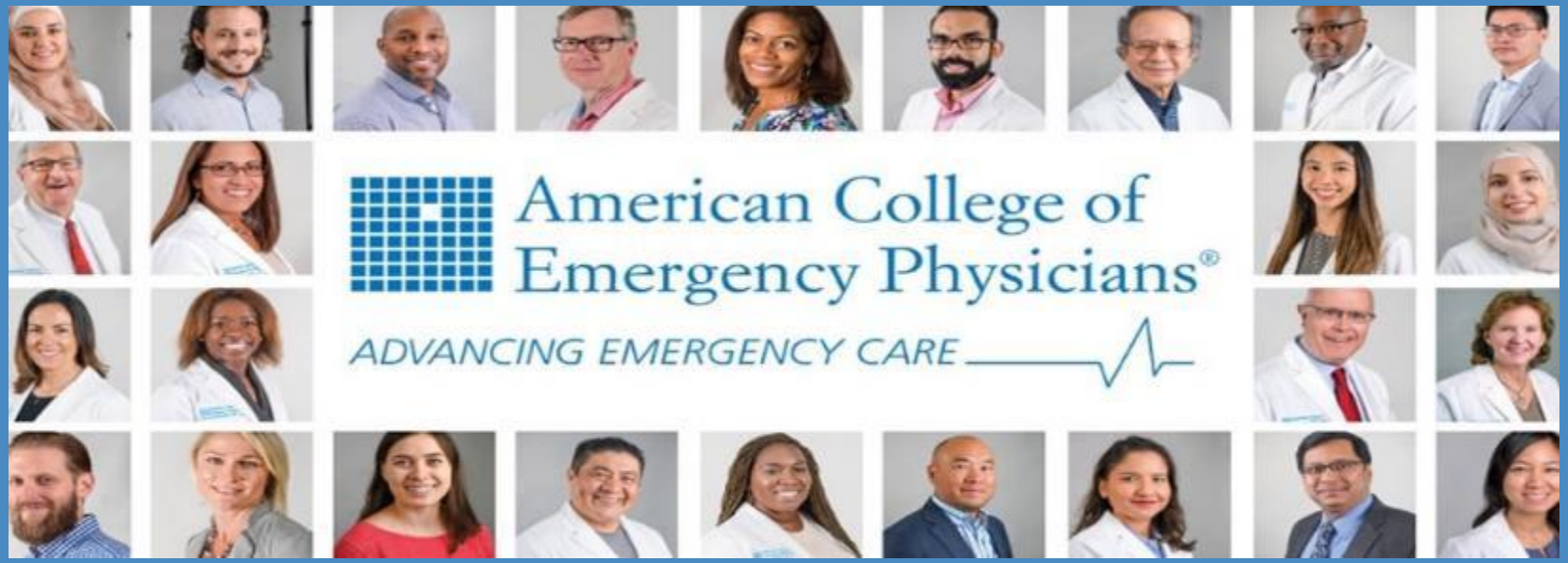
2024 ACEP Update
Maine Chapter Spring Leadership



Jeffrey M. Goodloe, MD, FACEP
Chair, Board of Directors,
American College of Emergency Physicians
Professor of Emergency Medicine
University of Oklahoma
Department of Emergency Medicine

UNITE. PROTECT. EMPOWER.

#STRONGERTOGETHER

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Key Messages:

- ACEP advocacy focus areas:
  - Boarding and ED crowding
  - Workplace violence
  - Workforce
  - Corporate Practice of Medicine/Consolidation

- Operational priorities for ACEP and the Board of Directors:
  - Communications
  - Membership
  - Innovation
  - Leadership Pipeline

ED Boarding & Crowding

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Boarding and ED Crowding Efforts and Progress

- ACEP Council Resolution: "Focus of ED Patient Boarding as a Health Equity Issue," October 2022
- ACEP Boarding Task Force convened and made recommendations
- Letter to the White House: Boarding is a Public Health Emergency, November 2022
- Collection of Boarding and ED Crowding Stories from Emergency Physicians

"I can't remember the last time I got to consistently see and examine patients appropriately in a room/bed, and not from a chair. I have seen people code in the waiting room and admitted people to the ICU from the waiting room. It's unsafe for patients and frankly unsafe for us too..."

- Emergency Physician reflection from collected stories

- *The Improving Mental Health Access from the Emergency Department Act* (H.R. 1205/S. 2157) – funding for follow-up care for mental health crises


ACEP SUMMIT ON BOARDING
American College of Emergency Physicians
Staffing Shortages
Transfer Delays
Misaligned Financial Incentives

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

December 18, 2023

The Honorable Debbie Dingell
U.S. House of Representatives
Washington, D.C. 20515

Dear Representative Dingell:

Thank you for your letter expressing concern about overcrowding and the patient "boarding" crisis in emergency departments (EDs). This situation is far from ideal patient care and can exacerbate health inequities, cause workforce burnout, and create risks for patient safety and public health. Overcrowding and boarding are long-standing issues in local healthcare systems nationwide that the Department of Health and Human Services (HHS) has worked to address.

I appreciate your concerns and your suggestion to convene a task force with broad stakeholder representation to inform solutions to this urgent problem. In response, I have charged the Agency for Healthcare Research and Quality (AHRQ) to use its unique statutory authority to improve healthcare nationwide and its ability to work with HHS partners to convene a multistakeholder Director's Roundtable. We anticipate that this Director's Roundtable can be organized within the next six months and will identify actionable next steps and novel opportunities to chart a public-private strategy to address ED crowding and boarding.

I appreciate your shared commitment to addressing ED overcrowding and boarding problems to help ensure access to timely and safe care in EDs across the United States.

