESOLVED, That ACEP reaffirm that no legal or law enforcement process, including immigration enforcement, should interfere with patient care in the ED absent immediate safety threats or specific applicable laws; and be it further~~

~~RESOLVED, That ACEP encourage emergency departments to adopt or develop clear hospital policies to guide medical staff in navigating the presence of immigration agents, thereby reducing confusion and uncertainty and promoting accessible, equitable, patient-centered care, consistent with ACEP's existing policy encouraging hospital partnerships with community groups and law enforcement agencies to develop clear ED access policies; and be it further~~

RESOLVED, That ACEP discourage the routine inclusion of immigration status in clinical documentation, including EMS records, unless clinically relevant or required by law~~; and be it further~~.

~~RESOLVED, That ACEP reaffirm that a medical screening examination and any resulting documentation reflect emergency medical evaluation only, do not constitute a fitness-for-confinement determination, and should not be relied upon by law enforcement or immigration agencies for custodial health decisions.~~

ORIGINAL RESOLUTION LANGUAGE AS SUBMITTED

RESOLVED, That ACEP recognize the impact of federal law enforcement in hospital spaces and how it may deter vulnerable populations, regardless of immigration status, from seeking care, or providing pertinent health information during visits due to fear of confidentially breaches, in emergency departments leading to worsening disparities in health outcomes of an already marginalized population; and be it further

RESOLVED, That ACEP affirm that emergency departments are spaces dedicated to unbiased, nondiscriminatory emergency medical care, and supports policies that protect safe access to emergency care regardless of immigration status; and be it further

RESOLVED, That ACEP reaffirm that no legal or law enforcement process, including immigration enforcement, should interfere with patient care in the ED absent immediate safety threats or specific applicable laws; and be it further

RESOLVED, That ACEP encourage emergency departments to adopt or develop clear hospital policies to guide medical staff in navigating the presence of immigration agents, thereby reducing confusion and uncertainty and promoting accessible, equitable, patient-centered care, consistent with ACEP's existing policy encouraging hospital partnerships with community groups and law enforcement agencies to develop clear ED access policies; and be it further

RESOLVED, That ACEP reaffirm that a medical screening examination and any resulting documentation reflect emergency medical evaluation only, do not constitute a fitness-for-confinement determination, and should not be relied upon by law enforcement or immigration agencies for custodial health decisions.

Summary of Asynchronous Testimony

Asynchronous testimony broadly supported protecting vulnerable patients and emergency department staff from law enforcement deterrence in the emergency department, particularly by discouraging the routine inclusion of immigration status in medical records. Testimony opposed highlighted many of the resolveds reaffirm current policy and does not advance the College or the issue. An amendment removing redundant reaffirmations to strictly focus the resolution on discouraging routine immigration status documentation was proposed.

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10. **AMENDED RESOLUTION 51(26): Physician Staffing Requirements for Pediatric Ready Designation**

RESOLVED, That ACEP advocate for amendment of the current "Pediatric Readiness in the Emergency Department" policy statement, developed in collaboration with the American Academy of Pediatrics, to require that any hospital designated as "pediatric ready" maintain continuous on-site physician presence in the emergency department 24 hours per day, 7 days per week, 365 days per year~~; and be it further~~.

~~RESOLVED, That ACEP work collaboratively with national stakeholders to support implementation of the standard to require continuous on-site physician presence in the emergency department 24 hours per day, 7 days per week, 365 days per year, including consideration of resource allocation, workforce development, and rural access to care.~~

ORIGINAL RESOLUTION LANGUAGE AS SUBMITTED

RESOLVED, That ACEP advocate for amendment of the current "Pediatric Readiness in the Emergency Department" policy statement, developed in collaboration with the American Academy of Pediatrics, to require that any hospital designated as "pediatric ready" maintain continuous on-site physician presence in the emergency department 24 hours per day, 7 days per week, 365 days per year; and be it further

RESOLVED, That ACEP work collaboratively with national stakeholders to support implementation of the standard to require continuous on-site physician presence in the emergency department 24 hours per day, 7 days per week, 365 days per year, including consideration of resource allocation, workforce development, and rural access to care.

Summary of Asynchronous Testimony

Asynchronous testimony was primarily in support. Testimony supported requiring onsite physician coverage for emergency departments seeking "Pediatric Ready" designations, framing it as essential to maintaining physician-led care for children. Further testimony emphasized tiered readiness levels create positive incentives toward physician staffing without shutting down small, critical access departments in rural communities and high-risk pediatric interventions, such as emergency intubation, warrant dedicated physician expertise. Additional testimony suggested strengthening the proposal further by requiring board-certified or emergency medicine–experienced physicians rather than general credentials. To streamline the text, testimony recommended deleting the second resolved clause because its call for 24/7 physician-led EDs merely reaffirms policy adopted in 2025.

