Leadership & Healthcare: Where is ACEP?

Christopher S. Kang, MD, FACEP

ACEP President

Susan Sedory, MA, CAE

ACEP Executive Director

American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

Objectives

External

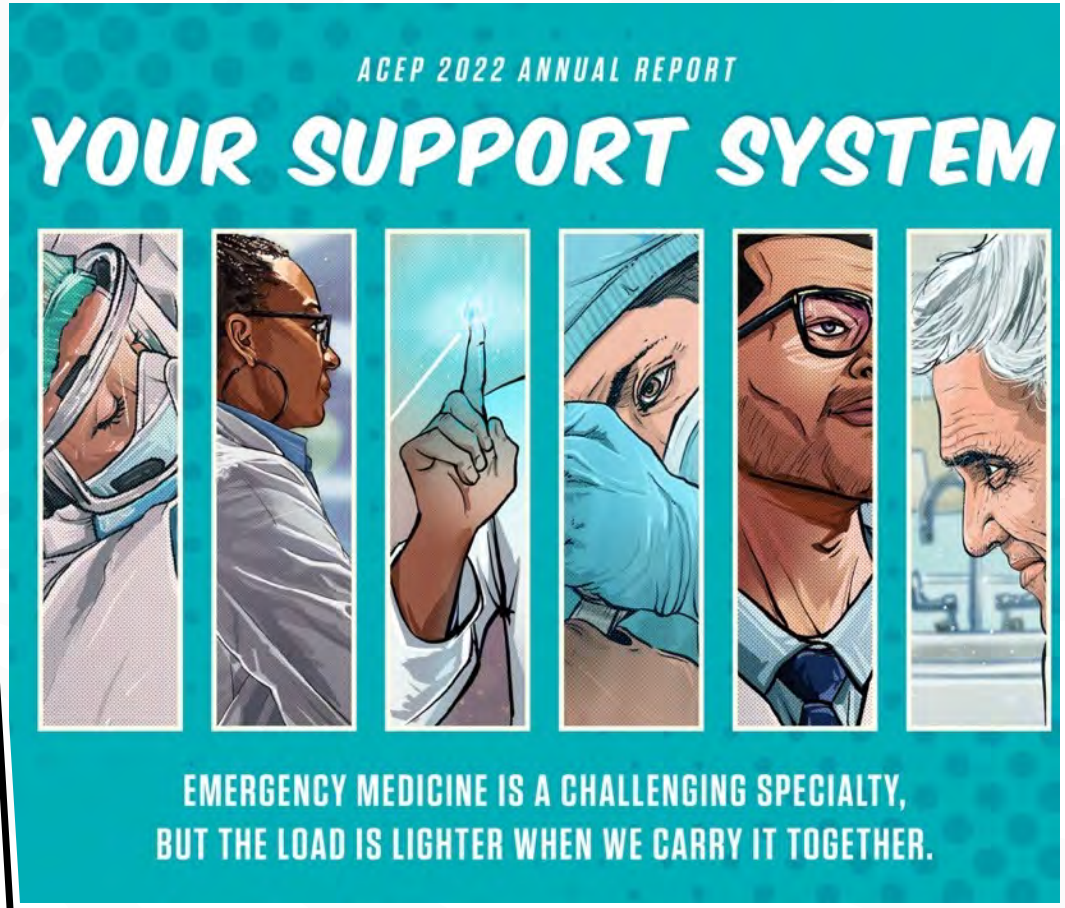
Summarize current macro (healthcare) and micro (EM) priorities

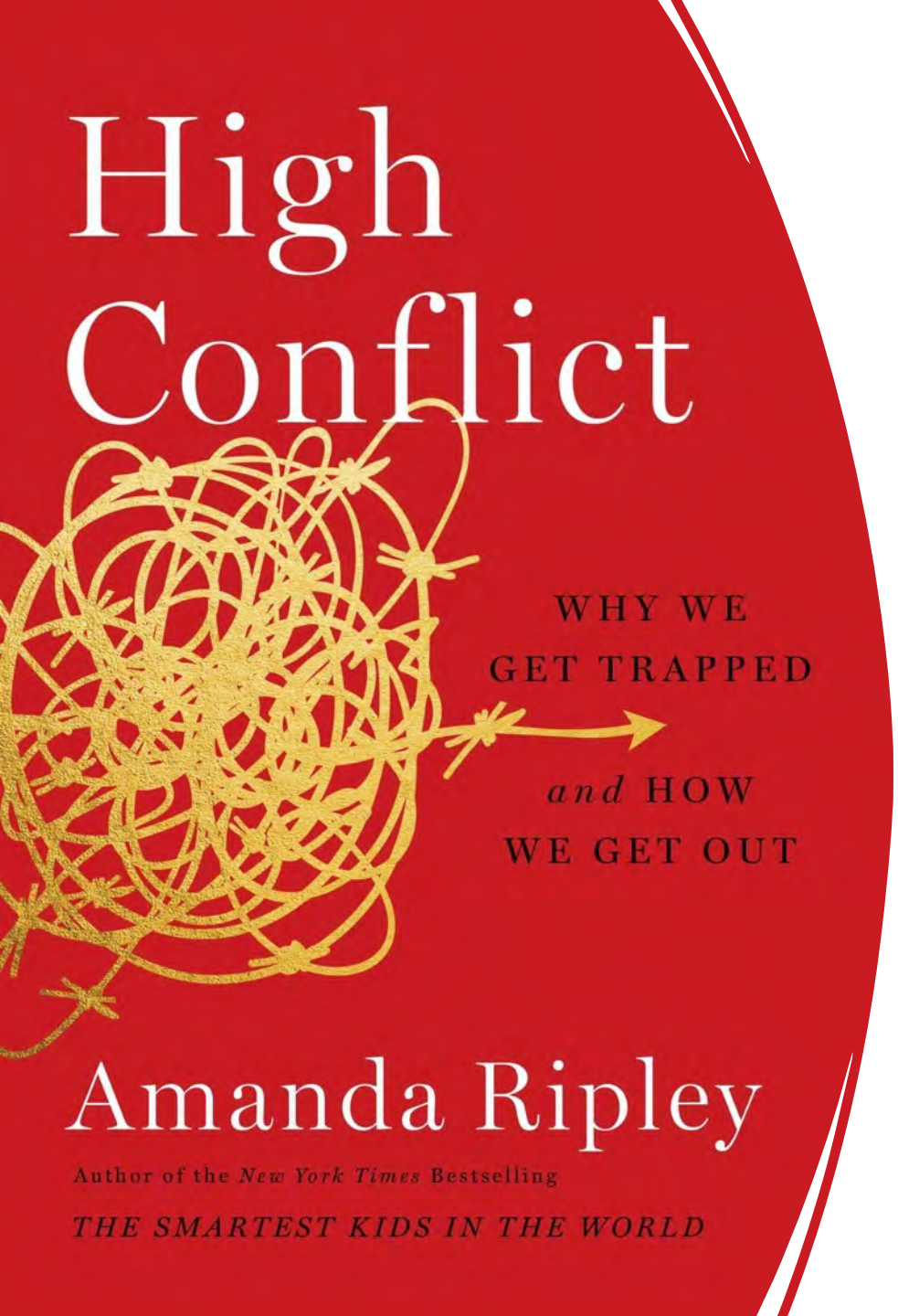
Internal

Understand ACEP's strategies and actions

You

Discuss evolving EM concerns for the profession, organization and individuals…you





Objectives

- Values are often simple, issues can be complex
- Oversimplification is not necessarily good
- Personal experiences and biases can be powerful
- Talk with - not at - each other

The NP field is the fastest-growing occupation according to the US Bureau of Labor Statistics, which projects that employment will grow by 46% between 2021 and 2031 with an additional 112,700 NP jobs expected to be added over the next decade. The NP profession grew by 9% between 2021 and 2022 with 355,000 NPs currently in practice, Dr Kapu said.

As ER waits stretch for days, Mass. turns to in-home care for children's mental health

January 20, 2023

By Martha Bebinger

UnitedHealth Group posts $4.9B profit in fourth quarter

Jakob Emerson - Friday, January 13th, 2023

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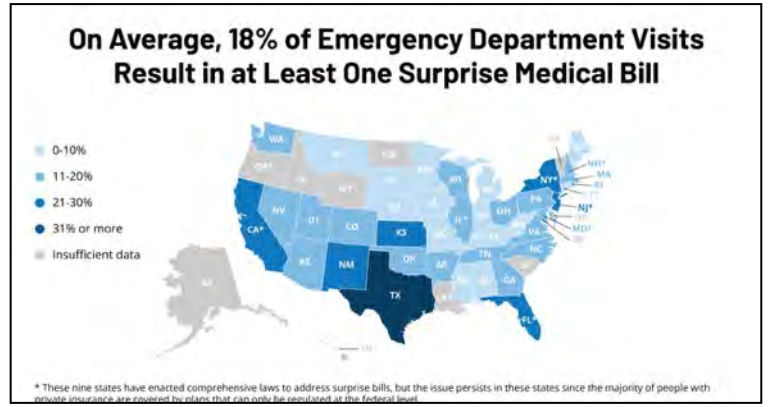
UnitedHealth Group recorded double-digit growth in revenues year over year across its lines of business at UnitedHealthcare and Optum, according to the company's fourth quarter earnings report released Jan. 13.

