American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

November 15, 2021

The Honorable Ron Wyden
Chairman
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Mike Crapo
Ranking Member
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Chairman Wyden and Ranking Member Crapo:

On behalf of the American College of Emergency Physicians (ACEP) and our 40,000 members, thank you for your attention to the critical issue of unmet behavioral health needs, especially as the COVID-19 pandemic has exacerbated the worrisome trends in Americans' overall mental health and continued lack of access to desperately needed behavioral health care services. ACEP is grateful for the opportunity to respond to the Committee's request for information (RFI) on policy proposals to improve access to mental health and substance use disorder (SUD) care throughout Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Affordable Care Act (ACA) marketplaces.

As the health care safety net, the emergency department (ED) is often the first – and sometimes only – point of contact for individuals experiencing mental health crises or other behavioral health challenges, such as SUD or overdose. While the ED is the critical frontline safety net and the most appropriate setting for acute unscheduled care for individuals suffering from a mental health crisis, it is not ideal for long-term treatment of mental and behavioral health needs. However, 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 contribute to long ED wait times and aggravate "boarding" issues, a scenario where patients are kept in the ED for extended periods of time due to a lack of available inpatient beds or space in other facilities where they could be transferred. **Overcrowding and boarding are not failures of the emergency department; rather, they are symptoms of larger systemic issues that must be addressed to eliminate bottlenecks in health care delivery and reduce the burden on the already-strained health care safety net.**

We appreciate the Committee's attention to several key areas of focus: strengthening the mental/behavioral health workforce; increasing integration, coordination, and access to care; ensuring parity; furthering the use of telehealth; and improving access to behavioral health care for children and young people. **As part of this effort, ACEP also strongly urges the Committee to include physician and provider mental health and burnout as necessary considerations in comprehensive mental health policy initiatives, especially in light of the significant mental health toll the COVID-19 pandemic has taken on frontline health care providers over the course of nearly two years.** Improving and ensuring 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 they need and deserve. Additionally, we hope you will examine the many innovative solutions that emergency physicians throughout the country have developed and successfully implemented to reduce emergency psychiatric patient boarding.

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Strengthening the Mental/Behavioral Health Workforce

Shortages of physicians, nurses, and other health care providers across the health care continuum, exacerbated by an influx of extremely sick patients (both due to COVID-19 cases as well as non-COVID-19-related cases resulting from delayed care during the pandemic), have significantly contributed to the growing issue of boarding. Empirical studies have shown boarding contributes to worse patient outcomes and increased mortality related to downstream delays of treatment for both high- and low-acuity patients. In addition to disrupting the ED workflow and creating operational inefficiencies, it often also creates additional dangers, such as ambulance diversion, increased adverse events, preventable medical errors, more walkouts by patients, lower patient satisfaction, violent episodes in the ED, and higher overall health costs. This problem is only worsening as ED volumes return to normal levels after a substantial drop in visits during the early stages of the COVID-19 pandemic.

Reducing boarding and mitigating its effects on all patients is critical in improving patient outcomes and their overall health, especially for those with mental or behavioral health needs. **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.** Some research has shown that 75 percent of psychiatric emergency patients, if promptly evaluated and treated in an appropriate location – away from the active and disruptive ED setting – have their symptoms resolve to the point they can be discharged in less than 24 hours, further highlighting the need to provide timely, efficient, and appropriate mental health care.

One of the significant workforce challenges affecting the provision of emergency psychiatric care is the increased risk of violence against physicians, nurses, and other health care workers. A 2018 ACEP survey found that nearly half of emergency physicians report being physically assaulted at work, and that the risk of being attacked increases in the delivery of acute psychiatric care. But beyond the immediate physical and mental harm to health care professionals, ED violence adversely affects patient care as well. These effects include loss of productivity from emergency physicians or staff, emotional trauma and increased anxiety, increased wait times, less focus from health care professionals as their attention is diverted elsewhere, potential physical harm, and an increased likelihood of leaving without being seen or treated. Unfortunately, many health care workers report that workplace violence has only intensified over the course of the COVID-19 pandemic. This has further stressed a health care system in crisis, increasing the difficulty of recruiting and retaining qualified health care professionals and exacerbating the substantial mental health burden and burnout challenges facing the emergency medical workforce in particular.

