American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

February 9, 2023

To the Members of the 118th Congress:

On behalf of the American College of Emergency Physicians (ACEP) and our 40,000 members, we look forward to working with you and your staff to ensure continued access to the affordable, lifesaving emergency care that our patients and communities depend upon. The emergency department (ED) serves as the "front door" to the health care system, receiving more than 131 million visits in 2020, with more and more of our patients older in age and arriving via emergency medical services (EMS) transport. Of these visits, 16 to 18 percent of patients are admitted to the hospital, accounting for more than half of all inpatient admissions nationwide. And for many Americans, the ED may be the first – and only – interaction they have with the health care system, especially for safety-net and otherwise underserved populations.

For the last several years, emergency physicians have served under exceptional circumstances and with limited access to necessary resources and protective equipment. As we work to care for our patients, we are eager to continue partnering with Congress to identify these challenges and develop policy solutions that will improve and sustain our nation's health care safety net. Emergency physicians stand ready for our patients 24 hours a day, 7 days a week, 365 days a year, and likewise, ACEP stands ready to work with and serve as a resource to you and your staff.

We appreciate the opportunity to share some of the key priorities for emergency medicine. These include stabilizing the health care safety net by addressing conditions and factors that lead to "boarding" and crowding in emergency departments, a crisis overwhelming EDs across the country, straining the physician and nursing workforce and even causing avoidable patient deaths; protecting emergency physicians, nurses, and staff from violence in the ED; improving access to care for those in mental health crisis, providing more pathways to recovery for patients with substance use disorders, and promoting research in emergency medicine, public health, and injury prevention efforts; and, ensuring fairness and stability in Medicare physician payments through necessary reforms and improvements, among many others.

Emergency Department Boarding

Patient "boarding" occurs when a patient continues to occupy an ED bed even after being seen and treated by a physician, while waiting to be admitted to an inpatient bed in the hospital, or transferred to psychiatric, skilled nursing, or other specialty facility. As our health care system becomes increasingly strained, these patients must stay in the ED for days or even weeks on end waiting for a bed to become available so they can be admitted or transferred. Patients being boarded in the ED limits the ability of ED staff to provide timely and quality care to all patients, forcing other newly arriving patients with equally important emergency conditions to wait in the ED waiting room for care, with wait times as long as eight or even twelve hours rapidly becoming a new norm, and patients even dying during these waits as staff struggle to keep up with an unsupportable volume of sick patients to care for.

Boarding has become its own public health emergency. Our nation's safety net is on the verge of breaking beyond repair; EDs are gridlocked and overwhelmed with patients waiting – waiting to be seen, waiting for admission into an inpatient bed in the hospital, waiting to be

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transferred to psychiatric, skilled nursing, or other specialized facilities that have little to no available beds, or, waiting to simply return to their nursing home. And this breaking point is entirely outside of the control of highly skilled emergency physicians, nurses, and other ED staff doing their best to keep everyone attended to and alive.

Any emergency patient can find themselves boarded, regardless of their condition, age, insurance coverage, income, or geographic area. Even patients sick enough to need intensive care may board for hours in ED stretchers not set up for the extra monitoring they need. Those in mental health crises, often children or adolescents, board for *months* in chaotic EDs while waiting for a psychiatric inpatient bed to open anywhere. But boarding does not just affect those waiting to receive care elsewhere. When ED beds are already filled with boarded patients, other patients are decompensating and, in some cases, dying while in ED waiting rooms during their tenth, eleventh, or even twelfth hour of waiting to be seen by a physician.

> *"At peak times which occur up to 5 days per week we have more patients boarding than we have staffed beds. High numbers have include last week when our 22 bed emergency department had 35 boarders and an additional 20 patients in the waiting room…In addition, we have patients who unfortunately have died in our waiting room while awaiting treatment. These deaths were entirely due to boarding. Our boarding numbers have unfortunately skyrocketed in the wake of COVID as a consequence of increasing surgical volumes and decreasing inpatient nurse staffing."*
>
> – anonymous emergency physician

To illustrate the stark reality of this crisis, ACEP asked its members to share examples of the life-threatening impacts of ED boarding. The stories paint a picture of an emergency care system already near collapse. While the causes of ED boarding are multifactorial, unprecedented and rising staffing shortages throughout the health care system have recently brought this issue to a crisis point, further spiraling the stress and burnout driving the current exodus of excellent physicians, nurses, paramedics, and other health care professionals.