"We expect the efforts by the people of our company that led to strong performance in 2022 will define 2023 as well, especially delivering balanced growth enterprise-wide, improving support for consumers and care providers, and investing to make high-quality care simpler, more accessible and affordable for everyone," CEO Andrew Witty said.

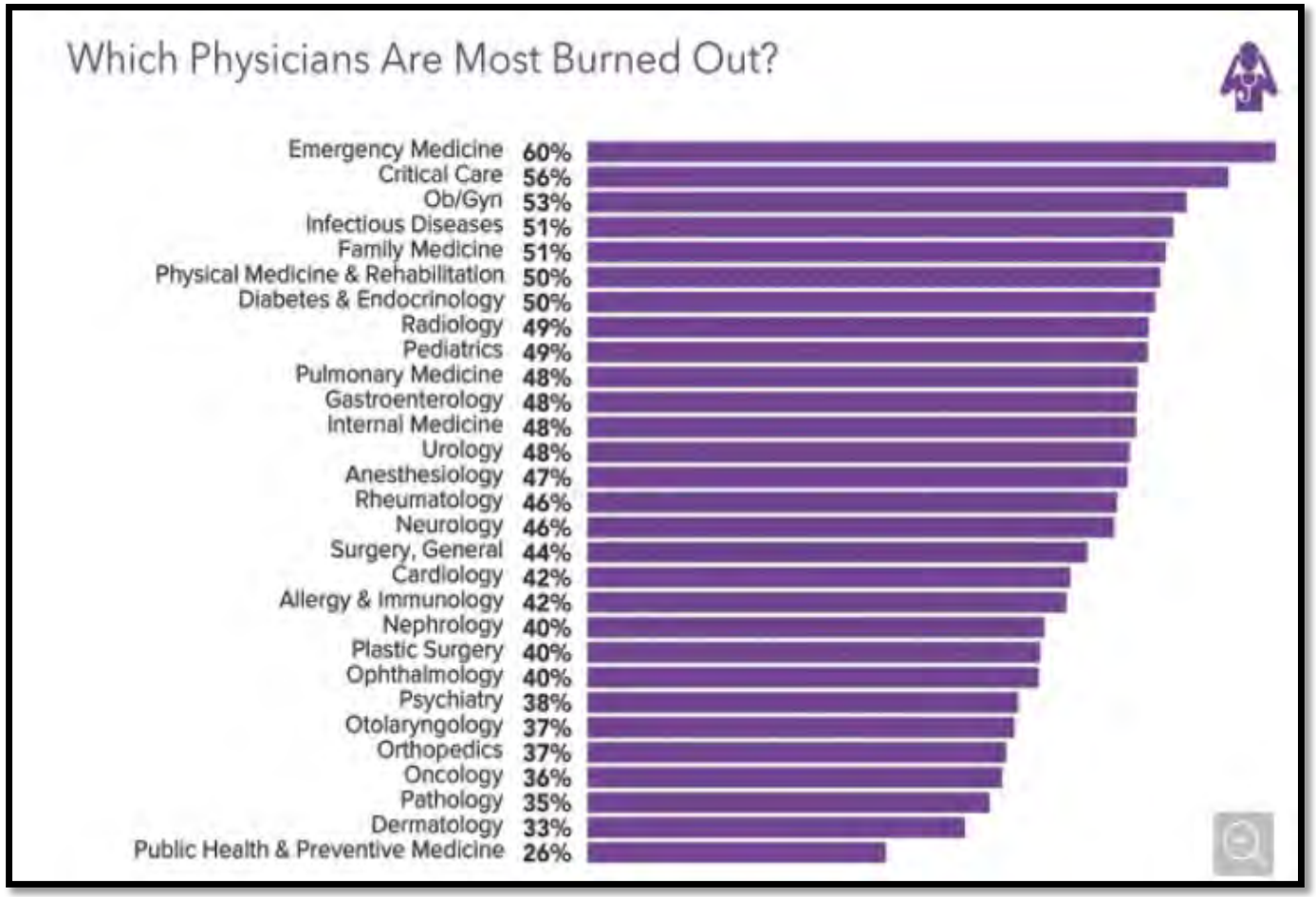
UnitedHealth Group

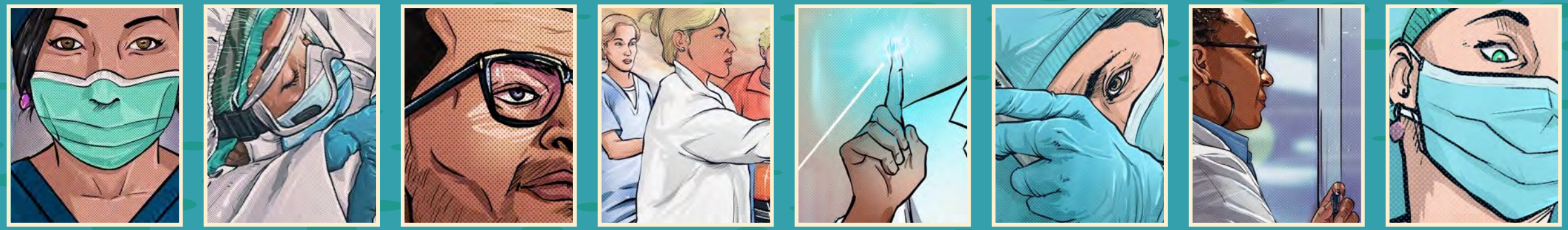


Significance

Significance

PHYSICIANS REPORTING AT LEAST ONE BURNOUT SYMPTOM RISES FROM 38.2% IN 2020 TO 62.8% IN 2021





Where is ACEP? 50 2022 Council Resolutions

- Billing/Collections Transparency
- Corporate Practice of Medicine
- ED Boarding
- Law Enforcement/ Intoxicated Pt
- Nurse Practitioners
- Rotation in EM
- Telehealth
- Buprenorphine
- Due Process
- ED Safety
- Medicaid Expansion
- Reproductive Health Care
- Rural Care
- Violence

https://www.acep.org/council

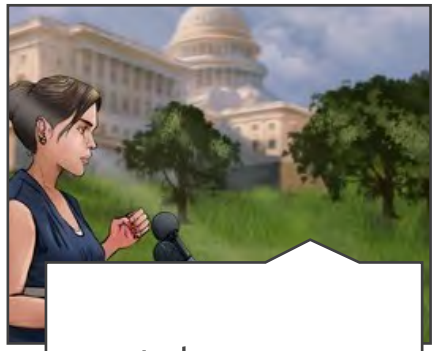
Where is ACEP – Strategically?

Our mission is resolute. To promote the highest quality of emergency care and serve as the leading advocate for emergency physicians, their patients, and the public.

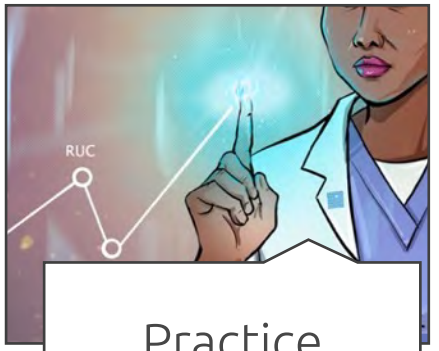
Our vision is clear. To ensure emergency physicians believe that ACEP is their home and community for career fulfillment and professional identity.

See What We're Doing
www.acep.org/strategicplan

Career Fulfillment



Advocacy



Practice Innovation

Member Engagement & Trust

Resources & Accountability

Priorities

Boarding

Reimbursement

Workforce

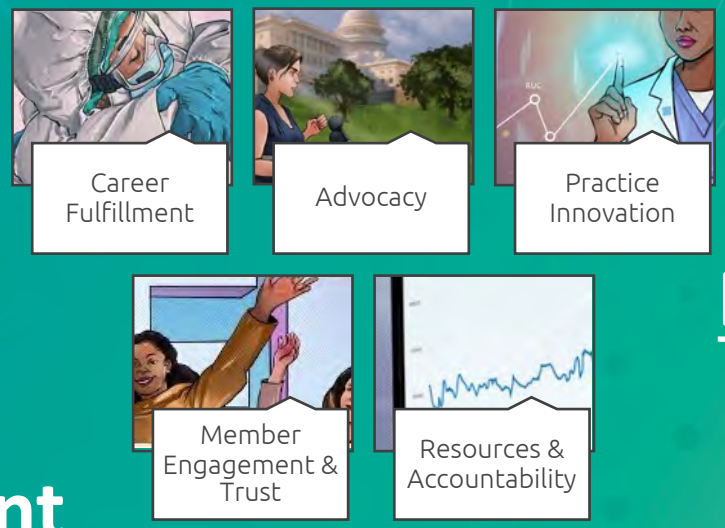
Mental Health

Member Engagement

Chapter & National Ops

Need for Data

Accreditation



Consolidation

Corporatization

DEI

Due Process/Non-Compete

ED Violence

Innovation

Reproductive Health

Scope of Practice

Boarding

November 7, 2022

The President
The White House
1600 Pennsylvania Avenue NW
Washington, D.C. 20500

Mr. President:

There is no question that Americans have suffered great loss of life and endured financial hardships, across all sectors, over the past 32 months due to the COVID-19 pandemic. Frontline healthcare workers risked their lives, provided care during physically and emotionally demanding situations, and bore witness to their patients' goodbyes to loved ones from afar.