ACEP strongly supports the bipartisan Workplace Violence Prevention for Health Care and Social Service Workers Act (H.R. 1195), introduced by Representative Joe Courtney (D-CT). This legislation directs the Secretary of Labor to issue an occupational safety and health standard to establish procedures to ensure that emergency physicians, nurses, health care workers, social service workers, and patients are protected from violence in the workplace. H.R. 1195 received bipartisan support in the House and was approved by that chamber on April 16, 2021. **We strongly urge the Senate to take up and pass this critical legislation to improve the safety and well-being of our health care workforce**.

These significant issues, combined with the unprecedented physical and emotional toll of the COVID-19 pandemic on frontline health care professionals, have contributed to worsening physician mental health and increased levels of professional burnout. Optimal physical and mental well-being of physicians and other medical clinicians is necessary to ensure high-quality patient care. The stigma surrounding mental illness is a well-known barrier to seeking care among the general population, but it can have an even stronger impact among health care professionals. For most physicians, seeking treatment for mental health triggers legitimate fear of resultant loss of licensure (some state licensing boards continue to ask questions about clinicians' mental health histories or past treatment), loss of credentialing at your site of employment (for similar reasons), loss of income, professional reprisal, or other career setbacks. Such fears have deterred many from accessing necessary mental health care, leaving them to suffer in silence, or worse.

A poll from ACEP and Morning Consult released one year ago showed that despite the growing toll that serving on the frontlines of the COVID-19 pandemic was having on emergency physicians, many were still hesitant to seek mental health treatment. The results of the poll, conducted among a national sampling of emergency physicians, found:

- More than eight in 10 (87 percent) of emergency physicians reported feeling more stress since the start of the pandemic, with an additional 72 percent experiencing burnout on the job.
- Despite increased levels of stress and burnout, nearly half (45 percent) of the nation's emergency physicians did not feel comfortable seeking mental health treatment.
- When it came to seeking mental health treatment, 73 percent of emergency physicians felt there was stigma in their workplace.

- Nearly three in five (57 percent) of emergency physicians reported they would be concerned for their job if they were to seek mental health treatment.
- More than a quarter (27 percent) reported they had avoided seeking mental health treatment in fear of professional repercussions.
- Emergency physicians who reported not seeking mental health treatments for fear of professional repercussions cited job security, professional stigma, and future job opportunities as their reasons.

While COVID-19 certainly exacerbated the stress and burnout of emergency physicians, those concerns and the fear of seeking help existed long before the pandemic. As a country, we must show support for emergency physicians and other health care providers for their mental well-being, not just as we continue to combat COVID-19, but long after this crisis has passed.

ACEP is deeply grateful that the Senate adopted the "Dr. Lorna Breen Health Care Provider Protection Act" (S. 610/H.R. 1667) by voice vote on August 6, 2021. This bipartisan legislation introduced by Senator Tim Kaine (D-VA) is named in honor of emergency physician and longtime ACEP member Lorna Breen, MD, FACEP, who died by suicide in April 2020 after treating COVID-19 patients and contracting the virus herself. Her loss is still deeply felt by ACEP and our members and remains a tragic reminder that many of our colleagues continue to suffer in silence. The House of Representatives Committee on Energy and Commerce will likely consider this bill in the near future, and we are hopeful for full consideration and passage by the House of Representatives soon thereafter **so that any changes can quickly be reconciled to ensure this legislation is enacted and fully implemented as expeditiously as possible**.

Thanks to the work already undertaken by Congress to fund these grants as part of the American Rescue Plan, the framework for these support services has been established, but the authorizing legislation is still needed. This legislation would not only provide more specific guidance to the federal agencies tasked with implementing these grants, but would also require a comprehensive study to be conducted on health care professional mental health and behavioral health and burnout. This study, which was not part of the American Rescue Plan because it did not meet the criteria required for inclusion in a reconciliation bill, would also examine barriers to seeking and accessing mental and behavioral health treatment by providers, including stigma and concerns about licensing and credentialing. **The grant money is very much appreciated and needed, but if health care providers are still reluctant to access these programs for fear of impeding their careers or losing their ability to practice medicine altogether, then they cannot fulfill their purpose.**

On the regulatory front, despite ED boarding at a seemingly all-time high, the Centers for Medicare & Medicaid Services (CMS) recently finalized the FY2022 Medicare Hospital Inpatient Prospective Payment Systems (IPPS) rule, changing the Hospital Inpatient Quality Reporting (IQR) program by eliminating the electronic clinical quality measure (eCQM) version of ED-2, the Admit Decision Time to ED Departure Time for Admitted Patients Measure, beginning in the calendar year 2024 reporting period. **ACEP strongly opposed the removal of this measure to track how long patients wait before a decision is made as ED boarding represents one of the single greatest threats to patient safety in the ED setting, and noted that unlike other clinical areas for which multiple measures may exist, ED-2 is the only measure to track this statistic and provide incentives or enforcement to help reduce wait times and boarding.**