Sincerely,

Xavier Becerra

American College of Emergency Physicians
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Quality Measure on Boarding

+

→

Equity of Emergency Care Capacity and Quality (ECCQ)
Electronic Clinical Quality Measure (eCQM)

- 1 hour wait time > 1 hours to be placed in ED treatment space
- Encounter ended without a medical screening exam being done
- Patient boarded for > 4 hours
- Patient had ED length of stay > 8 hours

Workplace Violence

Prevalence of Workplace Violence in Health Care/Emergency Departments

Workers in the **health care** sector make up about

50%

of all victims of workplace assault.[1]

From 2002–2013, serious incidents of **workplace violence** were

4x

more common for workers in the **health care** sector than for all other workers in the U.S.

Studies show that **emergency nurses** and other personnel in the ED experience a **violent event** about

once every 2 months.[2]

100%

of emergency nurses reported **verbal assault** and

82%

reported **physical assault** in the past year.

Emergency nurses have the **highest rate of physical assaults** of all nurses.[3, 4]

ED workers are exposed to **significant rates** of **physical** and **verbal abuse**. Under-reporting of workplace violence in the ED is common and contributes to the difficulty in accurately tracking violence.[5, 6]

Published January 6, 2021

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Lack of Protections

There is not enough support from law enforcement and hospital administration to address the increasing violence.

Only 2% of assaults in the ED result in charges pressed against attackers.

29% say most common response from hospital is to place behavioral flag on patient's chart.

* Methodology: These results are the product of a series of polls conducted by Marketing General Incorporated on behalf of ACEP between July 25 and August 1, 2022, among a sample of 2,712 emergency physicians to better understand their experiences regarding the level, type, frequency, and impact of violence experienced in the emergency department. Providing a response rate of approximately nine percent and a margin of error of plus or minus 1.9 percent.

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Some ACEP Policies on Workplace Violence

- Violence Prevention and Intervention for Emergency Medical Services Systems, approved April 2019
- Safer Working Conditions for Emergency Department Staff, approved April 2021
- Protection from Violence and the Threat of Violence in the Emergency Department, revised June 2022

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What else is ACEP Doing to Address Violence in the ED?

- A two-pronged policy approach:
  - Strengthening prevention programs
  - Establishing equitable penalties for assailants
- *Workplace Violence Prevention Act for Health Care and Social Service Workers*
- *Safety from Violence for Healthcare Employees (SAVE) Act*

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How Safe is Your Workplace?

Checklist for Assessment

This sample checklist, created from national accreditation standards and ACEP policies includes items, controls, and protocols that emergency physicians can ask their workplace about in order to understand what safety and violence prevention measures are in place.

NOTE: Every facility is different and the individual needs for a particular hospital, facility, or community may vary significantly, with some of these listed factors less appropriate for a particular location. Exclusions should therefore not necessarily be construed as a failing or shortcoming, but rather as a starting point to begin the conversation with your facility's administration to ensure emergency physicians and other health care personnel in the ED are protected from harm. If you'd like to help inform ACEP's ongoing advocacy, you can anonymously share your experiences (whether good or bad) with violence prevention policies in your workplace by clicking here or scanning the QR code on the reverse.

Prevention Plans

- ☐ **1.** Protocols are in place for handling violent episodes (both physical and verbal assaults) from patients, patient families, or other visitors, and coordinated with local law enforcement.
- ☐ **2.** Staff are made aware of and familiar with these protocols as part of new employee onboarding and reinforcement in periodic trainings.
- ☐ **3.** Protocols are in place for violence from other health care workers/staff.
- ☐ **4.** Policies have been implemented to ensure firearms and/or other weapons are appropriately secured outside the ED.
- ☐ **5.** The hospital/facility/system has a mechanism in place to flag potentially violent patients, patient families, or other visitors.
- ☐ **6.** Easily accessible processes are in place that empower staff to report incidents.
- ☐ **7.** Staff are surveyed regularly and/or offered mechanisms to provide anonymous feedback.
- ☐ **8.** The hospital/facility/system administration acknowledge potential threats or workplace safety challenges.

Transparency

- ☐ **9.** Results of the worksite analysis required annually by The Joint Commission are readily available to health care workers/staff.
- ☐ **10.** (Appropriately deidentified) logs of incidents are available to health care workers/staff.
- ☐ **11.** Other transparency measures are in place so that health care workers/staff are aware of overall workplace safety, such as incident frequency, reported physical injuries, facility responses, and law enforcement involvement/actions.

Analysis & Response

- ☐ **12.** The hospital/facility/system has taken specific actions and made institutional level-investments to improve workplace violence prevention efforts.
- ☐ **13.** Improvements have been made in response to previous incidents or in response to HCW/staff requests.
- ☐ **14.** The hospital/facility/system provides individual victims with follow up and support resources (e.g., trauma/psychological counseling, time off for recovery, etc.).
- ☐ **15.** Specific threats, more common types of violence, or patterns specific to the location/department inform preparedness training for health care workers/staff.

Personnel & Law Enforcement

- ☐ **16.** The hospital/facility/system has a workplace violence prevention program led by a multidisciplinary team.
- ☐ **17.** The selection process for this team is transparent and accessible.
- ☐ **18.** The hospital/facility/system coordinates with local law enforcement to prevent or respond to assaults.
- ☐ **19.** The hospital/facility/system follows up with law enforcement to ensure that assaults are appropriately investigated, charged, and prosecuted as appropriate to ensure that perpetrators are held responsible.

https://www.acep.org/siteassets/sites/acep/blocks/advocacy-action-center/acep-workplace-violence-checklist.pdf

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Virginia Status – 2024

- All Hospitals with an Emergency Department (“ED”) must conduct a Security Risk Assessment and develop and implement a Security Plan
- Security Plan requires the presence of at least one specifically trained law enforcement officer to always be present in the ED
- Training for law enforcement officers shall be based on trauma informed approach and address the potential use of and response to weapons, defensive tactics, de-escalation techniques, appropriate patient intervention activities, and crisis intervention.

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North Carolina Status – 2024

- All Hospitals with an Emergency Department (“ED”) must conduct a Security Risk Assessment and develop and implement a Security Plan
- Security Plan requires the presence of at least one law enforcement officer to always be present in the ED or on the same hospital campus as the ED
- DHHS shall have access to all Security Plans
- Training for law enforcement officers shall be based on trauma informed approach and address the potential use of and response to weapons, defensive tactics, de-escalation techniques, appropriate patient intervention activities, and crisis intervention.
- The hospital shall also provide appropriate hospital WPV prevention program training, education and resources to staff and non-law enforcement officer security personnel.

