American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

February 23, 2022

Dawn O'Connell
Assistant Secretary for Preparedness and Response
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Re: Request for Information; National Health Security Strategy

Dear Assistant Secretary O'Connell:

On behalf of our 40,000 members, the American College of Emergency Physicians (ACEP) appreciates the opportunity to provide comments on the "Request for Information; National Health Security Strategy." As you know, emergency physicians have been and continue to serve on the front lines combating the COVID-19 pandemic since it first arrived in the United States over two years ago. Our collective experience, both as physicians providing direct patient care and as representatives involved in state, regional, and local planning of responses to all manner of threats and disasters, provides us with a unique perspective on the challenges, successes, and failures of our nation's response to this public health emergency.

Unfortunately, our country's response to infectious disease outbreaks, natural and man-made disasters, and other public health emergencies has been, and continues to be, consistently reactive. COVID-19 exposed glaring weaknesses, systemic failures, and an overall lack of preparedness by the world at large. The pandemic has cost millions of lives across the globe and disrupted every aspect of everyday life, and the full magnitude and scope of its impacts are almost incalculable. We must be better prepared for and ready to respond to future serious public health challenges than we were for COVID-19.

The overarching themes identified by this crisis and our country's response to it are the need for improved collaboration and communication at the federal, state, and local levels and significant investment in the mental health of our nation's healthcare workers. We recognize these are not insignificant challenges, especially in the context of a national and international threat, but they must be addressed because future outbreaks or major disasters are not a matter of if, but when.

With that context in mind, ACEP provides the following responses to the specific questions included in the request for information.

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1. *What are the most critical national health security threats and public health and medical preparedness, response, and recovery challenges that warrant increased attention over the next five years?*

There are numerous public health and medical preparedness and response challenges that we face both now and going forward. Among the weaknesses exposed by the COVID-19 pandemic is the continued lack of a sophisticated, integrated system for biosurveillance capabilities and public health data collection and reporting. Given technology that is currently available (and in many cases already in use at system, local, or state levels), it is incomprehensible that much of this data is still not publicly available in real-time or near-real-time. At present, syndromic surveillance is limited to those health departments and hospitals who 'want' to share their data, leaving large gaps in the data collected (for example, nearly the entire state of California does not participate). A truly interoperable, seamless exchange of health data should be standard practice in everyday health care delivery to be most effective in public health emergencies.

Current variations of rules and protocols regarding emergency response and patient treatment both within and between states leads to confusion among the public and a reduced capability to acquire the data that can best direct care. The lack of coordinated protocols and best practices provokes the spread of misinformation and an erosion of trust in institutions that will continue to interfere with the ability to develop and implement public health response and recovery plans.

Recent trends have commodified advance medical care to an increasingly singularly urban capacity. Rural hospitals cannot compete financially, so they have reduced services, including critical care, obstetrics, and in many areas, even general surgery. Increasingly, patients who need an appendectomy or other emergency procedure are transferred to larger urban centers. As hospitals have become overwhelmed with COVID-19 patients, the ability to transfer patients is inhibited by the lack of services offered at hospitals in more rural settings, therefore reducing access to services available to rural populations.

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

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

- More than eight in 10 (87 percent) of emergency physicians reported feeling more stress since the start of the pandemic, with an additional 72 percent experiencing burnout on the job.

- Despite increased levels of stress and burnout, nearly half (45 percent) of the nation's emergency physicians did not feel comfortable seeking mental health treatment.
- When it came to seeking mental health treatment, 73 percent of emergency physicians felt there was stigma in their workplace.
- Nearly three in five (57 percent) of emergency physicians reported they would be concerned for their job if they were to seek mental health treatment.
- More than a quarter (27 percent) reported they had avoided seeking mental health treatment in fear of professional repercussions.
- Emergency physicians who reported not seeking mental health treatments for fear of professional repercussions cited job security, professional stigma, and future job opportunities as their reasons.

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

Finally, the COVID-19 response has created unprecedented challenges for the health care workforce and imposed significant strains on staffing operations. These challenges have led many to leave the health professions, retire early, or reconsider their career paths and avoid the public health workforce. The shortage of nurses, emergency medical technicians (EMTs), paramedics, and other healthcare workers will last well beyond the pandemic and will take decades to rebuild. Current reimbursement and quality requirements penalize institutions, therefore creating barriers to reduce the workload of nurses and support staff.