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11. **AMENDED RESOLUTION 56(26): Strengthening ACEP Policy on the Appropriate Use of ED Patient Experience Surveys**

~~RESOLVED, That ACEP reaffirm its existing policy opposing the inappropriate use of patient experience survey results for physician reimbursement, compensation, credentialing, or employment decisions; and be it further~~

RESOLVED, That ACEP advocate that patient experience survey results should not be used for physician performance evaluation, physician compensation, contractual subsidies, staffing agreements, professional services agreements, incentive payments, credentialing, employment decisions, or other contractual determinations when the survey population excludes admitted, observation, transferred, or other emergency department patients and therefore does not represent the physician's overall emergency medicine practice; and be it further

RESOLVED, That ACEP oppose the use of patient experience survey results for physician compensation, contractual subsidies, staffing agreements, professional services agreements, incentive payments, credentialing, employment decisions, or physician performance evaluation unless the survey is administered, sampled, analyzed, scored, and reported in accordance with the scientifically validated methodology established for that survey instrument; and be it further

RESOLVED, That ACEP advocate that physician performance assessment in emergency medicine prioritize evidence-based clinical quality measures, patient safety outcomes, operational performance measures, and other scientifically valid metrics that accurately reflect the delivery of emergency care.

ORIGINAL RESOLUTION LANGUAGE AS SUBMITTED

RESOLVED, That ACEP reaffirm its existing policy opposing the inappropriate use of patient experience survey results for physician reimbursement, compensation, credentialing, or employment decisions; and be it further

RESOLVED, That ACEP advocate that patient experience survey results should not be used for physician performance evaluation, physician compensation, contractual subsidies, staffing agreements, professional services agreements, incentive payments, credentialing, employment decisions, or other contractual determinations when the survey population excludes admitted, observation, transferred, or other emergency department patients and therefore does not represent the physician's overall emergency medicine practice; and be it further

RESOLVED, That ACEP oppose the use of patient experience survey results for physician compensation, contractual subsidies, staffing agreements, professional services agreements, incentive payments, credentialing, employment decisions, or physician performance evaluation unless the survey is administered, sampled, analyzed, scored, and reported in accordance with the scientifically validated methodology established for that survey instrument; and be it further

RESOLVED, That ACEP advocate that physician performance assessment in emergency medicine prioritize evidence-based clinical quality measures, patient safety outcomes, operational performance measures, and other scientifically valid metrics that accurately reflect the delivery of emergency care.

Summary of Asynchronous Testimony

Asynchronous testimony largely supported the resolution. Testimony supported restricting the use of patient experience surveys in physician compensation, credentialing, and employment decisions unless the survey instrument is scientifically validated for individual attribution and emphasized that individual performance evaluations should prioritize evidence-based clinical quality and safety metrics rather than subjective satisfaction scores. Multiple members warned against clauses that merely reaffirm existing policy and recommended the fulfillment of the second and third resolveds could be achieved by being incorporated into the 2025 policy statement "Patient Experience of Care Surveys." Addressing the widespread nature of the issue, ACEP leadership highlighted ongoing collaboration with the American Medical Association to advance survey reform across the broader House of Medicine.

Recommended NOT for Adoption

12. **RESOLUTION 48(26): No-Cost Solutions to ED Boarding**

RESOLVED, That ACEP have a focused message on crowding and boarding solutions including:

1. Practical solutions to boarding and capacity exist at little or no cost that are not being implemented.

2. Smoothing of elective admissions have been shown to improve capacity to the benefit of patients, staff, physicians, and hospital finances.
3. Early discharge of patients to a sufficient degree has shown to decrease length of stay and increase capacity to the benefit of the patient, staff, physicians, and hospital finances.
4. Enhanced weekend discharges has been shown to decrease length of stay and increase capacity to the benefit of the patient, staff, physicians, and hospital finances.
5. Expanded hours for ancillary services on evenings and weekends improves flow, increases capacity, and shortens length of stay.

Summary of Asynchronous Testimony

Asynchronous testimony was mixed with many of those providing testimony requesting further clarification from the authors as to what new value the resolution adds. Testimony highlighted that ACEP already has resources titled "Emergency Department Crowding: High Impact Solutions" and "Toolkit for Enacting Meaningful Legislative and Regulatory Solutions for ED Boarding and Hospital Crowding" that already address the five points the resolution request fulfilled. Testimony also highlighted that boarding is a systemic hospital problem rather than an isolated ED issue and the primary challenge is no longer identifying interventions, but actively convincing hospitals, legislators, and regulators to implement them.