We need a health care system that can accurately track available beds and other relevant data in real-time, appropriate metrics to measure ED throughput and boarding, contingency plans and "load balancing" plans for boarding/crowding scenarios, and fewer regulatory or other "red tape" burdens that delay necessary care. Recognizing all EDs are different and there is no one-size-fits-all solution to this multifactorial problem, ACEP is in the process of developing a broad range of potential legislative and regulatory solutions that will alleviate the burdens and overall strain on EDs caused by patient boarding. As we finalize these recommendations and policy solutions, we will share more broadly with you and your staff in the coming weeks. Further, we strongly urge Congress to direct its attention to this critical issue and work with us and other stakeholders through roundtables, hearings, and legislation to provide both short- and long-term solutions to this public health crisis.

Violence Against Emergency Physicians and Health Care Workers

Violence in the emergency department is a serious and growing concern, causing significant stress to emergency department staff and to patients who seek treatment in the emergency department (ED). According to a survey conducted by ACEP in 2022, two-thirds of emergency physicians report being assaulted in the past year alone, while more than one-third of respondents say they have been assaulted more than once. Nearly 85 percent of emergency physicians say the rate of ED violence has increased within the last year.

Beyond the immediate physical impacts and injuries, the risk of violence increases the difficulty of recruiting and retaining qualified health care professionals and contributes to greater levels of physician burnout. In fact, 87% of emergency physicians report a loss of productivity from the physician or staff as a result, and 85% of emergency physicians report emotional trauma and an increase in anxiety because of ED violence. Most importantly, patients with medical emergencies deserve high-quality care in a place free of physical dangers from other patients or individuals, and care from staff that is not distracted by individuals with behavioral or substance-induced violent behavior.

And unlike the significantly more visible violence against airline employees and other travelers that has become more ubiquitous over the last several years, violence against health care workers often is not seen or addressed because of inadequate reporting and tracking of violent incidents, and other systemic barriers that do not hold violent individuals accountable for their actions. As a result of the inability to prosecute those who are arrested, many health care workers are discouraged from even pressing charges and being forced to accept that it's "just part of the job." Violence is not accepted in any other workplace, and it must not be accepted especially in a setting focused on improving the health and well-being of individuals.

There are many factors contributing to the increase in ED and hospital violence, we recognize there is no one-size-fits-all solution to this issue either. In fact, one of the challenges is that the types of violence one ED typically experiences can be

significantly different from another ED, even in the same town. Therefore, ensuring there are adequate resources to help identify best practices and outfitting facilities with resources appropriate to their specific needs is imperative. Overall, employers and hospitals should develop workplace violence prevention and response procedures that address the needs of their particular facilities, staff, contractors, and communities, as those needs and resources may vary significantly.

ACEP supports multi-pronged legislative efforts to address various aspects of health care workplace violence prevention. During the 117th Congress, ACEP supported two bipartisan bills to address workplace violence: the "Workplace Violence Prevention for Health Care and Social Service Workers Act," (H.R. 1195/S. 4182), introduced by Reps. Joe Courtney (D-CT), Don Bacon (R-NE), and others in the House, and by Sen. Tammy Baldwin (D-WI) in the Senate; as well as the "Safety From Violence for Healthcare Employees (SAVE) Act," (H.R. 7961) introduced by Reps. Madeline Dean (D-PA) and Larry Bucshon (R-IN). The Workplace Violence Prevention for Health Care and Social Service Workers Act would ensure that health care workplaces implement violence prevention plans and techniques and are prepared to respond to acts of violence, while the SAVE Act would establish federal legal penalties for individuals who knowingly and intentionally assault or intimidate health care workers and provide grants to help hospitals and medical facilities establish and improve workplace safety, security, and violence prevention efforts. We are hopeful these bills will be reintroduced as soon as possible and that Congress will consider these and other efforts to reduce the threat and incidence of violence against emergency physicians and other health care workers.

