

Advocacy at Home: August Recess Toolkit for ACEP Members

August 2022

Table of Contents

Contents

Tools and Tips for Meetings with Legislators In-District	1
Requesting Your Meeting	1
Preparing for Your Meeting	1
During Your Meeting.....	1
After the Meeting	2
Key Messages	2
Physician-Led Care Teams.....	2
Violence in the Emergency Department.....	3
Insurance Company Misbehavior	4

Tools and Tips for Meetings with Legislators In-District

What is an in-district visit? You meet with your elected official or their staff in the district instead of traveling to Washington, D.C. You share your expertise and experience and encourage the elected official to act on specific issue(s).

Requesting Your Meeting

- Request a meeting via email and/or phone call to the elected official's scheduler. [Check here](#) to find contact information for the D.C. and District offices.
- Your meeting request should include: a range of times you are available to meet; your contact information; the fact that you are a constituent; and specific issue(s) or legislation you would like to discuss.

Preparing for Your Meeting

- Check ACEP's [Advocacy](#) and [Media](#) resources for the latest information on relevant issues.
- There are three specific issues strategically chosen for timeliness and urgency. Prepare for your meetings by reviewing the included talking points and identifying a relevant personal story for each topic, if possible. The goal is to use your experience to personalize the need for a specific policy "ask," such as urging a legislator to sponsor a bill.
- Print any informational materials you may want to leave with the office.
- Let the office know if you are planning to bring any colleagues, residents, medical students, etc. with you to the meeting. A maximum of four attendees is recommended.
- If you are bringing anyone with you, discuss talking points, and which stories you want to share as examples, in advance.
- Check your [elected official's website](#) to familiarize yourself with their priority issues and anything that will help you relate your talking points and stories to their interests.

During Your Meeting

- Bring ID in case you are asked for it when you arrive.
- Silence your phone during the meeting but keep it available if you have an opportunity for a photo with your elected official. Please send any relevant photos to Liz Demorest in the ACEP D.C. office at ldemorest@acep.org.
- Be prompt and patient. Elected officials have tight schedules that may change. If your meeting changes to a meeting with staff, that is still valuable and worthwhile!
- Start the meeting by introducing yourself, thank them for taking time to meet with you, and mention any personal connection you may have with the office.
- Keep your remarks focused and stick to your planned topic. You will likely have 20 minutes or less with staff, and ten minutes or less with an elected official.
- Provide personal and local examples of the impact of the legislation you are advocating for.
- Thank them for any recent votes in support of ACEP priority issues.
- If you do not know the answer to a question or if they request additional materials, this can be a great opportunity to follow up afterward and/or connect them with ACEP Advocacy staff. Please direct any questions or follow-up to Jeanne Slade in the ACEP DC office at jslade@acep.org.

After the Meeting

- Immediately after the meeting, debrief with anyone who joined you on how you feel it went, and agree on how and when to follow up.
- Each person who participated in the meeting should send a personal thank you to the elected official and/or staff you spoke with. This can include follow up information and materials, or a timeline for sharing more information.
- Share a summary of the meeting, and the response to your specific ask, with ACEP Advocacy staff at jslade@acep.org.

Key Messages

Few things are more valuable to policymakers than the firsthand experience of their constituents. These conversations are your opportunity to share your experience in the emergency department and call for the policy changes that help you do your job and save lives.

These talking points are meant to support advocacy conversations, media interviews, and the creation of relevant materials. The most effective way to make your point is to personalize the issues—talk about a time you dealt with ED violence, explain how insurance company tactics make it harder for you to do your job, share a patient scenario you have seen that differentiates physician training and experience from others on the care team.

Check with your chapter for the most up-to-date legislative information around the issues in your state. Please contact PR@acep.org with any questions about how to utilize and customize these points for social media posts, speaking engagements or other thought leadership activations.

Physician-Led Care Teams

Read more about ACEP policies, statements, and campaigns to address scope of practice concerns [here](#). For ACEP's full Spokesperson and Chapter toolkit on scope of practice, [click here](#).