Workforce

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Workforce:
Protecting our Greatest Resource and Preparing for our Future

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5 Pillars of Workforce Efforts

1. Define EM Residency standards for the future
2. Ensure business interests do not supersede education or patient care
3. Support Emergency Physicians in all communities
4. Protect unique role of Emergency Physicians
5. Broaden demand of Emergency Services to meet evolving needs of community

The Emergency Medicine Physician Workforce: Projections for 2030

Catherine A. Marco, MD*; D. Mark Courtney, MD, MSc; Louis J. Ling, MD; Edward Salsberg, MPA; Earl J. Reisdorff, MD; Fiona E. Gallahue, MD; Robert E. Suter, DO, MHA; Robert Muelleman, MD; Bradley Chappell, DO, MHA; Dian Dowling Evans, PhD, ENP-C; Nathan Vafaie, MD, MBA; Chelsea Richwine, PhD, MA

*Corresponding Author. E-mail: catherine.marco@wright.edu.

Study objective: The goals of this study were to determine the current and projected supply in 2030 of contributors to emergency care, including emergency residency-trained and board-certified physicians, other physicians, nurse practitioners, and physician assistants. In addition, this study was designed to determine the current and projected demand for residency-trained, board-certified emergency physicians.

Methods: To forecast future workforce supply and demand, sources of existing data were used, assumptions based on past and potential future trends were determined, and a sensitivity analysis was conducted to determine how the final forecast would be subject to variance in the baseline inputs and assumptions. Methods included: (1) estimates of the baseline workforce supply of physicians, nurse practitioners, and physician assistants; (2) estimates of future changes in the raw numbers of persons entering and leaving that workforce; (3) estimates of the productivity of the workforce; and (4) estimates of the demand for emergency care services. The methodology assumes supply equals demand in the base year and estimates the change between the base year and 2030; it then compares supply and demand in 2030 under different scenarios.

Results: The task force consensus was that the most likely future scenario is described by: 2% annual graduate medical education growth, 3% annual emergency physician attrition, 20% encounters seen by a nurse practitioner or physician assistant, and 11% increase in emergency department visits relative to 2018. This scenario would result in a surplus of 7,845 emergency physicians in 2030.

Conclusion: The specialty of emergency medicine is facing the likely oversupply of emergency physicians in 2030. The factors leading to this include the increasing supply of and changing demand for emergency physicians. An organized, collective approach to a balanced workforce by the specialty of emergency medicine is imperative. [Ann Emerg Med. 2021;78:726-737.]

Please see page 727 for the Editor's Capsule Summary of this article.

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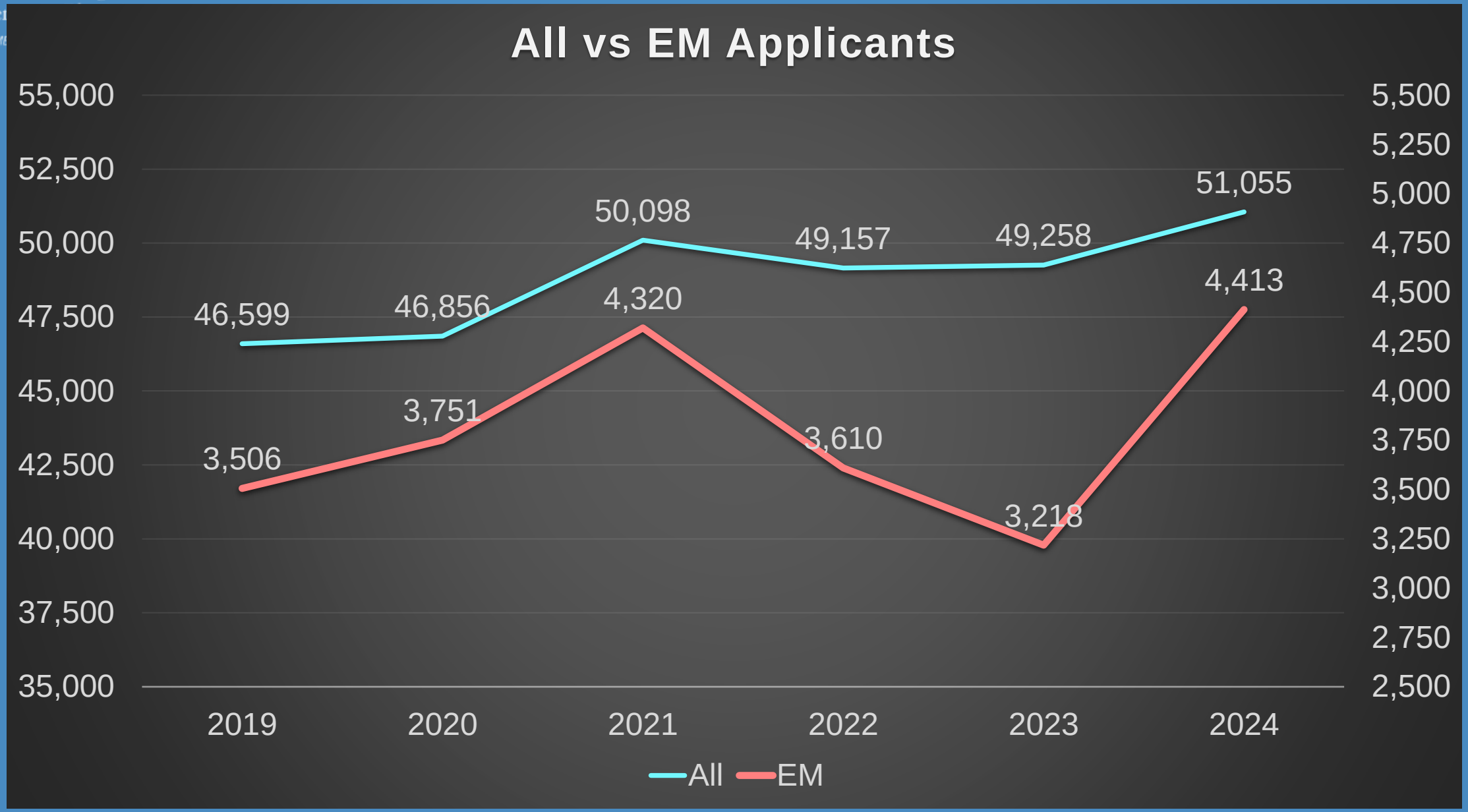