Yet, in recent months, hospital emergency departments (EDs) have been brought to a breaking point. Not from a novel problem – rather, from a decades-long,[1] unresolved problem known as patient "boarding," where admitted patients are held in the ED when there are no inpatient beds available. 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 and other health care professionals.

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 to an inpatient bed in the hospital; waiting to be transferred to psychiatric, skilled nursing, or other specialized facilities; or, waiting simply to return to their nursing home. And this breaking point is entirely outside the control of the 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. Patients in need of intensive care may board for hours in ED beds 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. Boarding doesn't just impact 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. The story recently reported[2] about a nurse in Washington who called 911 as her ED became completely overwhelmed with waiting patients and boarders is not unique – it is happening right now in EDs across the country, every day.

> *"At peak times which occur up to 5 days per week we have more patients boarding than we have staffed beds. High numbers have included 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, the American College of Emergency Physicians (ACEP) recently asked its members to share examples of the life-threatening impact the recent uptick in boarding has brought to their emergency departments. Excerpts of the responses received, as well as key findings from a qualitative analysis of the submissions, are included in this letter to summarize aspects of the problem. The full compilation of anonymized stories, attached as an appendix, paint a picture of an emergency care system already near collapse. As we face this winter's "triple threat" of flu

Emergency Department Boarding and Crowding

Patients "boarding" in the emergency department (ED), or placed in a holding pattern while waiting for care or transfer, are overwhelming emergency physicians, care teams and staff who do all they can to treat or stabilize every patient that needs care.

While the causes of boarding are multifaceted, staffing shortages and the resulting burnout only exacerbate the crisis and perpetuate a dangerous and sometimes deadly cycle. To help address this crisis, ACEP President Christopher S. Kang, MD, FACEP is currently forming a task force to develop clinical recommendations as well.

ED Boarding: Frontline Stories

ACEP members are sharing stories about the impact of rising patient boarding, and the picture painted is bleak—emergency departments and hospitals are at a breaking point.

READ THEIR STORIES | SHARE YOUR STORY

Reimbursement


Court Sets Aside Key Parts Of No Surprises Act Rule

Katie Keith

FEBRUARY 24, 2022 10.1377/forefront.20220224.298748

HEALTH INSURANCE CLAIM FORM

+Medical

BILLING STATEMENT

Admission Date : August 14, 2016

Discharge date : August 17, 2016

escription	Code	Amount
	851000095	87.00
	172001525	174.00
		37.60

★ ADD TO FAVORITES < SHARE

Update, March 1


Georgia fines Anthem/Blue Cross $5 million for consumer violations

By Ariel Hart, The Atlanta Journal-Constitution

Insurance commissioner cites pattern of violations


Federal judge rules against HHS — again — over surprise-billing arbitration rule

Jakob Emerson - Tuesday, February 7th, 2023

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A federal judge in Texas has handed another win to the Texas Medical Association and medical providers nationwide against HHS over a challenge to the arbitration process between out-of-network providers and payers that was established under the No Surprises Act.

On Feb. 6, U.S. District Judge Jeremy Kernodle ruled that the revised arbitration process "continues to place a thumb on the scale" in favor of insurers and "that the challenged portions of the final rule are unlawful and must be set aside..."

Anthem and UnitedHealthcare Have Announced Controversial ER Rules

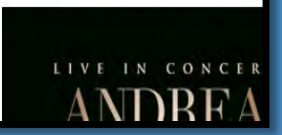
For the most part, insurers pay for those trips to the emergency room. But Anthem caused controversy in 2017 with new rules in six states (Georgia, Indiana, Missouri, Ohio, New Hampshire, and Kentucky) that shift the cost of ER visits to the patient if a review of the claim determines that the situation was not an emergency after all.

UnitedHealthcare generated headlines in 2021 with the announcement of a similar policy that was slated to take effect as of July 2021. But amid significant pushback from emergency physicians and consumer advocates, [4] UnitedHealthcare quickly backpedaled, announcing just days later that they would delay the implementation of the new rules until after the end of the COVID pandemic.[5]

State Medicaid program to stop paying for unneeded ER visits

Originally published February 9, 2012 at 3:20 pm | *Updated February 9, 2012 at 5:31 pm*

Starting April 1, Medicaid will no longer pay for such visits, even when patients or parents have reason to believe they're having an emergency. Hospitals and doctors are pressing lawmakers to undo the policy.



Workforce

ACGME

Shaping GME: The Future of Emergency Medicine
Major Revisions to the Program Requirements for Emergency Medicine
Summary of Themes and Insights

Overview
Every 10 years, the ACGME Review Committees are required to evaluate the applicable specialty-specific Program Requirements for revision. In 2017, the ACGME re-envisioned the process by which this is done and piloted a new approach within the specialty of internal medicine. The new process, which includes scenario-based strategic planning, requires a writing group (composed of Review Committee members and ACGME Board members, including public members) and the specialty community to think rigorously and creatively about what the specialty will look like in the future prior to proposing any revisions, recognizing the future is marked with significant uncertainty.

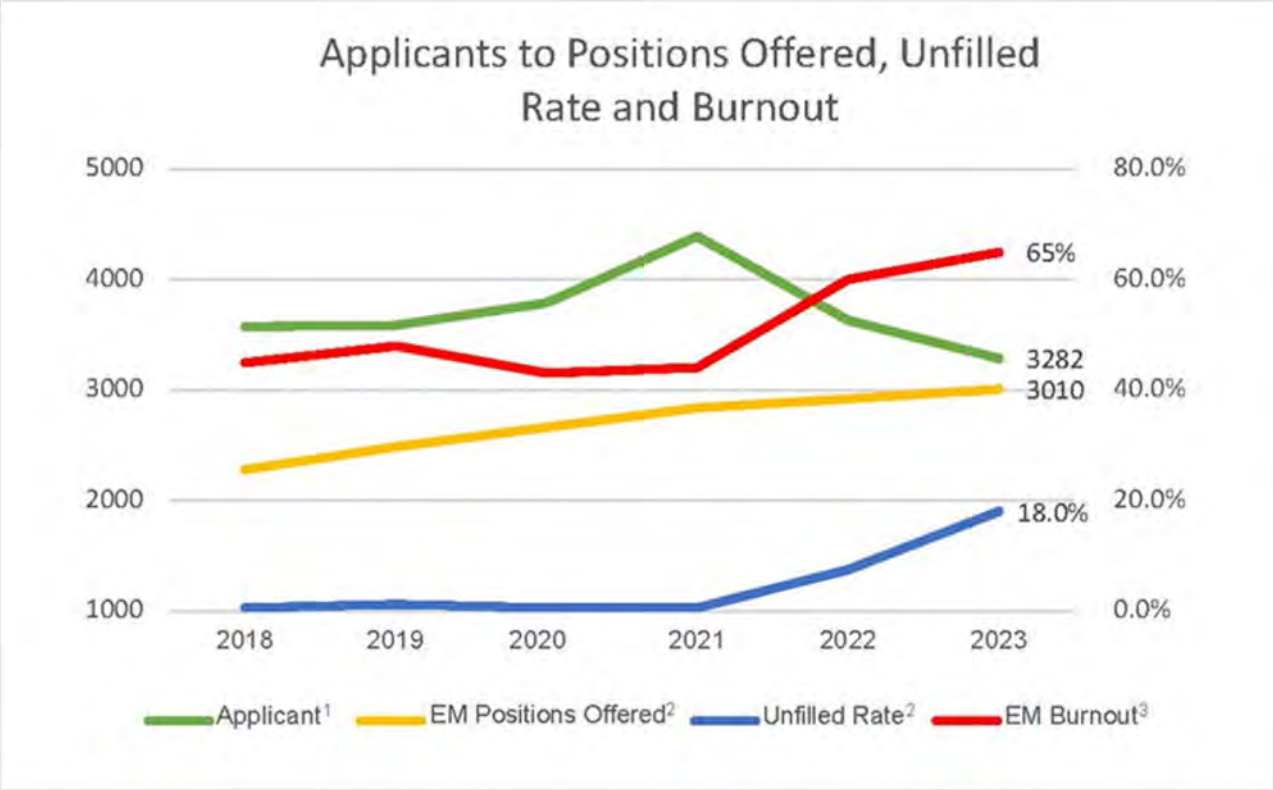
Key Insights about the Practice of the Emergency Medicine Physician of the Future
Several themes emerged from the scenario planning efforts that provide insight into the emergency medicine physicians of the future and their practice. It is recognized that the emergency medicine physician of the future will not achieve mastery of all these competencies during residency alone. Residency must serve as the foundation for career-long professional development and adaptation to a changing health care system and community need.