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13. **RESOLUTION 52(26): Prioritizing Inpatient Medical Admission for Geriatric Psychiatric Patients When Psychiatric Beds Are Unavailable**

RESOLVED, That ACEP develop a policy statement supporting admission to an inpatient medical unit, with appropriate psychiatric consultation and geriatric-focused care, as the preferred alternative to prolonged emergency department boarding for geriatric psychiatric patients who require inpatient-level mental health care when an appropriate psychiatric bed cannot be secured within 24 hours; and be it further

RESOLVED, That ACEP advocate, through policy, education, and external partnerships, that admission to an inpatient medical unit with appropriate psychiatric consultation and geriatric-focused care should be the preferred alternative to prolonged emergency department boarding for geriatric psychiatric patients who require inpatient-level mental health care when an appropriate psychiatric bed cannot be secured within 24 hours; and be it further

RESOLVED, That ACEP work with accrediting and regulatory bodies, hospital leaders, and health systems to remove barriers and clarify that admission to inpatient medical services for such patients is an acceptable and preferred safety practice when psychiatric beds are unavailable; and be it further

RESOLVED, That ACEP advocate for national quality standards that discourage prolonged emergency department boarding of geriatric psychiatric patients and support timely admission to inpatient medical settings when psychiatric placement is unavailable; and be it further

RESOLVED, That ACEP evaluate incorporation of more explicit guidance into the Geriatric Emergency Department Accreditation (GEDA) Program encouraging accredited emergency departments to establish policies that prioritize inpatient admission for geriatric psychiatric patients when psychiatric placement is unavailable and prolonged emergency department boarding would otherwise occur.

Summary of Asynchronous Testimony

Asynchronous testimony was largely in opposition. Testimony argued that inpatient bed allocation should be based strictly on clinical medical necessity rather than demographic profiles or specific patient cohorts. Testimony also warned that medical units and nursing staff are frequently unequipped to safely care for unstable psychiatric patients, especially in rural and community settings and urged caution against attaching contentious admission requirements to the fledgling Geriatric Emergency Department Accreditation (GEDA) program, favoring broader solutions such as telepsychiatry and expanding overall psychiatric bed capacity. It was suggested softening phrasing in the resolution's title by replacing "prioritizing" with "recommending."

14. **RESOLUTION 54(26): Radiology Turn-Around Time**

RESOLVED, That ACEP promote the following standard: from the time the patient is ready for a plain film or CT to the time the test is completed and definitively interpreted should be no more than 60 minutes; and be it further

RESOLVED, That emergency department radiology turn-around time should be included in ACEP's Clinical Emergency Data Registry.

Summary of Asynchronous Testimony

Asynchronous testimony was largely in opposition. Testimony pointed out that "ready for study" is not a standardized health record timestamp and that integrating this metric into data registries would carry heavy financial costs. It was also emphasized that imaging delays are driven by systemic factors beyond physician control, such as transport, IV access, lab processing, and scanner capacity, making a single national threshold unrealistic. Additional testimony reflected that setting a 60-minute radiology turnaround time would impose practice mandates on another specialty and would encourage reciprocal standards on emergency medicine and the establishment of a hard cutoff would create severe medical-legal liability. It was suggested that instead of a top-down mandate, collaborating with the American College of Radiology and local hospital leadership would help address throughput bottlenecks.

Recommended for Referral

15. **RESOLUTION 55(26): Responsible Use of AI in Emergency Medicine Documentation**

RESOLVED, That ACEP support the use of responsible AI-enabled documentation tools in emergency medicine while recognizing clinical documentation as a core component of the emergency physician's practice and affirming that such tools should augment, not replace, physician work; and be it further

RESOLVED, That ACEP affirm that the treating emergency physician remains responsible for the accuracy, clinical reasoning, and narrative integrity of the medical record and must ensure that the documentation reflects their clinical judgment; and be it further

RESOLVED, That ACEP support development of educational resources and practical guidance for the safe, effective, and responsible use of AI-enabled documentation tools in emergency medicine, while recognizing variation in documentation workflows and physician practice styles.

Summary of Asynchronous Testimony

Asynchronous testimony supported the intent of the resolution widely agreeing that artificial intelligence in emergency medicine will ease documentation, particularly for clinical documentation, requires regulation and oversight, but pointed out that much of the work requested in this resolution will likely be accomplished through ACEP's Health Information Technology Committee/Artificial Intelligence Subcommittee. EMRA cautioned against algorithmic bias and urging balanced training so residents master core skills before using artificial intelligence. Several members providing testimony suggested withdrawing the resolution, referring it to the Board, or deleting clauses that duplicate existing 2026 consensus statements.

Mr. Speaker, this concludes the preliminary report of Reference Committee C. I would like to thank Patsy Chenpanas, MD; Frank Y. Duncan, III, MD, FACEP; Laura Janneck, MD, MPH, MS; Ira R. Nemeth, MD, FACEP; Monika Pitzele, MD, PhD, FACEP; Joya Coffman MS, CHES, ASQ-CQIA; Travis Schulz, MLS, AHIP; for their excellent work in developing this preliminary report.