Access to Mental Health Care

The emergency department is not only a safety net for those with physical care needs, but also for individuals suffering from a mental health crisis or acute psychiatric emergency. However, it is not ideal for long-term treatment of mental and behavioral health needs. Due to the fragmented nature of the mental health care infrastructure in the U.S., persistent lack of sufficient resources, and longstanding shortages of mental and behavioral health professionals, far too many Americans have limited options for the longer-term follow-up treatment they need and deserve. These challenges also contribute to the long ED wait times and aggravate ED boarding issues detailed above. In fact, ED boarding challenges disproportionately affect patients with behavioral health needs who wait on average three times longer than medical patients because of these significant gaps in our health care system.

Across the country, communities have adopted innovative alternative models to improve emergency psychiatric care and reduce psychiatric patient boarding. These include Behavioral Health Emergency Rooms (BHERs), separate areas of the ED that specialize in caring for patients experiencing a behavioral health crisis; Emergency Psychiatric Assessment Treatment and Healing (EmPath) Units, a separate, hospital-based setting solely for psychiatric emergencies with the safe, calming, homelike environment of a community mental health crisis clinic but with the ED's ability to care for any patient presenting for treatment; and Psychiatric Emergency Service (PES) models, a "hub-and-spoke" model with a dedicated psychiatric ED serving as a central hub with bidirectional spokes going out to a wide variety of mental, behavioral, and physical care, as well as social services.

To ensure that communities can implement models that best fit their needs, ACEP supports the bipartisan "Improving Mental Health Access from the Emergency Department Act" (H.R. 1205/S. 2157 in the 117th Congress), led by Reps. Raul Ruiz (D-CA) and Brian Fitzpatrick (R-PA) and Sens. Shelley Moore Capito (R-WV) and Maggie Hassan (D-NH). This legislation would provide critical funding to help communities implement and expand programs to expedite transition to post-emergency care through expanded coordination with regional service providers, assessment, peer navigators, bed availability tracking and management, transfer protocol development, networking infrastructure development, and transportation services; increase the supply of inpatient psychiatric beds and alternative care settings; and, expand approaches to providing psychiatric care in the ED, including telepsychiatry, peak period crisis clinics, or dedicated psychiatric emergency service units. H.R. 1205 was passed by the House of Representatives during the 117th but was not considered by the Senate. We anticipate this bill will be reintroduced in the near future and urge Congress to consider and pass this important legislation.

In addition to the mental health needs of the public, ACEP also strongly urges Congress to continue working to address physician and provider mental health and burnout as part of larger policy efforts, especially in light of the significant mental health toll the pandemic response has taken on frontline health care providers. According to a recent report, 65 percent of emergency physicians reported burnout – the highest rate among 29 physician specialties surveyed. Improving and providing for the mental health and well-being of the health care workforce is a unique challenge, but one that is absolutely essential to ensure that patients have access to the full continuum of high-quality health care. We are deeply grateful for Congress' bipartisan work to pass the Dr. Lorna Breen Health Care Provider Protection Act (P.L. 117-105), which was signed into law on March 18, 2022. We urge Congress to ensure that the critical programs and resources provided under this law are adequately funded to improve the mental health of the health care workforce.

Pandemic and All-Hazards Preparedness Act (PAHPA) Reauthorization

As the experience of combating the COVID-19 pandemic has shown, we must ensure that our country's public health and medical preparedness response capabilities are equipped to respond to future pandemics, outbreaks, natural disasters, deliberate attacks, and other mass casualty events. On the pandemic preparedness front, the Consolidated Appropriations Act, 2023, included significant provisions informed by the lessons of our nation's response to COVID-19, including efforts to improve medical countermeasure research and manufacturing capacity, strengthening the supply chain for essential medications, personal protective equipment (PPE), and other resources, and reinforcing the Strategic National Stockpile (SNS). We are deeply appreciative of Congress' efforts to respond to the lessons learned from the pandemic. However, there are still more steps we can take to improve our emergency preparedness infrastructure on all fronts through reauthorization of the Pandemic and All-Hazards Preparedness Act (PAHPA), for which the current authorization expires on September 30.