CMS' decision relied heavily on one meta-analysis of 12 studies that did not find a clear association between ED boarding and in-hospital mortality, thus concluding the costs associated with the measure outweigh its continued use in the program. Despite being provided with nearly 70 studies that clearly establish a link between boarding and patient mortality (many of which also detail the prevalence of psychiatric boarding), CMS finalized the rule and eliminated the only available measure to help track and mitigate boarding. We believe there was and continues to be validity and value in this measure and we ask you to work with CMS to reverse this decision, or alternatively, whether through legislative or regulatory action, develop a new and meaningful measure to determine how long an ED patient has waited before a medical decision has been made.

Increasing Integration, Coordination, and Access to Care

Improving coordination of care across the health care continuum must be one of the highest priorities for any mental health reform effort. The emergency department serves as the critical health care safety net not only for acute injuries, but for psychiatric emergencies as well. However, most EDs are not ideal facilities to provide longer-term care for patients experiencing a mental health crisis – they are often hectic, noisy, and particularly disruptive for behavioral health patients.

Across the country, communities have adopted innovative alternative models to improve emergency psychiatric care and reduce psychiatric patient boarding. Some examples include:

- **Behavioral Health Emergency Rooms (BHERs).** BHERs are separate areas of the ED that specialize in proactive rapid-assessment, stabilization, and treatment of patients in experiencing a behavioral health crisis. Care is delivered via a multidisciplinary team of emergency physicians, psychiatrists, psychiatric nurses, and social workers. This service is operational 24 hours a day, 7 days a week, 365 days a year. These dedicated spaces provide patients with a safer, private, and more peaceful setting in which to deescalate and receive specialized care.

  By initiating proactive assessments in a BHER, 40-50 percent of patients can be safely discharged home, reducing ED boarding time. Additionally, optimizing transition of care through Integrated Outpatient Care clinics ensures ongoing high-quality medical and behavioral health care follow-up with convenient and comprehensive treatment options for patients.

- **EmPath (Emergency Psychiatric Assessment Treatment and Healing) Units.** The EmPath unit is a separate, hospital-based setting solely for psychiatric emergencies with the safe, calming, homelike environment of a community mental health crisis clinic with the ED's ability to take care of any patient who presents for treatment. This unit accepts all suitable patients regardless of the severity of their illness, legal status, dangerousness, substance use intoxication or withdrawal, or co-morbid medical problems, as these patients are typically excluded from community programs and thus would likely experience boarding in an ED in the traditional medical system.

  EmPath units provide immediate access to individualized care from a comprehensive mental health care team of psychiatrists, psychologists, mental health nurses, social workers, and other licensed mental health care professionals. This team partners directly with patients and their families to address the immediate mental crisis and to develop a longer-term care plan through appropriate follow-up services. In some instances, EmPath Units have reduced regional ED boarding by 80 percent, and have also reduced the need for -- and incidence of -- coercive measures (such as physical restraints), episodes of agitation, and psychiatric hospitalization.

- **Psychiatric Emergency Service (PES).** The PES model is a multipronged approach for emergency psychiatric patients treated in the ED based on increased availability of psychiatrists and dedicated case managers who focus on psychiatric patients. This model is referred to as 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. Recognizing that psychiatric patients have vastly different needs and circumstances affecting their overall health, this model helps address the patient's immediate mental health needs and swiftly directs them to the most appropriate follow-up services, which helps alleviate the overall load on the mental health care system. These two-way spokes may also serve to reconnect patients with the psychiatric ED should they require acute stabilization while receiving follow-up services, potentially avoiding an inpatient hospitalization and ensuring the patient receives the most appropriate care and treatment throughout the mental health care continuum.

These innovative approaches have helped communities improve coordination of emergency psychiatric care and they can serve as models for other communities to implement and build upon. **However, what is clear from experience is that the ultimate success of any model hinges on the availability of resources, whether monetary, staffing, or access to follow-up services and patient access to long-term mental and behavioral health care**. One of the persistent challenges in emergency medicine is that "one emergency department is one emergency department" – i.e., the needs of each community and the resources available to local EDs, hospitals, and other facilities vary widely, and a model that is successful in one community may not be the best fit for another community.