Proposed Definition of the Emergency Medicine Physician
Emergency medicine physicians provide patient-centered care that rapidly evaluates, diagnoses, stabilizes, and manages life-threatening, emergent, and urgent episodic illness and injury. Emergency medicine physicians treat any patient across the spectrum of acuity, age, illness, or injury. Emergency medicine physicians are prepared to care for any patient seeking care, at any time, across varied geographic, resourced, and system configurations. They are team leaders within the emergency department, in any extension of the emergency department, including pre-hospital or remote locations, and they collaborate within the health care system to coordinate the care of the acutely ill or injured patient.

The Emergency Medicine Physician Workforce: Projections for 2030

Catherine A. Marco, MD • D. Mark Courtney, MD, MSc • Louis J. Ling, MD • ...
Dian Dowling Evans, PhD, ENP-C • Nathan Vafaie, MD, MBA • Chelsea Richwine, PhD, MA • Show all autho

Open Access • Published: August 02, 2021 • DOI: https://doi.org/10.1016/j.annemergmed.2021.05.029 •



Mental health

HEALTHCARE

"Boarding" Of Psychiatric Patients In Emergency Departments Unconstitutional In Washington State

Robert Glatter, MD

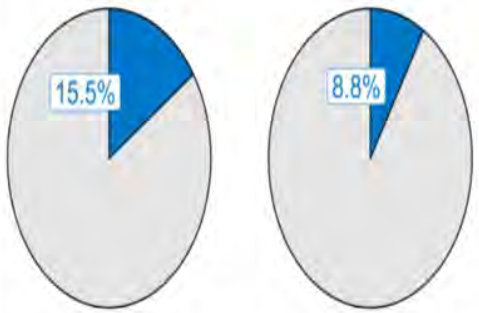
Follow

This article is more than 7 years old.

The Washington State Supreme Court ruled last week that "psychiatric boarding", whereby psychiatric patients are admitted to a hospital, but stay for prolonged periods in an emergency department—sometimes for hours or days, until psychiatric beds are available—violates the state's Involuntary Treatment Act, and is therefore unconstitutional. While the practice may once have been considered inhumane or cruel, it is now illegal.

This new ruling stems from a 2013 case in Pierce County involving ten psychiatric patients who were treated in acute care facilities or emergency departments. The facilities, however, were not certified to deliver individualized psychiatric care. As a result of a lawsuit by the ten patients challenging their lack of appropriate care, the judge declared the practice of boarding illegal.

Individuals in Missouri Reporting a Major Depressive Episode in the Past Year, by Age Group, 2018-2019



SOURCE: SAMHSA, 2018-2019 NSDUH: State Model-Based Prevalence Estimates, Table 31.

KFF

Doctors hit hardest by pandemic at higher risk of burnout

MAR 30, 2022 • 4 MIN READ

Sara Berg, MS
Senior News Writer

PRINT PAGE

At the national level, the overall rate of physician burnout—comprised of emotional exhaustion and depersonalization scores—improved during the early days of the COVID-19 pandemic (fall 2020) compared to earlier time points in 2011, 2014 and 2017, according to a new triennial study.

Membership fights burnout

The AMA is tackling the key causes of burnout through advocacy, research and the development of resources. Join the movement to fight burnout and help us provide relief for physicians.

Become a Member Today

Despite these global findings, experiences during the early days of the pandemic were diverse and varied widely based on specialty, personal COVID-19 experiences, and geography. The survey administration occurred prior to the first wave of the pandemic for many areas of the country and may not reflect physicians' experiences.

More than 7,500 physicians responded to a survey conducted by researchers from the AMA, the Mayo Clinic and Stanford University School of Medicine. The study found that, overall, 38.2% of U.S. physicians exhibited at least one symptom of burnout in 2020, compared with 43.9% in 2017, 54.4% in 2014 and 45.5% in 2011.

Despite the overall trend, burnout did not improve for physicians specializing emergency medicine, hospital medicine, infectious disease, or critical care and increased among physicians who had to deliver care without adequate personal protective equipment (PPE) or whose practice suffered disruptive economic consequences from COVID.

NASMHPD

National Association of State Mental Health Program Directors
66 Canal Center Plaza, Suite 302
Alexandria, Virginia 22314

Assessment #5

A Comprehensive Crisis System:
Ending Unnecessary Emergency Room Admissions and Jail Bookings Associated with Mental Illness

August 2018

Alexandria, Virginia

Fifth in a Series of Ten Briefs Addressing: Bold Approaches for Better Mental Health Outcomes across the Continuum of Care

This work was developed under Task 2.2 of NASMHPD's Technical Assistance Coalition contract/task order, HHSS283201200021I/HHS28342003T and funded by the Center for Mental Health Services/Substance Abuse and Mental Health Services Administration of the Department of Health and Human Services through the National Association of State Mental Health Program Directors.

Modern Healthcare

NEWS DIGITAL HEALTH INSIGHTS DATA/LISTS OPINION AWARDS EVENTS LISTEN

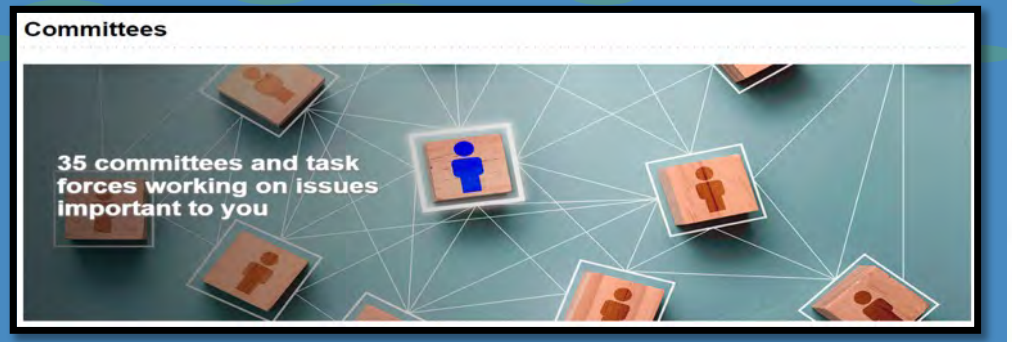
Emergency rooms fill up with psych patients — and then they wait

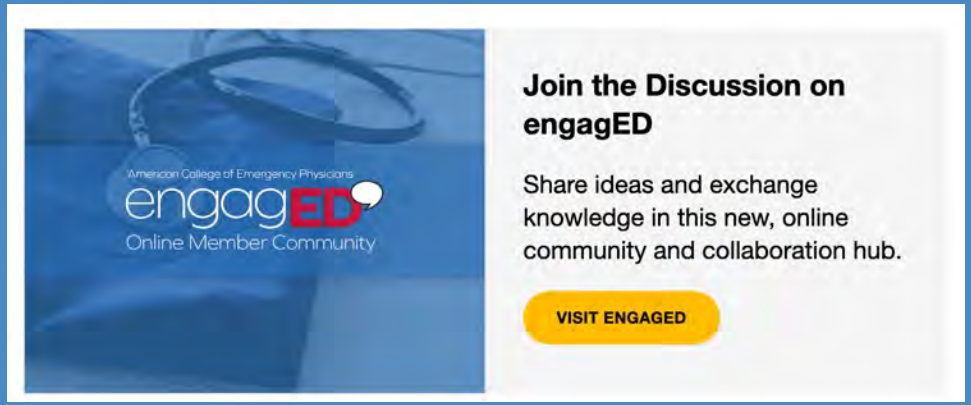
TWEET SHARE SHARE EMAIL REPRINTS PRINT

Throughout emergency rooms in Southeast Michigan, there are patients in the midst of a psychological crisis – and they're waiting, sometimes for days.

And healthcare organizations report that the amount of time it takes for people to go from

Member Engagement





- Air Medical Transport
- Careers in Emergency Medicine
- Cruise Ship Medicine
- Disaster Medicine
- Dual Training
- Emergency Medicine Practice Management and Health Policy
- Emergency Telehealth
- EMS-Prehospital Care
- Exploring Retirement Section
- Freestanding Emergency Centers
- American Association of Women EPs
- Critical Care Medicine
- Democratic Group Practice
- Diversity, Inclusion and Health Equity
- Emergency Medicine Informatics
- Emergency Medicine Workforce
- Emergency Ultrasound
- Event Medicine
- Forensic Medicine
- Geriatric Emergency Medicine
- International Emergency Medicine
- Medical Directors
- Observation Medicine
- Palliative Medicine
- Quality Improvement and Patient Safety
- Rural Emergency Medicine
- Sports Medicine
- Toxicology
- Undersea and Hyperbaric Medicine
- Wilderness Medicine
- Locum Tenens Section
- Medical Humanities
- Pain Management and Addiction Medicine
- Pediatric Emergency Medicine
- Research, Scholarly Activity and Innovation
- Social Emergency Medicine
- Tactical and Law Enforcement Medicine
- Trauma and Injury Prevention
- Wellness
- Young Physicians

Chapter and National Operations

Chapter Leader Resource Center

ACEP's Chapter Services offers a wide range of services and resources to help ACEP chapters and their leaders maximize their effectiveness. This support includes tools designed to enhance chapter management practices and strengthen chapter operations.