Many hospitals are responding to resource constraints and staffing challenges by allowing midlevel practitioners—like physician assistants (PAs) or nurse practitioners (NPs)—to perform complex medical procedures without supervision. However, these policies undermine, rather than strengthen, emergency care.

Patients trust and prefer emergency physicians to lead their care.

- Research shows that patients [overwhelmingly trust emergency physicians](#) to lead their care in the emergency department and [prefer to see a physician when they're having an emergency](#), according to an ACEP/Morning Consult poll.
- Nearly 80% of adults trust a physician to deliver their medical care in an emergency, compared to a nurse practitioner (6%), physician assistant (5%) or registered nurse (8%), according to an ACEP/Morning Consult poll.

PAs and NPs are integral members of the care team, but, they do not have the training or expertise of an emergency physician.

- A licensed and board-certified emergency physician completes thousands of hours of training, and more than a decade of expert-level education, so that they are prepared in a moment's notice for any challenge that comes their way.
- An emergency physician is required to complete 11 or more years of training and is the only member of a care team that completes a medical residency. In comparison:
 - Registered nurse: four years of training
 - Nurse practitioner: five to eight years of training
 - Physician assistant: seven years of training
- Emergency physicians also have significantly more hands-on training with real patients than the other professionals on their team.
 - A nurse practitioner is required to clock at least 500 clinical hours.
 - For a physician that requirement is at least 12,000 hours.

Safety and cost concerns arise when PAs and NPs take on responsibilities that exceed their training.

- Research shows that PAs and NPs order more tests, scans, and referrals to specialists than physicians.
 - Nurse practitioners [prescribed more opioids](#) than physicians, according to one analysis. It states that allow independent prescribing, nurse practitioners were 20 times more likely to overprescribe opioids than those in prescription-restricted states.
 - Non-physicians [ordered more imaging](#) over a 12-year period, according to another study. Scans increased more than 400% by non-physicians, primarily nurse practitioners and physician assistants.

Support for physician-led teams aligns with most state scope of practice laws.

- Policies meant to address pressing health care challenges, such as access to emergency care in rural communities, or emergency department staffing shortages or resource constraints, should also support the gold standard of care: physician-led care teams.

Violence in the Emergency Department

Physical and verbal attacks on emergency physicians, nurses, and staff in the emergency department are rampant and unacceptable.

- Almost half of emergency physicians report being physically assaulted at work, according to an [ACEP poll](#) of its members in 2018. And the pandemic has only exacerbated the situation.
- Violence in the emergency department is not only physically dangerous, it also contributes to already high rates of physician burnout and impacts physicians' mental health.
- The vast majority (80%) of emergency physicians also say violence in the emergency department harms patient care.

The full impact of violence against healthcare workers is understated because so many incidents are never reported.

- Many health care workers decline to report assaults because, for a variety of reasons, assailants are not always held accountable.
- Physicians and their care teams deserve a support system that helps prevent these incidents and protects them when they occur.

Emergency physicians continue to lead the way toward solutions that address and prevent attacks on health care workers.

- The American College of Emergency Physicians and the Emergency Nurses Association have partnered since 2018 on the [No Silence on ED Violence](#) campaign to raise awareness, advocate for policy changes and strengthen protections for frontline workers.

Emergency physicians are calling for a two-pronged policy approach that addresses violence in the emergency department: establishing criminal penalties for assailants and strengthening workplace prevention programs for employees.