For example, in 2017, Oregon implemented a dedicated psychiatric ED model in Portland based closely on the Alameda Model (California), but the transition has been marked by challenges for both the dedicated psychiatric ED and surrounding facilities. The dedicated psychiatric ED that was intended to reduce the burden on individual EDs is frequently at capacity or overcrowded, but emergency physicians at other facilities have noted that they are still seeing the same number of acute psychiatric patients in their own EDs. Additionally, the dedicated psychiatric ED has struggled to transfer patients to long-term follow-up treatment at Oregon State Hospital, contributing to long wait times, crowding, and poor outcomes for patients. Despite these challenges, stakeholders have been working to address the shortcomings of the system and adapt the model to better meet the needs of the Portland community, but the experience has highlighted that new care models are not necessarily "plug-and-play" and do not guarantee immediate results.

To better ensure that communities can implement models that best fit their needs, ACEP urges the Senate to consider and pass the "Improving Mental Health Access from the Emergency Department Act of 2021" (S. 2157), legislation that provides critical funding to help communities implement and expand programs to ensure individuals in mental health crisis receive the high-quality care they need and deserve. This bill will:

- 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 such as regional emergency psychiatric units; and,
- expand approaches to providing psychiatric care in the emergency department, including telepsychiatry support and other remote psychiatric consultations, peak period crisis clinics, or creating dedicated psychiatric emergency service units.

The House companion of this legislation (H.R. 1205) was approved by voice vote in the House of Representatives on May 12, 2021, and **we urge the Senate to either approve S. 2157 or take up and pass H.R. 1205, which will help communities expand their mental and behavioral health services and streamline care for patients.**

Another longstanding barrier to providing adequate mental health treatment services is the Medicaid Institutions for Mental Disease (IMD) exclusion that prohibits the federal government from providing Medicaid reimbursement to states for care provided to most patients in an inpatient psychiatric or SUD facility with more than 16 beds. Though this longstanding policy was intended to reduce the number of people committed to long-term psychiatric treatment facilities without receiving appropriate care, it has perpetuated the problem of disparate treatment of mental health and has stood as a major barrier in the effort to provide necessary non-hospital inpatient psychiatric care options.

As a limited workaround, states have been able to apply for Section 1115 Medicaid waivers to receive matching federal funds for short-term residential treatment services in an IMD. Congress also recently took steps to address some of the challenges posed by the IMD exclusion in the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act (P.L. 115-271), creating a limited new exception to allow states to provide Medicaid coverage for beneficiaries with at least one SUD in certain IMDs.

The IMD exclusion may also threaten the ability of communities to provide a continuum of crisis stabilization services that includes call centers, mobile crisis units, and crisis stabilization programs. Crisis stabilization programs are a resource distinct from traditional residential treatment facilities for mental health and SUD treatment. These provide individuals with additional immediate-access treatment options, helping them avoid settings detrimental to their condition such as jails, homeless shelters, or the streets. Unfortunately, the IMD exclusion was established before crisis stabilization beds were developed, and the 16-bed limitation for facilities severely restricts the ability of these services to meet the needs of communities with vulnerable Medicaid populations and high demand for such services. We agree with legislators' bipartisan efforts urging CMS to ensure Medicaid reimbursement for crisis stabilization beds and to ensure these programs are not adversely affected by the IMD exclusion.

ACEP has long advocated for full repeal of the IMD exclusion and strongly urges Congress to rescind this harmful policy either as a standalone effort or as a cornerstone of any comprehensive mental health reform legislation.

Ensuring Parity Between Behavioral and Physical Health Care

A lack of appropriate coverage, narrow provider networks, and low reimbursement for mental health services remain a barrier to achieving parity between mental and physical health care. Additionally, structural barriers exist, such as a lack of federal enforcement mechanisms for parity law violations, as well as burdensome and often duplicative requirements for administering treatment for SUD (the "X-waiver").

In recent years, Congress has taken important steps to improve parity between mental and physical health care by requiring insurers to provide the same level of coverage for mental health and substance use disorder treatment as they do for physical care. **But despite federal law, there is no mechanism for the federal government to enforce compliance against plans that continue to violate parity requirements and discriminate against patients with mental health conditions or SUD**. ACEP supports providing the Department of Labor (DOL) with the ability to issue civil monetary penalties (CMPs) for violations of the "Mental Health Parity and Addiction Equity Act" (MHPAEA; P.L. 110-343) by group health plan sponsors, plan

administrators, or issuers. We support the "Parity Enforcement Act of 2021" (H.R. 1364) introduced by Representative Donald Norcross (D-NJ) to give the DOL the authority to issue CMPs and are encouraged that these provisions were recently included in the "Build Back Better Act" framework.