Chapter leaders, sign in to access more resources

SIGN IN HERE

Chapter Leader Resource Center

ACEP's Chapter Services offers a wide range of services and resources to help ACEP chapters and their leaders maximize their effectiveness. This support includes tools designed to enhance chapter management practices and strengthen chapter operations.

Governance & Compliance

Fundamentals of Chapter Management

Bylaws

Compliance and Checklists

Forms due to National

Leadership

Board Member Resources

Leadership Development Programs

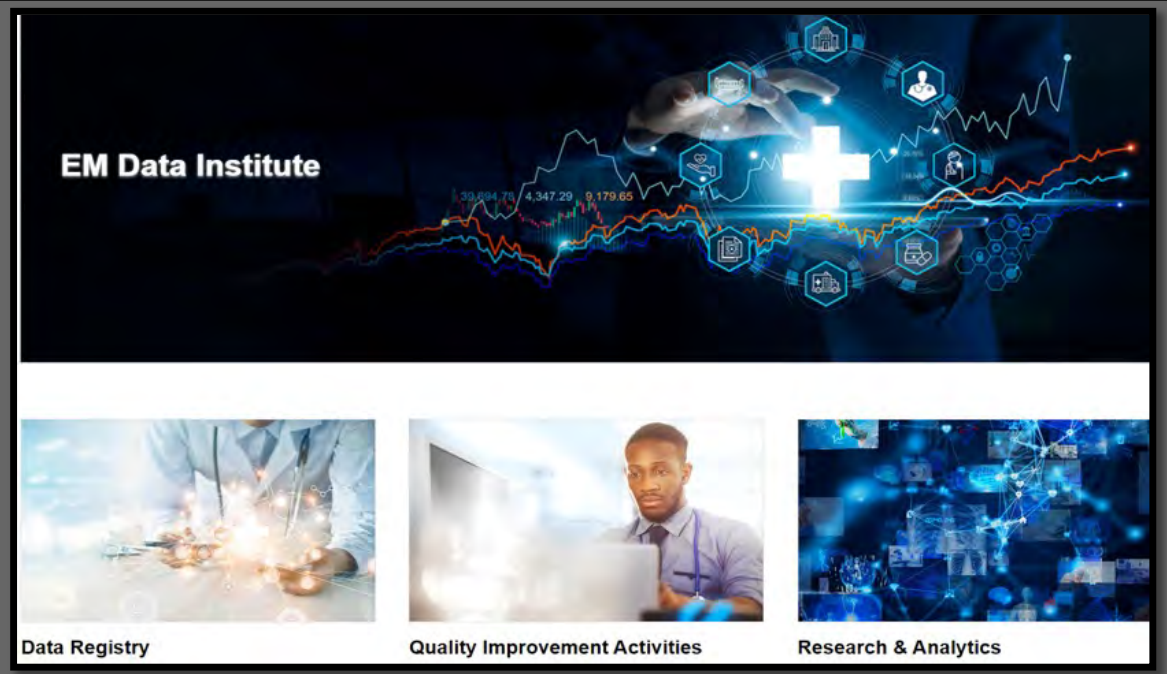
ACEP Events for Chapter Leaders

ACEP Leadership

State Advocacy Overview

ACEP provides information and resources for chapters and members to use in advocating on behalf of both our specialty and the patients for whom we provide care. In the links below, you will find information related to many of our key concerns. If you are looking for something not found here, feel free to reach out to Christopher Johnson, Sr. Director of State Government Relations.

Need for data



Accreditation

Clinical Ultrasound Accreditation

Clinical Ultrasound Accreditation Program (CUAP)

The use of ultrasound in emergency medicine has increased dramatically over the past several decades.

As the use of ultrasound has become mainstream in emergency medicine, a need has emerged to promulgate and support standards. The purpose of this emergency ultrasound accreditation body is to ensure that an entity with understanding of emergency ultrasound provides leadership in continuous quality management and patient safety, communication, responsibility, and clarity regarding the use of clinical ultrasound. Accreditation ensures that safe, quality examinations are performed in any ED that utilizes clinical, point-of-care ultrasound.

Geriatric Emergency Department Accreditation (GEDA)

20 million seniors visit our nation's EDs. With the number of older adults growing rapidly, there is a critical need for more geriatric-focused care.

In the interest of advancing clinical care in emergency medicine, transparency for the public, and improved care for our geriatric population, ACEP instituted the Geriatric Emergency Department Accreditation (GEDA) program. Geriatric EDs promote best clinical practices for older adults and have the potential to improve health outcomes, coordinate care more effectively, and reduce cost of care.

ACEP Geriatric Emergency Department Accreditation

PAIN AND ADDICTION CARE IN THE ED PACED ACEP ACCREDITATION

Pain and Addiction Care in the ED (PACED)

More than 2 million Americans have become dependent on or abused prescription pain pills and street drugs.

Emergency department clinicians are in a unique position to treat acute pain by providing optimal analgesia, educating patients, and combatting the opioid epidemic. ACEP seeks to improve acute pain management for patients in the ED and recognizes the need for prompt, safe, and effective pain management. The primary aim of this program is to accelerate the transfer of knowledge about acute pain management and secure appropriate resources to care for patients.

ACEP Emergency Department Accreditation Program

ACEP will soon offer a tiered Emergency Department Accreditation Program to establish transparency by recognizing hospitals with EDs that meet several key criteria and provide the best patient care possible.

Over the last 30 years, ACEP has been the leader in developing policies that set the standard for the practice of Emergency Medicine and support the emergency physician, the emergency patient and the entire emergency team.

Currently, no accreditation or classification programs recognize EDs that adhere to these policies and practice standards.

The nation's emergency departments vary in staffing, capabilities and working conditions. Hospitals and emergency departments committed to high, evidence-based standards, including staffing by board-certified emergency physicians, should be recognized for their efforts to provide the best care possible to the communities they serve.

The ED Accreditation Program will help improve patient care and promote fair, productive and safe working environments for emergency physicians and other members of the emergency care team through the implementation of evidence-based policies and practices across all practice settings and all staffing models.

Consolidation

OPERATIONS

March 22, 2022 05:00 AM

Vertically integrated payer-provider groups raise antitrust concerns

NONA TEPPER

ALEX KACIK

TWEET SHARE SHARE EMAIL

GETTY IMAGES

More commercial insurers are overhauling their business models in response to changes ushered in by the Affordable Care Act.

The ACA's cap on the amount of revenue payers can pocket—through medical loss ratio requirements—and the rise of Medicare Advantage have prompted private payers to purchase physician practices and employ thousands of doctors. UnitedHealth Group, Humana and Aetna are the largest Medicare Advantage carriers in the nation and have been the most active in blurring the payer-provider line.

"Everyone is trying to shift from either just being an insurer or just being a system to being a healthcare organization," said Bryan Komornik, a partner at the healthcare and life sciences division of consultancy West Monroe. "With shifts in strategy, and these types of announcements, come shifts in organization. But I think it's less about the organizational structure and more about the operational model that needs to be modernized and how everyone plays in the sandbox for the common goal."

Hospital systems trying to integrate health plans have the best shot because they are used to living in multiple disciplines, he added.

Meanwhile, the drivers of consolidation are not going away, experts said. Competition, heightened regulatory scrutiny and reimbursement cuts will likely spur more vertical integration, industry observers said.

"Vertical integration has the potential to convey significant benefits to consumers," said Susan Manning, senior managing director at FTI Consulting. "It all comes back to what we expect from health systems."

Corporatization

ecgi

While we find that PE acquirers are associated with significant employment cuts at acquired hospitals, they are also associated with a growing presence of core medical workers. Comparing those results to non-PE acquirers, we find that non-PE acquirers cut employment without increasing core worker ratio at the hospitals they acquire. Consistent with these findings, patient satisfaction roughly stays unchanged for PE acquirers but worsens significantly at target hospitals of non-PE acquirers. Finally, we do not observe a deterioration in real patient outcomes such as mortality rates or readmission rates at

PE-acquired hospitals, alleviating the concerns that PE firms improve efficiency at the expense of patients.