Electronic Residency Application Service (ERAS) Data and Statistics- https://www.aamc.org/data-reports/data/eras-statistics-data

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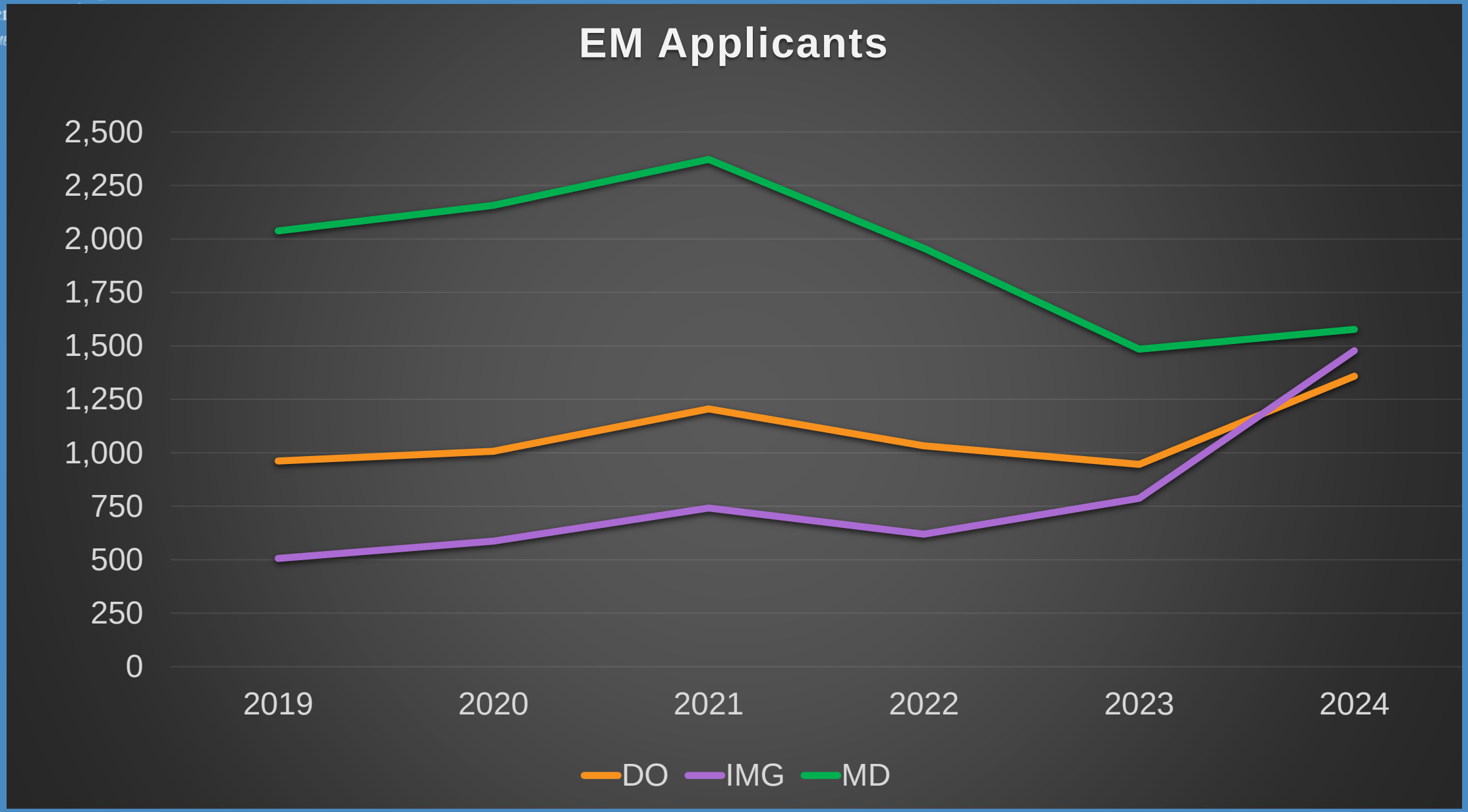