- We strongly encourage legislators to support these bills currently under discussion:
 - The “Workplace Violence Prevention Act for Health Care and Social Service Workers,” (S. 4182) introduced by Sen. Tammy Baldwin (D-WI). Its companion (H.R. 1195) in the House of Representatives, introduced by Rep. Joe Courtney (D-CT), passed in a bipartisan vote in April 2021, and now we need the Senate to act.
 - This bill calls on the Occupational Safety and Health Administration to issue an enforceable standard requiring health care and social service employers to create and implement workplace violence prevention plans.
 - The “Safety from Violence for Healthcare Employees (SAVE) Act,” introduced by Reps. Madeleine Dean (D-PA) and Larry Bucshon, MD (R-IN).
 - This bill establishes federal penalties for violence against health care workers, criminalizing intentional assault or intimidation against health care workers while ensuring reasonable protections for individuals who may be mentally incapacitated due to illness or substance use.
 - The bill is modeled after protections that exist for aircraft and airport workers, such as flight crews and attendants, whose exposure to violence and assault from unruly passengers has been extensively documented in recent years.

Emergency physicians and care teams should be able to focus on saving lives, without fearing for our personal safety.

- The pandemic has shown just how vital our health care safety net can be.

Policymakers have every reason to do all they can to strengthen protections for health care workers.

- Physical violence, intimidation, and threats are not accepted in any other workplace, and they should not be allowed or tolerated in a health care setting.

Insurance Company Misbehavior

Large insurance companies have been raking in profits while denying or reducing payments to emergency physicians, including many practices struggling to keep their doors open.

- The stress of the last several years has pushed health care workers to the brink while resource constraints and staffing challenges threaten the viability of many medical practices.
 - As of July 22, 2022 hospitals in nearly 40 states [reported](#) critical staffing shortages, while hospitals in all 50 states said they expected to experience a shortage within a week.

- Insurer efforts to avoid fair or timely reimbursement can prevent physicians from making critical investments in new equipment, staffing, and other improvements necessary to meet the medical needs of the community.
- Still, emergency physicians have committed to treating anyone, anytime—even while exhausted, understaffed, and managing continued, persistent shortages of critical medications.
- That’s a stark contrast to significant profits recently reported by many of the largest insurance companies.
 - In the second quarter of this year, UnitedHealth Group reported \$5 billion in profit and both Anthem and Cigna each reported more than \$1 billion in profit.

Emergency departments rely on fair reimbursement from insurers to keep the doors open 24/7. However, insurers continue to embrace tactics that threaten emergency physicians’ livelihood and put access to lifesaving care at risk.

“Downcoding” is when an insurer decides that the level of care billed does not match the level of service provided, so the physicians’ reimbursement decreases, often without sufficient justification.

There are also troubling instances of insurers denying physician claims outright.

- As a recent example, ACEP and its California chapter have alerted California members of Congress about [rampant misbehavior](#) from Anthem Blue Cross California: the insurer is refusing to reimburse physicians for millions of dollars in care provided.
- Anthem appears to be targeting small physician practices that do not have the resources to fight back.
- It is common for health plans to review physician claims and determine whether they believe the claim should be adjusted. But it is unprecedented for a payer to stop payment to a physician group entirely because of a purported disagreement by the insurer over the code billed.

In some states, insurers use the No Surprises Act to game the system.

- In North Carolina, as soon as the Biden Administration announced its plans to implement the new surprise billing law, emergency physicians received a chilling letter from Blue Cross Blue Shield of North Carolina, threatening to end their agreement to be in-network unless the physicians accept a 20% cut in reimbursement for necessary medical care.
- Similarly, UnitedHealthcare attempted to bully physicians to accept a 40% cut or lose their contract.
- ACEP [alerted legislators](#) about these strongarm tactics because insurance companies will continue unless they are stopped.

There are protections in state and federal law because insurers have a known history of this type of misbehavior.

- While physicians are required to provide care, insurance companies regularly violate the rules that require them to pay for it.

Without immediate action to strengthen the enforcement of existing laws meant to hold insurance companies accountable, we will see additional strain on emergency physicians that will hinder care delivery and could restrict patients’ options for care when they need it most.

[For California members:]

- Emergency physicians urge the California congressional delegation to request Anthem end its policy of rejecting Level 5 claims that have been correctly coded and billed by emergency physicians.
- Without immediate action, the continued non-payment of claims could result in emergency physician groups going out of business, destabilizing the health care safety net, and severely limiting access to the lifesaving emergency care that Californians need and deserve.