April 18, 2022

ACEP Statement on Private Equity and Corporate Investment in Emergency Medicine

Profit Motives Influencing Health Care Decisions Warrant Scrutiny

As part of how ACEP is Fighting for Emergency Physician Autonomy in a Changing Health Care Landscape, the ACEP Board of Directors approved this statement at their April 2022 meeting:

The American College of Emergency Physicians (ACEP) is increasingly concerned about the expanding presence of private equity[1] and corporate investment in health care, including emergency medicine. Emergency medical care is an essential and vital service, and the profit potential of expanding and commercializing emergency medicine practice is attracting attention from emergency physicians and non-physician investors. Emergency physicians may practice under a variety of compensation arrangements and quality emergency care is provided by physicians under different methods of compensation. However, consolidation is rapidly changing the health care landscape and may threaten the emergency physician's autonomy and ability to provide the highest quality emergency care, protect patient safety and maintain their own wellness.

ACEP reaffirms our core beliefs, including:

- The physician-patient relationship is the moral center of medicine. The integrity of this relationship must never be compromised. The physician must have the ability to do what they believe in good faith is in the patient's best interest.
- Medical decisions must be made by physicians and any practice structure that threatens physician autonomy, the patient physician relationship, or the ability of the physician to place the needs of patients over profits should be opposed.

ERs staffed by private equity firms aim to cut costs by hiring fewer doctors

February 11, 2023 · 7:00 AM ET

BRETT KELMAN BLAKE FARMER FROM KHN

But definitive evidence remains elusive that replacing ER doctors with nonphysicians has a negative impact on patients, said Dr. Cameron Gettel, an assistant professor of emergency medicine at Yale. Private equity investment and the use of midlevel practitioners rose in lockstep in the ER, Gettel said, and in the absence of game-changing research, the pattern will likely continue.

Researchers found that treatment by a nurse practitioner resulted on average in a 7% increase in cost of care and an 11% increase in length of stay, extending patients' time in the ER by minutes for minor visits and hours for longer ones. These gaps widened among patients with more severe diagnoses, the study said, but could be somewhat mitigated by nurse practitioners with more experience.

The study also found that ER patients treated by a nurse practitioner were 20% more likely to be readmitted to the hospital for a preventable reason within 30 days, although the overall risk of readmission remained very small.

Diversity, Equity and Inclusion

Diversity, Equity and Inclusion Committee

Draft Charge:

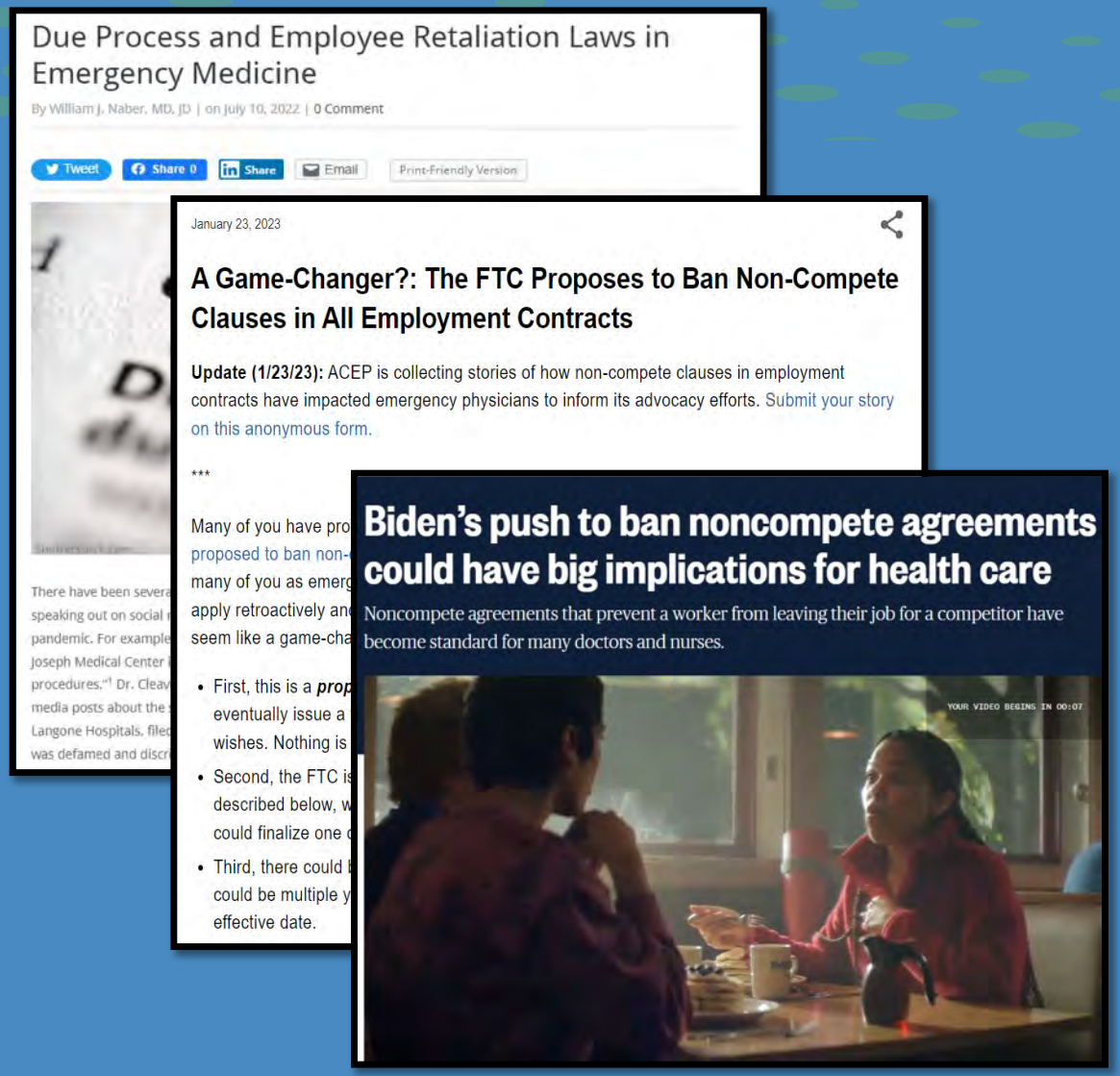
The Diversity, Equity, and Inclusion Committee works on behalf of ACEP's Board of Directors to develop policies, resources, and accountabilities to achieve diversity, equity and inclusive excellence within our organization, our membership, and our leadership. The committee identifies opportunities and supports ACEP's role as a leader in emergency medicine supporting our members in their everyday work to improve access for all patients and eliminating inequities in the delivery of health care and health care outcomes. The committee works closely with the Diversity, Inclusion, and Health Equity Section[i], the Social Emergency Medicine Section[ii], other ACEP Committees and Sections, and other ACEP operational initiatives to ensure inclusivity, maximize impact and minimize redundancy.

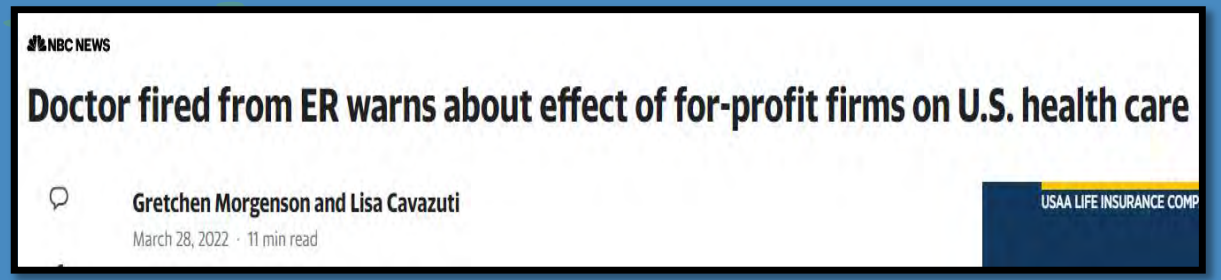
Overarching Priority Goals:

I. Health Equity & Advocacy
   a. Monitor or assist with other Active and Past Council Resolutions (Note: some resolutions may be assigned to more than one Committee)
      i. Expanding Diversity and Inclusion in Educational Programs [22(21)] Note: This initiative is being undertaken as ACEP's Capstone Project for the CMSS/ACGME Equity Matters program.
      ii. Caring for Transgender and Gender Diverse Patients in the Emergency Department [44(21)]
      iii. Addressing Systemic Racism as a Public Health Crisis [26(20)]
      iv. Creating a Culture of Anti-Discrimination in EDs and Healthcare Institutions [42(20)]
   b. Work with ACEP staff to amplify and integrate narratives of historically marginalized physicians and patients in ACEP's communication and outreach efforts