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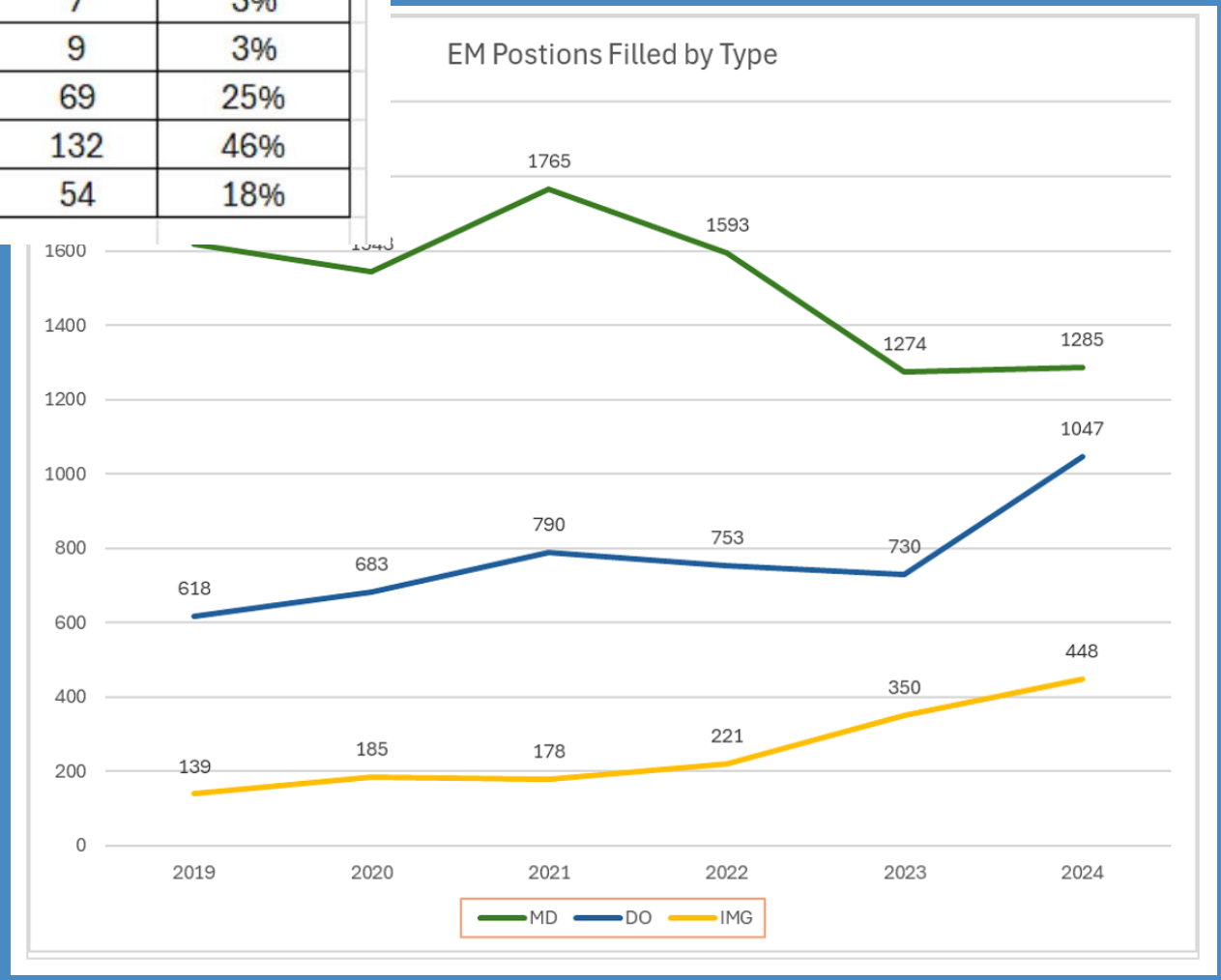
Year	ERAS Applicants	Programs	Total EM Positions	EM Matched Positions	Unfilled Positions	% Unfilled Positions	Unfilled Programs	% Unfilled programs
2019	3506	238	2488	2458	30	1%	15	6%
2020	3751	256	2655	2642	13	0%	7	3%
2021	4320	273	2840	2826	14	0%	9	3%
2022	3610	277	2921	2702	219	7%	69	25%
2023	3218	287	3010	2456	554	18%	132	46%
2024	4413	292	3026	2891	135	4%	54	18%



Corporate Practice of Medicine and Consolidation

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Protecting Emergency Physicians in the Shifting Landscape of Corporatization in Health Care

Consolidation and corporate investment in medicine are rapidly changing the health care landscape.

The past two years of the COVID-19 pandemic, in particular, have driven many to question the outsized impact of horizontal consolidation and vertical mergers and acquisitions on emergency physicians and their patients.

Yet there is no question that changes happening today will impact physician lives and livelihoods for years to come.

Through more than 50 years of policies and advocacy, **ACEP has fought to protect the autonomy of the emergency physician**. But we are hearing from you, our current, former and future members, that **ACEP should do more**.

More to **empower every physician** to be able to make the decisions that they believe are in the best interest of their patients and their livelihood. More to **uphold employer best practices** and level the playing field for physicians who deserve due process, transparency in billing and fair compensation. More to **stand up for and fight** for what we believe in.

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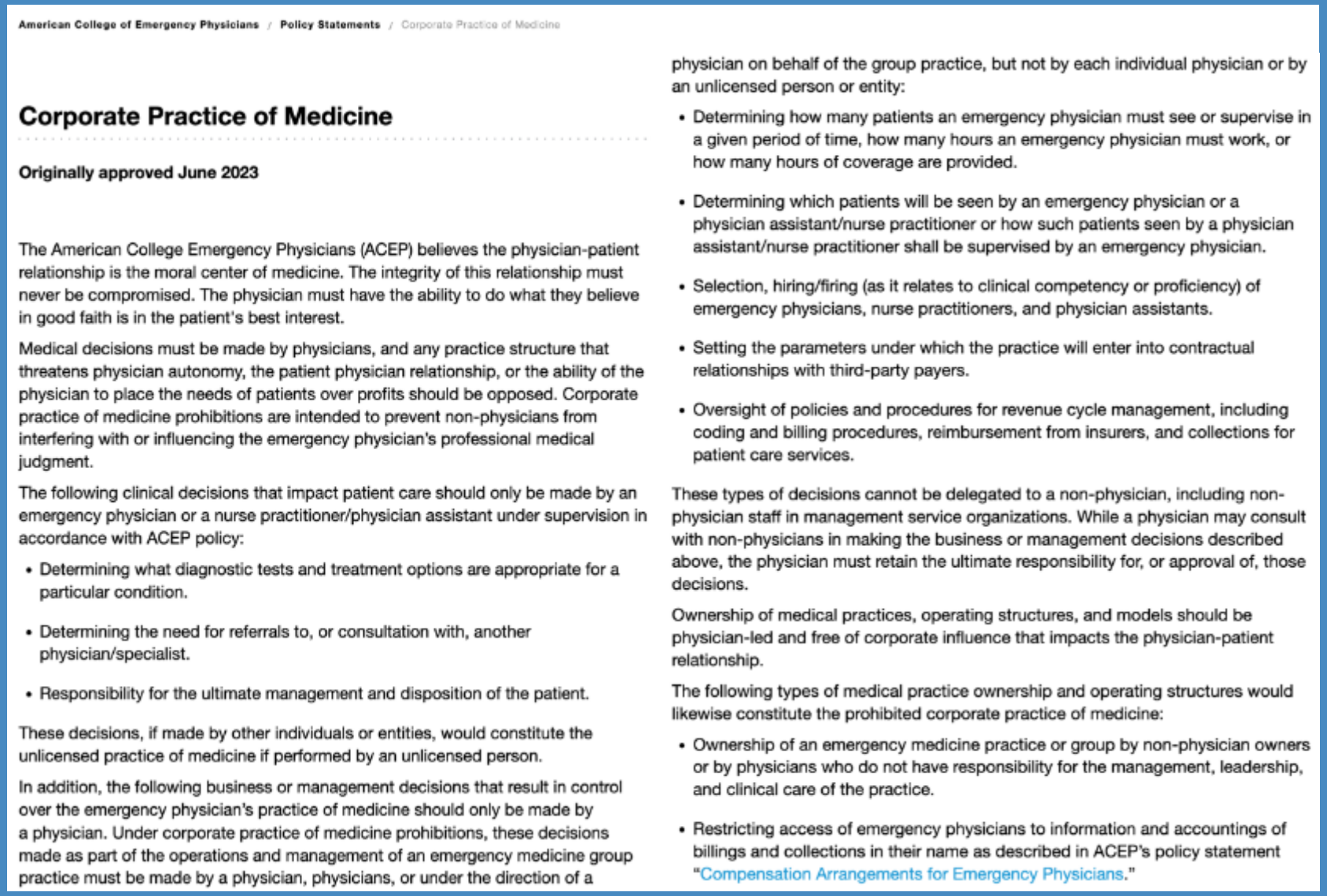
One voice against unfair corporate practice of medicine