Without enforcement penalties and more explicit parity requirements, we will continue to see insurers attempting to find their way around the law and limit the coverage available to beneficiaries experiencing mental health crisis. As a recent example, Optum in Maryland recently issued a policy establishing that only certain provider types are eligible to bill when the only diagnosis is a psychiatric issue, including homicidal ideation and suicidal ideation, precluding payment for an ED physician's evaluation and management services. This policy ignores the significant challenges emergency physicians are experiencing in seeing and treating mental health needs in the ED and will have disproportionate impacts on hospitals with high Medicaid populations. **Additionally, we believe this is yet another example of insurers attempting to disregard the Prudent Layperson Standard (PLP), a longstanding and critical policy that protects patients from retroactive denials of insurance coverage for emergency department visits that are ultimately determined to be non-emergent**. Patients who believe they are experiencing a medical emergency should not be discouraged from seeking treatment out of fear that their ED visit will not be covered by their insurer.

Ensuring parity for behavioral health care also requires appropriate treatment of substance use and opioid use disorders (SUD/OUD). To help reduce the pervasive stigma associated with SUD/OUD and treatment for these health conditions, **ACEP supports the elimination of the so-called "X-waiver" requirement to prescribe buprenorphine for medication assisted treatment (MAT) as mandated by the "Drug Addiction Treatment Act of 2000" (DATA 2000)**. Buprenorphine is one of the most effective means emergency physicians have to aid patients with OUD, but the X-waiver process necessitates the completion of eight to 24 hours of additional training – which is not required for *any* other prescribed medication – to dispense buprenorphine as part of an MAT protocol. As one of three drugs approved by the U.S. Food and Drug Administration (FDA) for treatment of opioid dependence, it is a safe and efficacious medication that is strong enough to reduce withdrawal symptoms and cravings but not enough to cause euphoria, allowing individuals with OUD to more effectively engage in treatment as they pursue recovery.

Buprenorphine is not a cure, but is a very effective tool in addressing the nation's opioid epidemic. Buprenorphine cuts the risk of overdose death in half, and patients started on buprenorphine in the ED are twice as likely to remain in treatment.[1] It also helps reduce illicit opioid use and infectious disease transmission when compared to treatment initiated after patients are discharged from the ED. In all, research suggests that the sooner patients are started on the right path and are kept engaged in treatment, the more successful their recovery can be.

But despite its safety and effectiveness, the X-waiver remains the greatest barrier to increased use of buprenorphine to treat OUD. The requirement of additional (and often duplicative) training, as well as the lengthy registration process with the U.S. Drug Enforcement Administration (DEA) that can take up to several months, unfortunately only serve to perpetuate the stigma that remains associated with these treatments, leading most health care providers to defer from using buprenorphine to treat OUD. As a result, the treatment of OUD remains unnecessarily isolated from standard health care delivery.

Though the Administration issued practice guidelines in April 2021 to loosen some of the federal restrictions on prescribing medications to patients with OUD, it noted that several remaining restrictions require an act of Congress to be removed, including the elimination of the X-waiver requirement. Some policymakers have also cited concerns about potential diversion of buprenorphine; however, according to federal officials – including the DEA – the primary reason for buprenorphine diversion today is a lack of access to treatment, and expanding access to buprenorphine will likely **reduce** diversion.

We therefore urge Congress to enact the bipartisan "Mainstreaming Addiction Treatment (MAT) Act" (S. 445/H.R. 1384) to remove the X-waiver requirement, allowing all health care practitioners with a standard controlled medication license to prescribe buprenorphine for OUD. It will also establish a national education campaign to educate practitioners about the elimination of the separate DEA registration requirement, encourage them to integrate SUD treatment into their practices, and inform them of publicly available educational resources and training modules that can assist practitioners in treating patients with SUD. This legislation is supported by 120 organizations, including ACEP.

Initiating buprenorphine in the ED is one of the most effective interventions that emergency physicians have at their disposal to help put patients on the path to recovery and tackle the nation's opioid epidemic. ACEP acknowledges there is much more to

[1] D'Onofrio G, O'Connor PG, Pantalon MV, et al, JAMA. 2015 Apr 28;313(16):1636-44.

treating OUD than simply prescribing a medication, but facilitating access to buprenorphine and decreasing the stigma associated with OUD treatment are critical steps forward.