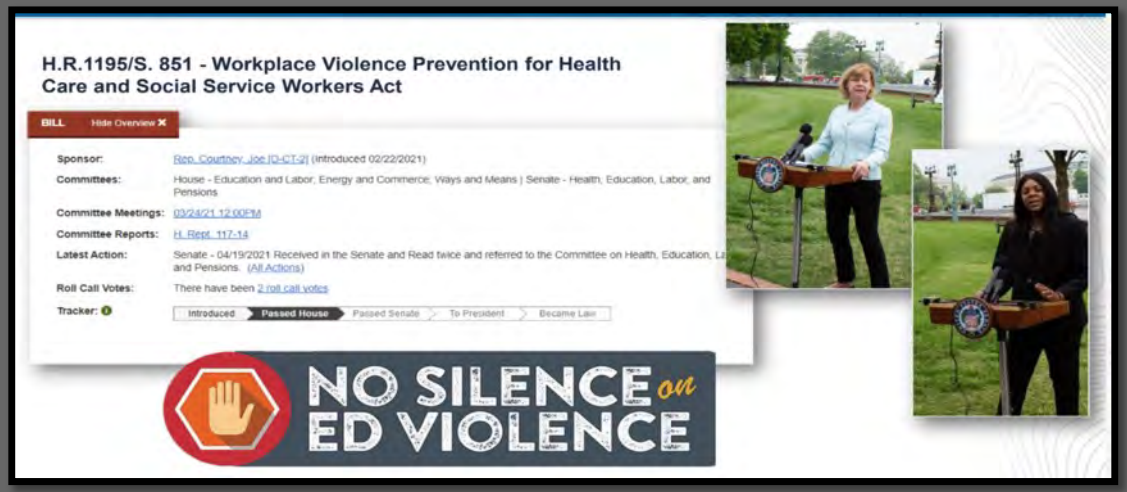
II. Data Collection & Monitoring

Due process/non-compete





ED Violence



West J Emerg Med. 2017 Apr; 18(3): 466–473.
PMCID: PMC5391897
Published online 2017 Mar 3. doi: 10.5811/westjem.2016.10.30271
PMID: 28435498

Security, Violent Events, and Anticipated Surge Capabilities of Emergency Departments in Washington State

Innovation


ADEPT
Confusion and Agitation in the Elderly ED Patient
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Manage ED Patients that Present with Atrial Fibrillation
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ALTERD
Recognition and Treatment of Hepatic Encephalopathy in the ED
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ASD
Manage Autism Spectrum Disorder Patients in the ED
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BEAM ED
Bariatric Examination, Assessment, and Management
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BUPE
Buprenorphine use in the Emergency Department
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DART
Recognition and Treatment of Sepsis and Septic Shock
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Dizzy+
Dizzy, Dysarthria, Dysmetria, Dystaxia, and Down and Out
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ED Vaccinations
Guidelines for the Vaccination of Patients in the ED
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HYPER K
Recognition and Treatment of Hyperkalemia in the ED
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Managing the Suicidal Patient in the Emergency Department
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Determine Ischemic Stroke Risk with Atrial Fibrillation
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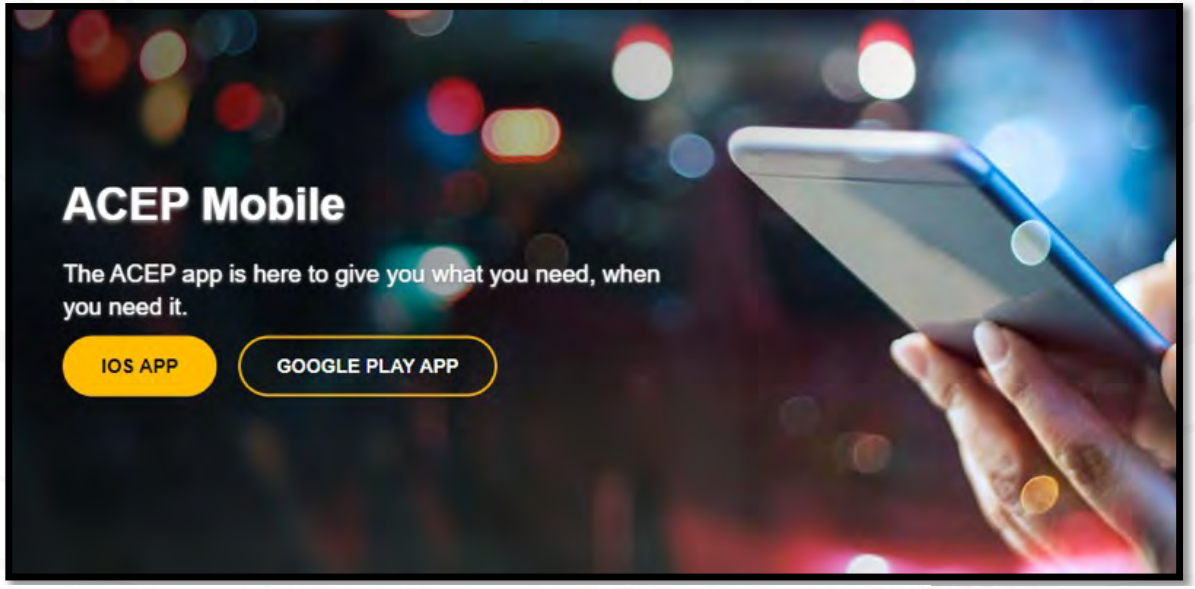
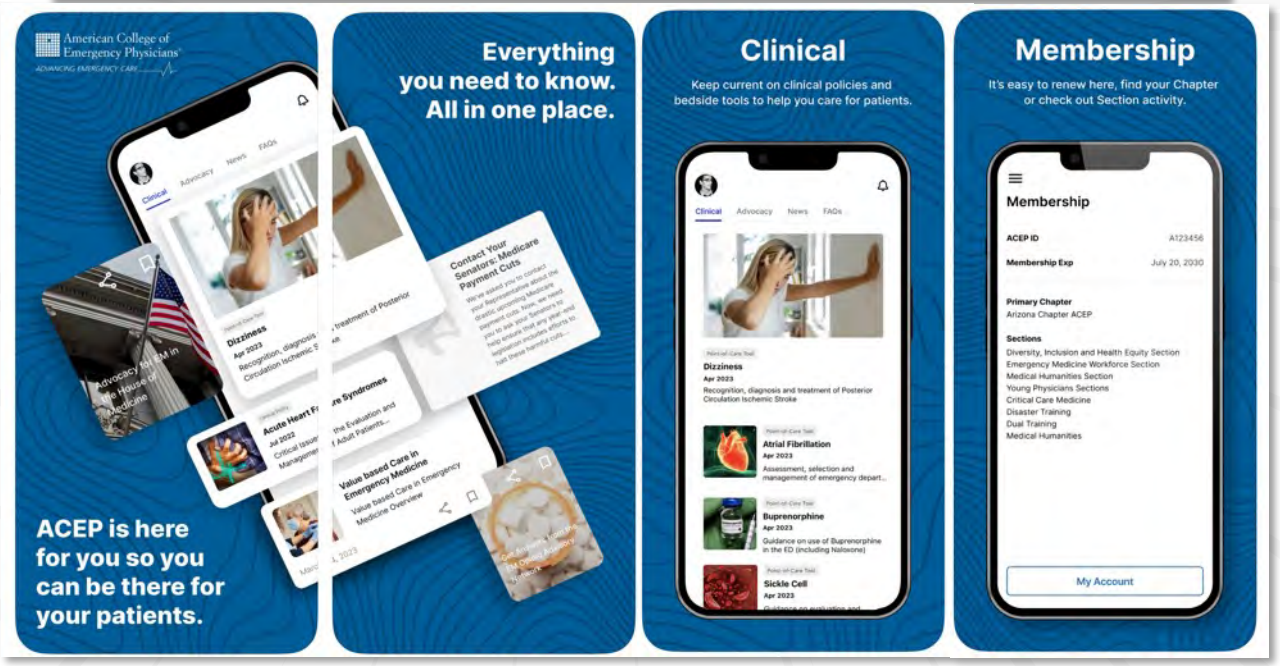