ACEP has developed numerous resolutions and policies over the years supporting

This June 2023 policy bolsters ACEP's commitment to protecting and empowering its members and builds on an April 2022 statement from the ACEP Board regarding Private Equity and Corporate Investment in Emergency Medicine.



American College of Emergency Physicians / Policy Statements / Corporate Practice of Medicine

Corporate Practice of Medicine

Originally approved June 2023

The American College Emergency Physicians (ACEP) believes 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. Corporate practice of medicine prohibitions are intended to prevent non-physicians from interfering with or influencing the emergency physician's professional medical judgment.

The following clinical decisions that impact patient care should only be made by an emergency physician or a nurse practitioner/physician assistant under supervision in accordance with ACEP policy:

- Determining what diagnostic tests and treatment options are appropriate for a particular condition.
- Determining the need for referrals to, or consultation with, another physician/specialist.
- Responsibility for the ultimate management and disposition of the patient.

These decisions, if made by other individuals or entities, would constitute the unlicensed practice of medicine if performed by an unlicensed person.

In addition, the following business or management decisions that result in control over the emergency physician's practice of medicine should only be made by a physician. Under corporate practice of medicine prohibitions, these decisions made as part of the operations and management of an emergency medicine group practice must be made by a physician, physicians, or under the direction of a physician on behalf of the group practice, but not by each individual physician or by an unlicensed person or entity:

- Determining how many patients an emergency physician must see or supervise in a given period of time, how many hours an emergency physician must work, or how many hours of coverage are provided.
- Determining which patients will be seen by an emergency physician or a physician assistant/nurse practitioner or how such patients seen by a physician assistant/nurse practitioner shall be supervised by an emergency physician.
- Selection, hiring/firing (as it relates to clinical competency or proficiency) of emergency physicians, nurse practitioners, and physician assistants.
- Setting the parameters under which the practice will enter into contractual relationships with third-party payers.
- Oversight of policies and procedures for revenue cycle management, including coding and billing procedures, reimbursement from insurers, and collections for patient care services.

These types of decisions cannot be delegated to a non-physician, including non-physician staff in management service organizations. While a physician may consult with non-physicians in making the business or management decisions described above, the physician must retain the ultimate responsibility for, or approval of, those decisions.

Ownership of medical practices, operating structures, and models should be physician-led and free of corporate influence that impacts the physician-patient relationship.

The following types of medical practice ownership and operating structures would likewise constitute the prohibited corporate practice of medicine:

- Ownership of an emergency medicine practice or group by non-physician owners or by physicians who do not have responsibility for the management, leadership, and clinical care of the practice.
- Restricting access of emergency physicians to information and accountings of billings and collections in their name as described in ACEP's policy statement "Compensation Arrangements for Emergency Physicians."

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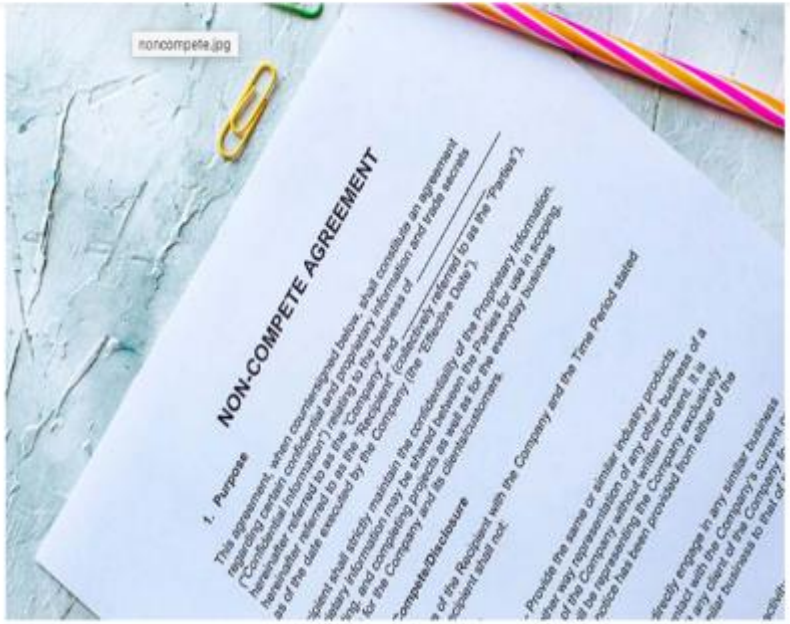
EMERGENCY PHYSICIANS.ORG



ACEP Urges FTC to Finalize Ban on Non-Compete Clauses in Employment Contracts

March 8, 2023

The American College of Emergency Physicians (ACEP) urges the Federal Trade Commission (FTC) to finalize its proposed rule to ban non-compete clauses in employment contracts. In a letter to the Commission, ACEP unequivocally supports a ban on these predatory clauses which can limit the ability of emergency physicians to practice medicine in their communities and hinder their ability to effectively advocate for their patients.