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 the Centers for Medicare & Medicaid Services (CMS) 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.

2. *What medium-term and long-term (i.e., over next five years) actions should be taken to mitigate these challenges at the federal government and/or state, local, tribal, and territorial level?*

The COVID-19 pandemic has made the need for a single national dashboard for resources and data collection and reporting abundantly clear. At present, a few national dashboards for therapeutics and ECMO exist. These should, be consolidated into a single site, in addition to an updated inventory tracker of essential items such as availability of inpatient beds, ICU beds, and ventilators. We encourage ASPR to look to the private sector or other public partners to fully realize the goal of increased biosurveillance capabilities. For example, throughout much of the pandemic, decision-makers turned to the Johns Hopkins University COVID-19 dashboard to get information about the number of tests, reported cases, deaths, and recovered individuals. Many other public and private entities also developed unique and innovative data collection technologies that have helped identify new disease vectors, provide predictive modeling to track the evolution COVID-19 and new variants, or help assess medical supply chains and surge capacity, among others. However, we urge an exercise of caution in how additional electronic data or information sharing standards are implemented to ensure that they do not impose additional burdens on physicians or further hinder clinical workflows, especially during times of crisis.

Much like increased coordination in health data collection and reporting, we also support coordination efforts between and within states regarding public health directives. Best practices and lessons learned from the current public health emergency should inform the planning of future protocols and prevent reactive response strategies, which are more prone to discord. Likewise, research networks that would work together using common protocols and established data use agreements would allow a more rapid assessment of the best way to care for patients.

In addition, ACEP believes it is essential to incorporate the lessons learned during the COVID-19 response to inform the provision of trauma care, and we support the establishment of a coordinated National Trauma and Emergency Preparedness System (NTEPS) that can provide awareness of resources and surge capacity throughout the health care system, as well as the ability to load balance the system to match patients with appropriate resources and specialty expertise.

Currently, we rely on a patchwork of regional and state trauma systems that have developed to meet the needs of patients in need of acute care. We believe a national trauma system is needed to provide a rapid, effective, and coordinated response to public health emergencies. This coordinated should be built upon a framework of an interconnected network of Regional Medical Operations Coordination Centers (RMOCCs) to improve regional care delivery by facilitating the most appropriate level of care based on individual patient acuity, while also maintaining patient safety and keeping patients in local facilities that are capable of providing high quality care.

We envision these RMOCCs as having the following essential functions:

- Operationalize the regional plan for patient distribution and health system load balancing for any mass casualty or large public health event;
- Facilitate clinical expertise and consultation for all health-related hazards and coordinate the expertise into the regional plan through current hazard vulnerability assessments;

- Integrate all levels of healthcare leadership (public health, administrative, physician and nursing) from the regional health systems and hospitals into the framework of the emergency operations center and operational plans;
- Provide real time situational awareness of health care capability and capacity to all regional healthcare systems and other salient healthcare entities. This function includes data collection, analysis, and dissemination (i.e., hospital and EMS capacity data);
- Support dynamic movement of patients when required and load balance the medical facilities to mitigate the need for crisis standards implementation and resource rationing;
- Provide a single point of contact at both the RMOCC and at each hospital/health system for referral requests and life-saving resource sharing;
- Align and coordinate regional resources (e.g., supplies, equipment, medications, etc.) and personnel with the goal of maintaining regional systems for time sensitive care such as cardiac, stroke and trauma that may or may not be directly impacted by the surge event; and
- Provide a communication link to other RMOCCs to lead or participate in a broader coordinated multiregional, state, or national effort. This includes both a multi-state response and nationwide network integration.

Though some of these concepts are included in ASPR's *Draft Guidelines Regional Health Care Emergency Preparedness and Response Systems*, we and our partners in this effort continue to encourage ASPR to make Medical Operations Coordination Centers the centerpiece of the regionalized approach. As it stands now, our country does not yet have a National Trauma System capable of mounting a rapid, effective, and coordinated response to future pandemics, mass casualty events, or other public health emergencies. Given our extensive experience in responding to these types of events, we would welcome the opportunity to work with ASPR to help realize the promise of a truly coordinated medical preparedness and response system.