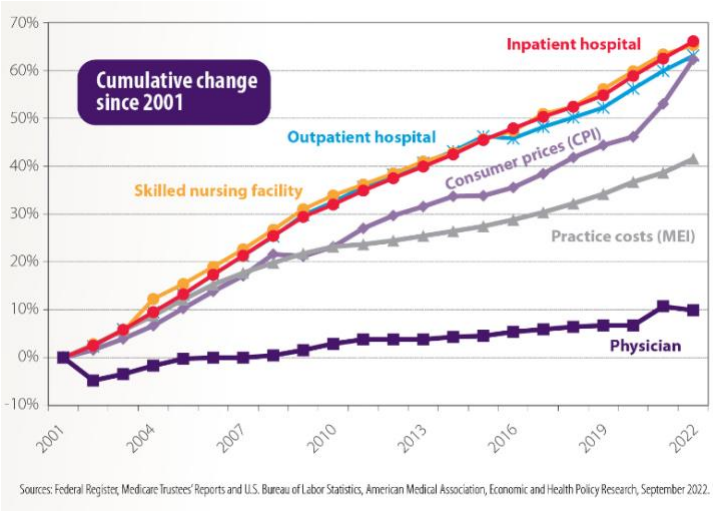
Among our priorities as Congress begins to consider reauthorization are:

- Development of a robust, coordinated national trauma and emergency preparedness system that can provide awareness of resources and surge capacity throughout the health care system (as well as the ability to "load balance" the system to match patients with appropriate resources and specialty expertise);
- Additional efforts to incentivize and operationalize domestic production of essential emergency medications, equipment, and PPE and ensure that distribution of these resources is prioritized for frontline providers and responders;
- Reauthorization of the successful MISSION ZERO program that awards grants to enable military trauma care providers and trauma teams to provide trauma care and related acute care at civilian trauma centers (improving not only care provided in our communities but bolstering our military readiness capabilities);
- Protecting our emergency response systems and infrastructure from cyberattacks and other potential vulnerabilities; and,
- Promoting research through the NIH's Office of Emergency Care Research (OECR) to foster basic, translational, and clinical research and research training for the emergency setting.

Fulfilling Medicare's Promise to Seniors

Financial stability and certainty are critical in ensuring that Medicare can fulfill its promise to the millions of American seniors that deserve and depend upon this program. The annual issue of significant Medicare physician payment cuts not only threatens the viability of the health care safety net, but also affects our ability to effectively partner with Congress to address other critical challenges facing the physician community, and most importantly, our ability to advocate on behalf of our patients. We share legislators' significant frustrations with the perennial task of finding costly, short-term fixes for long-term problems, and to this end, we support efforts to provide greater and stability and certainty in this system.

While the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 helped avoid short-term physician payment issues, according to the 2022 Medicare Trustees Report, there are "…important long-range concerns that will almost certainly need to be addressed by future legislation." The Trustees note that without changes, future access to Medicare-participating physicians will become a significant long-term problem. ACEP strongly agrees with this assessment.



Overall, we believe that with improvements, developed through collaboration with Congress, regulators, and stakeholders as originally intended, MACRA can be significantly more effective in facilitating the transition to value based care delivery. It does not necessitate the wholesale dismantling of the current system as we did with the SGR, but does require more regular oversight and iteration to help us attain a sustainable payment system that truly incentivizes high-quality, cost-effective care and to ensure that we do not expend our time and resources in vain trying to achieve that ultimate goal. ACEP was encouraged by the efforts led by Representatives Ami Bera, M.D. (D-CA), Larry Bucshon, M.D. (R-IN), Kim Schrier, M.D. (D-WA), Michael Burgess, M.D. (R-TX), Earl Blumenauer (D-OR), Brad Wenstrup, D.P.M. (R-OH), Bradley Schneider (D-IL), and Mariannette Miller-Meeks, M.D. (R-IA) in September 2022, requesting information from stakeholders on how Congress can stabilize the Medicare payment system, without dramatic increases in Medicare spending while ensuring successful value-based care incentives are in place. We ask Congress to work with us to identify long-term, substantive reforms by holding hearings and roundtables to explore potential solutions that will guarantee the stability and security of the Medicare program, ensuring our nation's seniors have access to the high-quality care they need and deserve.

Once again, thank you for the opportunity to share some of our legislative priorities, and we look forward to working with you during the 118th Congress to help ensure that our health care safety net is there to support our patients, their families, and our communities. Should you have any questions or require any further information, please do not hesitate to contact Ryan McBride, ACEP's Congressional Affairs Director, at rmcbride@acep.org.

Sincerely,

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