



February 10, 2022

The Honorable John Hickenlooper
Chair
Senate Health, Education, Labor, and Pensions
Committee
Subcommittee on Employment and Workplace
Safety
428 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Mike Braun
Ranking Member
Senate Health, Education, Labor, and Pensions
Committee
Subcommittee on Employment and Workplace
Safety
428 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Hickenlooper and Ranking Member Braun:

On behalf of the American College of Emergency Physicians (ACEP) and our 40,000 emergency physicians, and the Emergency Medicine Residents' Association (EMRA) and our 17,000 members, thank you for your attention to the issue of health care workforce shortages and efforts to improve recruitment and to revitalize and diversify the health care workforce. The health professions, especially those on the front lines of the pandemic response, have been strained like never before, and the underlying workforce challenges that existed even before the COVID-19 pandemic have been exacerbated by the overwhelming and prolonged effects of and response to this disease. Physicians, nurses, and other essential health care workers have tirelessly given their all – often at great personal cost – to provide high-quality care during this unprecedented public health crisis, and dedicated efforts are needed to rebuild and maintain the health and well-being of the individuals who provide our health care safety net.

Workforce shortages are especially pronounced in rural and underserved areas throughout the country, and numerous barriers to providing equitable care in these communities persist. Among these are the inability to recruit qualified and sufficiently experienced, educated, and trained physicians, nurses, ancillary support staff, and other health care providers. Despite a 28 percent increase in emergency medicine residency positions over the past 10 years, there has been no corresponding increase in emergency medicine residency trained or emergency medicine board certified physicians working in rural EDs. This is a complex problem due to a variety of factors, including limited opportunities for exposure to these communities during residency training, fewer full time employment opportunities overall due to ED staffing requirements and continued rural facility closures, a lack of recruitment tools and incentives such as those provided for primary care professions, among many others. Additionally, rural EDs, compared to their urban counterparts, are resource limited, financially stressed, and experience higher interfacility transfer rates. And while the COVID-19 pandemic has increased the use of telehealth, rural areas still suffer from inconsistent availability of telehealth access and structural challenges like limited/nonexistent broadband access. Transportation issues also limit many individuals' ability to reach hospitals, and emergency medical services (EMS) in rural areas also experience significant transportation delays due to issues with crew availability.

We hope the Committee's examination of current health care workforce shortages will include a focus on the ongoing nursing shortages and the recent practices of nurse staffing agencies that have resulted in exorbitant increases in costs to already-strained health care systems. The extreme physical and mental toll of the COVID-19 pandemic response has inflicted enormous trauma and stress on physicians and nurses, resulting in increased burnout and dissatisfaction for those on the front lines and greater attrition in the health care workforce. This

has left many health systems desperate to fill workforce gaps by relying on nurse staffing agencies, some of whom have imposed extreme rate hikes to supply travel nurses to hospitals.

Especially during the Omicron wave when hospitals have tried to continue providing care for COVID-19 patients and other conditions requiring hospitalization, facilities have been left with no other choice than to pay substantially inflated rates in their attempts to maintain staffing levels capable of meeting their community's needs. We appreciate the recent attention to this issue raised by some in Congress and other health care stakeholders and encourage continued investigation and oversight of potentially anticompetitive practices occurring in the health care workplace.

Such shortages also greatly exacerbate the issue of crowding and ED "boarding," 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 the patient can be transferred. 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. Solving ED boarding is not an isolated emergency department issue but rather a hospital-wide imperative.

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. 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.

Many emergency physicians report that given ongoing shortages and the influx of patients (both COVID- and non-COVID-related) that ED boarding is at an all-time high. Adding to this challenge is the fact that EDs are also not subject to the same staffing ratio requirements as other parts of the hospital often are, and as a result, the ED too often becomes the only place in which to keep many patients. While we have shared ideas and suggestions with legislators and regulators to provide both short- and long-term solutions to reduce ED boarding (such as regulatory waivers and flexibility around documentation requirements that contribute to burnout among nurses), more fundamental efforts to address the root causes of nursing and physician shortages are needed to ensure patients have timely access to care.

Finally, as you work to address these challenges, ACEP and EMRA urge Congress to ensure that American patients have access to high-quality lifesaving emergency care. We believe the gold standard for care in an emergency department (ED) is via a physician-led emergency care team, with that care performed or supervised by a board-certified/board-eligible emergency physician. Physician Assistants (PAs) and nurse practitioners (NPs) can and do serve integral roles as members of the emergency care team, but do not replace the medical expertise provided by emergency physicians. The physician-led emergency care team is the safest care model for our patients and particularly important for Medicare beneficiaries, who are some of the most medically vulnerable patients in our population, often suffering from multiple chronic conditions or other complex medical needs and account for nearly 20 percent of ED encounters each year.

Supporting physician-led health care teams is also aligned with most state scope of practice laws. For example, over 40 states require physician supervision of or collaboration with PAs. Most states require physician supervision of or collaboration with nurse anesthetists, and 35 states require some physician supervision of or collaboration with nurse practitioners, including populous states like California, Florida, New York and Texas. These states represent more than 85 percent of the U.S. population. Moreover, despite multiple attempts, in

the last five years no state has enacted legislation to allow nurse practitioners full-immediate independent practice.

Some have proposed expanding the scope of practice of nonphysician professionals in order to increase access to care, especially in rural and underserved communities. However, in reviewing the actual practice locations of nurse practitioners and primary care physicians, it is clear nurse practitioners and primary care physicians tend to work in the same large urban areas. There remain significant shortages of nurse practitioners in rural areas—the very problem with physician access that scope expansion has sought to address. This occurs regardless of the level of autonomy granted to nurse practitioners at the state level. We believe that the ongoing challenges in recruiting and retaining all levels of health care professionals in rural and underserved areas are more complex, and that this persistent issue requires more innovative solutions to incentivize physicians and other health care professionals to work in these communities. We would welcome the opportunity to work with you and your colleagues to find more effective and durable solutions to these longstanding workforce challenges to ensure that Americans in rural and underserved areas have access to high-quality emergency care, recognizing the level of expertise and training required for independent practice of emergency medicine and supporting the provision of physician-led team-based care.

Once again, we are grateful for the opportunity to share these comments with you and appreciate your attention to the ongoing workforce challenges facing health care professionals, especially in light of the continued response to the COVID-19 pandemic. ACEP and EMRA stand ready to work with you and your colleagues to respond to these challenges and ensure that all Americans have access to the high-quality health care they need and deserve.

Sincerely,



Gillian Schmitz, MD, FACEP
ACEP President



Angela G. Cai, MD, MBA
EMRA President