Furthering the Use of Telehealth

Telehealth has helped reduce barriers and increase access to care, especially during the COVID-19 pandemic, and we support both Congress' and the previous Administration's efforts to expand telehealth flexibilities during the public health emergency.

ACEP strongly supports the elimination of the geographic restrictions and adding the home as an originating site for telehealth services when used for the treatment of a mental health disorder. As emergency physicians, we see every day the end result of so many in our country having difficulty accessing mental health services. For some individuals, the ability to receive telehealth services at home could be a much better alternative than seeking mental treatment at the ED.

We are concerned, however, with CMS' policy in the final calendar year 2022 Physician Fee Schedule to require that patients must have an in-person visit with their treating physician or a physician from the same practice every twelve months. We believe that this length of time is arbitrary and may not be an appropriate interval in particular cases. Physicians are in the position to determine when in-person treatment is necessary for their patients, which could be a longer or shorter interval than every twelve months. **The Consolidated Appropriations Act, 2021 gives CMS the autonomy to determine appropriate follow-up periods for in-person visits, and we believe CMS should take advantage of this flexibility and give physicians the discretion to decide when in-person care may be necessary for their patients**.

The value of telehealth and its role in eliminating gaps in access to health care are but some of the many lessons learned from the response to the pandemic, and we urge Congress and the Administration to promote expanded access to appropriate telehealth services.

Improving Access to Behavioral Health Care for Children and Young People

The full effects of the COVID-19 pandemic are not limited to the staggering toll on American lives or the long-term physical health challenges from which many recovering patients still suffer. We are still collectively struggling to comprehend the true scope of the pandemic's impact on the mental health and well-being of millions of Americans, particularly on children and younger Americans.

As the recent U.S. Department of Education report, "Supporting Child and Student Social, Emotional, Behavioral, and Mental Health Needs" notes, children have experienced isolation, bereavement, depression, worry, and other issues throughout the pandemic, leading to reports of anxiety, mood, and eating disorders, as well as increased self-harm behavior and suicidal ideation at nearly twice the rate of adults. **Pediatric emergency department visits related to mental health significantly increased during the pandemic – a 24 percent increase for children 5-11 years of age, and 31 percent for children 12-17.** These stressors affect children's' development and ability to learn in both the immediate and long-term with lasting consequences should their mental health needs not be adequately addressed.

Adding to these long-term considerations are the mental health stresses associated with the loss of a caregiver. According to a recent pre-publication study in the October 2021 issue of the American Academy of Pediatrics journal, *Pediatrics*, more than 140,000 U.S. children under the age of 18 lost a primary or secondary caregiver due to COVID-19 between April 1, 2020 and June 30, 2021.[2] The consequences of the pandemic's disproportionate impact on racial and ethnic minorities, exacerbated by longstanding systemic inequalities, manifest here as well given that children of racial and ethnic minorities account for 65 percent of children who lost a primary caregiver (compared to 39% of the total population). The authors note the significant long-term impacts that orphanhood and caregiver loss have on the health and well-being of children, ranging from mental health problems and increased risks of suicide violence, sexual abuse, and exploitation, to disruptions in family circumstances such as housing instability and lack of nurturing support.

Our health care system is not currently well-equipped to address the long-term effects of the significant trauma so many young Americans have experienced over the course of the last year. **Given the substantial strains on the health care and social**

[2] COVID-19-Associated Orphanhood and Caregiver Death in the United States (aappublications.org)

safety nets that existed long before the pandemic hit, it is clear that emergency departments, child welfare systems, the child and adolescent mental health workforce, and other related services will need considerable investments and significantly expanded resources in order to appropriately address this unprecedented challenge. As policymakers and stakeholders evaluate suggestions to improve mental and behavioral health access, these proposals and any new treatment models must be considered through the lens of pediatric care in order to prioritize the most vulnerable of the vulnerable.

Once again, on behalf of the 40,000 emergency physicians we represent, thank you for the opportunity to respond to the committee's request for information. Should you have any questions or require any additional information, please do not hesitate to contact Ryan McBride, ACEP Senior Congressional Lobbyist, directly at rmcbride@acep.org or at (202) 370-9299.

Sincerely,

Gillian Schmitz, MD, FACEP

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ACEP President