ACEP Mobile
The ACEP app is here to give you what you need, when you need it.
IOS APP
GOOGLE PLAY APP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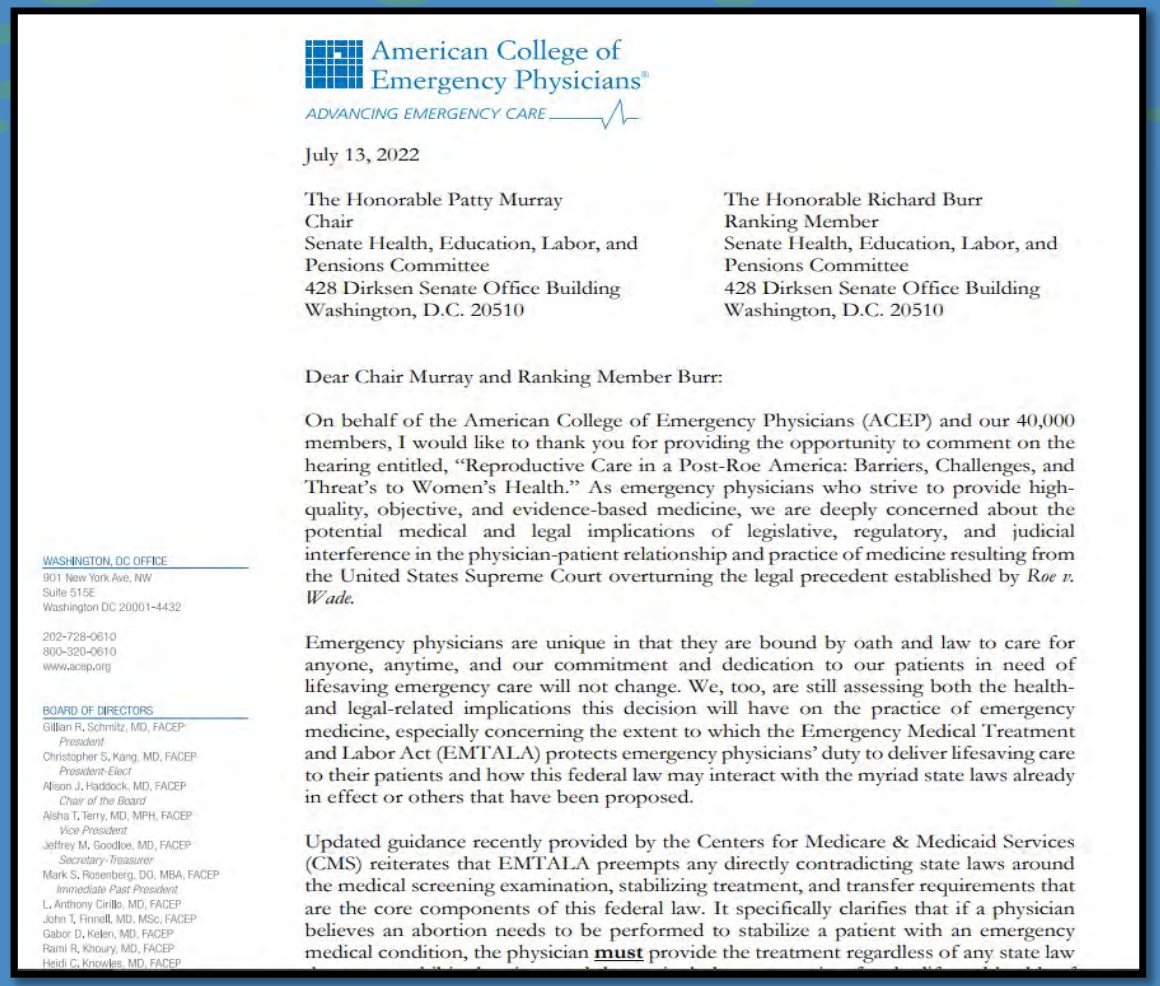
Reproductive health



American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

July 13, 2022

The Honorable Patty Murray
Chair
Senate Health, Education, Labor, and Pensions Committee
428 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Richard Burr
Ranking Member
Senate Health, Education, Labor, and Pensions Committee
428 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Chair Murray and Ranking Member Burr:

On behalf of the American College of Emergency Physicians (ACEP) and our 40,000 members, I would like to thank you for providing the opportunity to comment on the hearing entitled, "Reproductive Care in a Post-Roe America: Barriers, Challenges, and Threat's to Women's Health." As emergency physicians who strive to provide high-quality, objective, and evidence-based medicine, we are deeply concerned about the potential medical and legal implications of legislative, regulatory, and judicial interference in the physician-patient relationship and practice of medicine resulting from the United States Supreme Court overturning the legal precedent established by *Roe v. Wade.*

Emergency physicians are unique in that they are bound by oath and law to care for anyone, anytime, and our commitment and dedication to our patients in need of lifesaving emergency care will not change. We, too, are still assessing both the health- and legal-related implications this decision will have on the practice of emergency medicine, especially concerning the extent to which the Emergency Medical Treatment and Labor Act (EMTALA) protects emergency physicians' duty to deliver lifesaving care to their patients and how this federal law may interact with the myriad state laws already in effect or others that have been proposed.

Updated guidance recently provided by the Centers for Medicare & Medicaid Services (CMS) reiterates that EMTALA preempts any directly contradicting state laws around the medical screening examination, stabilizing treatment, and transfer requirements that are the core components of this federal law. It specifically clarifies that if a physician believes an abortion needs to be performed to stabilize a patient with an emergency medical condition, the physician **must** provide the treatment regardless of any state law

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August 25, 2022

Judicial Ruling Protects EMTALA-related Care in Idaho

The Idaho trigger law that went into effect 30 days after the *Dobbs* decision banned abortion except for rape, incest and to save the life of the mother.

Because of the implications of this law for EMTALA-related care of pregnant patients, on August 15, 2022, ACEP along with the Idaho College of Emergency Physicians, and ten of the nation's leading medical associations, submitted a brief in support of the U.S. Department of Justice's challenge in *United States v. State of Idaho*.

In the lawsuit, the Federal Government asked the Court to block a portion of Idaho's abortion statute - specifically the language allowing Idaho to criminalize medically indicated abortions provided by physicians in emergency situations. The amicus brief argues that well-established clinical guidelines for the treatment of pregnant patients in emergency conditions require treatment that the Idaho Law prohibits as abortion. Withholding this care is "directly contrary to EMTALA's mandate and to bedrock principles of medical ethics." If applied to emergency medical care, the Idaho Law would force physicians to disregard their patients' clinical presentations, their own medical expertise and training, and their obligations under EMTALA—or risk criminal prosecution.

On August 25, the Court ruled in favor of the Administration, and temporarily granted their request for a preliminary injunction. The court decision cites the amicus brief that ACEP participated in, also noting "It is impossible to comply with both statutes...[W]here federal law requires the provision of care and state law criminalizes that very care, it is impossible to comply with both laws. Full stop."

Scope of practice

Video Series

https://youtu.be/s-NxV2YQXw8

November 2022 Board Blog - New Data Underscores Cost and Health Outcome Concerns with Independent Practice

We know that everyone on an emergency care team is integral and valued. But our experience shows that nobody else has the training or expertise of an emergency physician.

As lawmakers and administrators evaluate whether to empower nurse practitioners and physician assistants beyond the scope of their training, new data from Stanford University reinforces our reservations about exposing non-physician practitioners to responsibility they are not prepared to assume.

The Stanford study is uniquely strong because the researchers evaluated three years of data on emergency department visits at the Veterans Health Administration, where NPs were practicing without physician supervision. Unlike previous studies on the topic, this data was based on real world experience and the analysis is causal, not just correlative.

Urgent action alert for South Dakota physicians

SB 175, a bill that would authorize physician assistants to have full practice authority without physician supervision, will likely be heard by the South Dakota Senate on Monday, Feb. 13. South Dakota Senators need to hear from you. If you are a South Dakota physician, please call or email and urge them to oppose SB 175.

Haven't subscribed?

Stay current on the latest on the issues impacting physicians, patients and the health care environment with the AMA's Advocacy Update newsletter.

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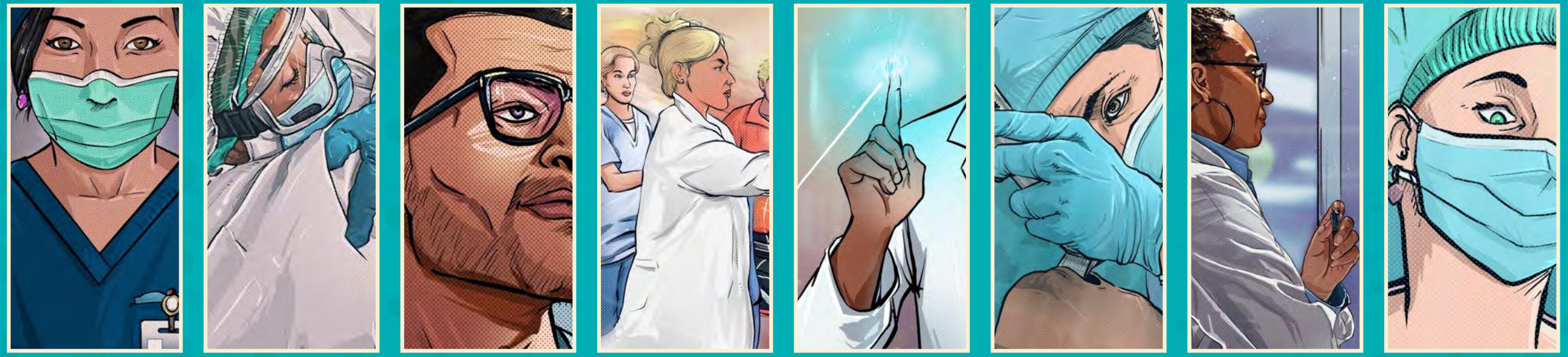
Here is the message from the South Dakota State Medical Association call to action:

> South Dakota Senate Bill 175 would authorize physician assistants full practice authority without the requirement of a supervising physician. This legislation would significantly expand the scope of practice for physician assistants by removing any requirements of clinical oversight.
>
> Physician assistants would be able to practice medicine independently upon graduation and completion of a mere 2,080 hours of collaboration which could be with someone other than a

Coming together is a beginning. Keeping together is progress. Working together is success.

The best way to not feel hopeless is to get up and do something.



Thank You!

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