October 11, 2023

FTC Chair Khan at ACEP23: "Your Voices are Just Essential for Us"

During a packed and engaged closing keynote session on Wednesday, FTC Chair Lina M. Khan and health care business researcher Lawton R. Burns, PhD, MBA, spoke frankly about the damaging effects of consolidation in health care and fielded questions from the audience about private equity, non-competes, and unchecked monopolies.

December 12, 2023

ACEP Leaders Meet with DOJ Antitrust Department

On Tuesday, Dec. 12, ACEP President Aisha T. Terry, MD, MPH, FACEP; ACEP Executive Director & CEO Susan Sedory, MA, CAE; and Senior Vice President of Advocacy & Practice Affairs Laura Wooster met with Jonathan Kanter, the United States Assistant Attorney General for Antitrust and other key Department of Justice staff to discuss the growing negative impact of insurer consolidation on emergency physicians and the patients they care for.

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March 26, 2022

ACEP Files Amicus Brief in CA Lawsuit on Physician Practice

On March 25, ACEP filed an amicus brief in the AAEMPG v. Envision case, which claims a violation of California state law, lay ownership of medical practices and unfair restraint of the practice of emergency medicine.

The ACEP brief sides with a physician's right to autonomy in medical decision-making. It was carefully crafted to emphasize the physician-patient relationship as the moral center of emergency medicine and includes several examples of ACEP's strong leadership in this area. Also filed was a Declaration of Interest from EMRA President Angela Cai, MD, MBA, in support of ACEP and the issues raised in our brief.

This is a novel approach to engaging with the legal system and is an attempt to educate the Court on the sanctity of a doctor's duty to patients and the importance of allowing them t treated without undue pressure from outside forces.

Chat wit

July 21, 2023

ACEP Offers Support for EM Physicians During Career Transitions

The announcement of the closing of American Physician Partners (APP) has created a disruption in the lives of thousands of emergency physicians, their families, patients and communities.

As you deal with the inevitable questions, concerns, decisions and anxiety, remember, you're not alone — ACEP has your back.

To get more clarity on what's happening:

- Help crowdsource transition information about the 119 emergency departments affected and which groups will be taking over APP's EM contract

As we determine next steps, we've gathered some of the most relevant benefits to help you as you make decisions in the coming days and weeks.

- Take care of yourself and, if you need them, utilize three free counseling sessions as you plan your next steps.
- If you want to connect with peers on questions or concerns, join the engagED community for those in the midst of job transitions.
- Receive 20% off employment contract review services from Resolve.
- Reviewing a contract and have a legal question? You have a members-only discount to pose

American College of Emergency Physicians

October 4, 2023

ACEP Files Notice of Appearance in American Physician Partners' Bankruptcy Case

This morning, ACEP filed a Notice of Appearance in the American Physician Partners bankruptcy case. While ACEP is neither a party nor a creditor, because of the bankruptcy's effect on our members, filing this notice allows ACEP to attend hearings, receive court notices, and file motions, objections or other legal documents pertinent to the case. Further, it sends an important message to the Court, trustees and other parties that ACEP is watching the case and will take action to protect the interests of our members, as needed.

ACEP is arranging a meeting in at ACEP23 in Philadelphia, inviting any attendees affected by the bankruptcy (or those who want to proactively protect themselves against possible future actions) to discuss their concerns and struggles. Bankruptcy and benefits experts from the law firm of Barnes & Thornburg will lead the discussion and field questions.

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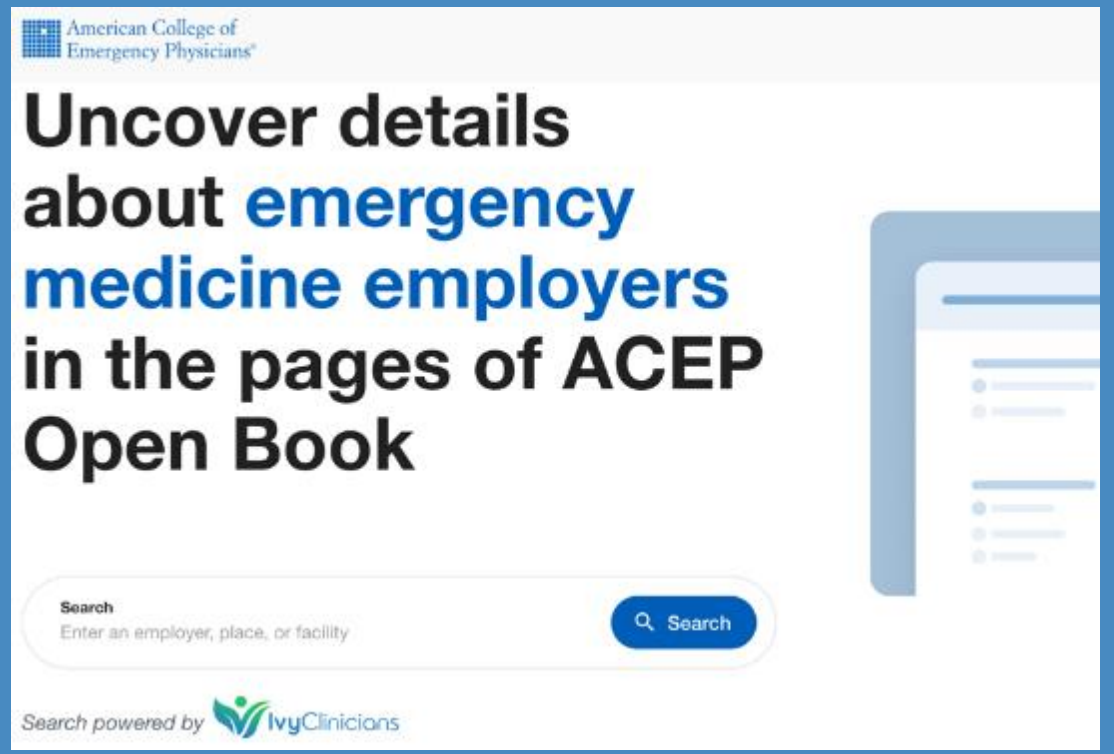
ACEP Open Book

openbook.acep.org



What's on the Minds of the Board? Focus Areas for the Year

American College of Emergency Physicians®
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Communication

- Clear and focused messaging on key topics
- Adjusting to digital publications
- ACEP Now

Membership

- Member recruitment and retention
- New engagement opportunities
- Chapter feedback

Innovation

- Meetings
  - Scientific Assembly
  - Leadership & Advocacy
  - ACEP Accelerate
- Emergency Medicine Data Institute (EMDI)
- Accreditation

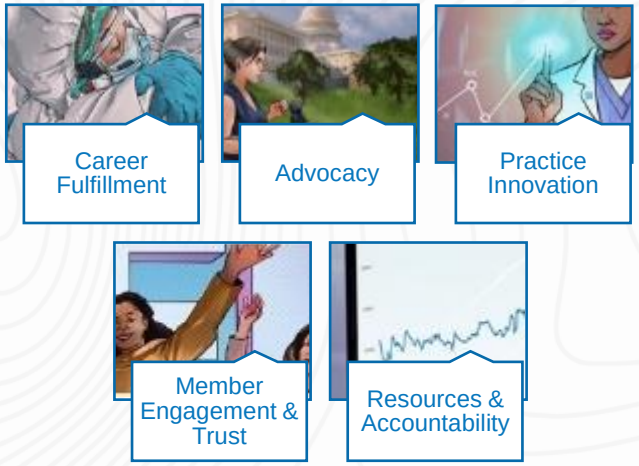
Finances & Operation

- Tech investment
- New membership models
- Transition corporate support to grants and alternative revenue
- Operational cash balances recovering
- Transparency & process

Board Focus Aligned to Vision and Strategy

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

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Board Focus: LEADERSHIP PIPELINE

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The Leadership Pipeline

- The demand for leaders exceeds the supply.
- Deliberate process whereby an adequate supply of leaders are sought, identified, prepared, funneled and retained.
- “Upstream” recruiting of future leaders early in their career journey is key.
- Facilitates diversification of talent pool; Diversity matters.
- Ensures consistent succession planning.

Taking our Story on the Road: Developing ACEP's Leadership Pipeline Portfolio

AAMC Association of American Medical Colleges

- Annual Career Fair
- Annual Virtual Medical School Fair
- Regular Webinars
- Minority Faculty Development Conference

Latino Medical Student Association · LMSA ·

Student National Medical Association, Inc. ESTABLISHED 1964

TOUR FOR DIVERSITY IN MEDICINE
TO EDUCATE, INSPIRE AND CULTIVATE

Mentoring in Medicine
Turning Dreamers into Health Professionals

BNGAP: Diversifying Academic Medicine

The Dr. Leon L. Haley Jr. Bridge to the Future of Emergency Medicine Academy

American Board of Emergency Medicine

BECOME CERTIFIED | STAY CERTIFIED | FOR PROGRAM DIRECTORS

Health Care Administration, Leadership, and Management

- The Business of Health Care
- Finance and Accounting
- Care Innovation, Health Equity, and Population Health
- Governance
- Health Care Policy, Law, and Advocacy
- Health Information Technology
- Human Resource Management and Workforce Development
- Leadership in Patient Safety and Quality Improvement
- Organizational Leadership and Communication Skills
- Professionalism and Ethics

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Recent Board Actions – January Board Meeting

- Disaster Telehealth – new
- ED Patient Rights and Responsibilities – new
- Reversal of NOACs in the Presence of Major Life-Threatening Bleeding – revised
- Medical Practice Review and the Practice of Medicine – revised
- Optimizing Advanced Imaging of Pediatric Patients in the ED – new joint policy statement with American Academy of Pediatrics and American College of Radiology
- Disposition of Policy Statements Scheduled for Sunset Review Process
- Approved Philadelphia- 2029 Scientific Assembly
- NEMPAC Revised Articles of Association
- **ED Accreditation Criteria**
- ED Accreditation Program Revised Governance Charter
- 15% of Section Dues Allocation – revised policy
- Pediatric Emergency Medicine Section revised section operational guidelines
- Proposed quality measure concepts for 2025-26

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Recent Board Actions – March

- 2024 Compendium of ACEP Policy Statements on Ethical Issues
- Colorado Chapter State Public Policy Grant Request
- Disaster Medical Services – reaffirm
- Human Resources Concepts Governing Physician Medical Directors of EMS – reaffirm
- The Role of the Legacy Emergency Physician in the 21st Century – revised
- **3-year dues package for graduating residents**
- Prioritization of Resident Education in Procedures – new policy statement

- Accelerate Meeting this week
- LAC innovation workgroup
- Scientific Assembly reimagined

American College of Emergency Physicians
Emergency Medicine Data Institute

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ADVANCING EMERGENCY CARE

Key Messages:

- ACEP advocacy focus areas:
  - Boarding and ED crowding
  - Workplace violence
  - Workforce
  - Corporate Practice of Medicine/Consolidation

- Operational priorities for ACEP and the Board of Directors:
  - Communications
  - Membership
  - Innovation
  - Leadership Pipeline

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Questions? Your Issues?

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