Inconsistencies in public health directives and confusing, frequently changing, and often conflicting information and guidance disseminated to both the public and to the health care community has accelerated the erosion of trust in science, healthcare, and governmental institutions. It is critical that trust in science be re-established.

As stated above, the shortage of nurses and other healthcare workers and support staff underscores the need for re-examination of current regulations and expectations of healthcare workers. It must be understood that clinical staff well-being, and therefore workforce retention, is primarily dependent upon an organizational culture supportive of wellness, as well as the efficiency of the practice environment. Ensuring peak performance from clinical staff is critical and cannot occur without an ongoing effort to support and protect staff wellness and resilience, not exclusively at times of crisis. ACEP supports the imperative critical efforts to address mental health challenges faced by healthcare workers as a result of the COVID-19 pandemic; however, a stigma against mental health persists in the healthcare community.

Furthermore, ACEP supports the expansion and implementation of research networks to collaborate on best practices and public health directives to develop proactive preparedness and response plans. Translating research into evidence-based practices to improve preparedness and response efforts means that we are taking concrete steps to learn from the lessons of the pandemic. It is critical that these activities take into account the unique challenges that public health emergencies pose both within and beyond the clinical environment.

3. What public health and medical preparedness, response, and recovery opportunities or promising practices should be capitalized on over the next five years?

The COVID-19 pandemic proved that the use of telehealth services is a crucial innovation in the delivery of healthcare services. Telehealth provided essential services to patients during this pandemic, allowing many patients to obtain care without travel or potential exposure.

During the COVID-19 crisis, CMS made two critical telehealth policy changes that impacted emergency medicine specifically – (1) allowing medical screening exams (MSEs), a requirement under the Emergency Medical Treatment and Labor Act (EMTALA), to be performed via telehealth; and (2) adding the ED evaluation and management (E/M) codes to the list of approved Medicare telehealth services. These policy changes have temporarily allowed some EDs to further invest in their existing telehealth programs and allowed others to initiate new programs to better serve their patients. Being able to perform MSEs via telehealth over the course of the pandemic has helped protect emergency physicians and their patients from unnecessary exposure to the virus and helped preserve the limited supply of PPE. Furthermore, having the ED E/M codes on the approved list of Medicare telehealth services has given EDs an appropriate and consistent reimbursement mechanism to support their telehealth programs.

ACEP strongly believes that we cannot let the great strides we have made in the delivery of emergency telehealth services simply come to an abrupt end once the pandemic ends. To ensure that patients continue to get timely, personalized, high-quality care, and that our nation's hospitals can maintain the capacity they need to provide emergency care at all times, we need to make sure that federal and state policies keep pace with clinical innovation. We have therefore requested that Congress change the Medicare telehealth statute. Once the pandemic ends, CMS loses its ability to grant Medicare the telehealth flexibilities that allow any physician to provide services from any physical location. Congress can ensure patient access to telehealth after the pandemic by repealing the "originating site" requirement, which forces patients to travel to certain healthcare facilities to receive telehealth services instead of allowing them to receive medical attention from the convenience of their home. CMS has temporarily instituted this change because of COVID-19 and Congress should make it permanent.

All state Medicaid programs and health plans should follow Medicare's lead as well. Health plans and states should embrace telehealth with the same enthusiasm as Medicare and align their telehealth policies with Medicare's to ensure consistent regulation, licensure, billing, and coding for emergency telehealth services. Different billing rules and state regulations make reimbursement inconsistent and adds administrative challenges that hinder the sustainability of these new and vital telehealth programs.

Another promising effort was the ability for the federal, state, and local governments to create and operate mass vaccination sites that helped get shots into arms as quickly as possible once the COVID-19 vaccines became available. It would be useful to keep the processes in place that allowed for such a coordinated and expediated effort. In addition, many emergency departments across the country were able to vaccinate their patients, although prior to the pandemic, vaccinations are not routinely provided in this setting. Maintaining the infrastructure and support necessary to conduct vaccinations in emergency departments will be extremely important to prepare for the next pandemic.

We appreciate the opportunity to share our comments. If you have any questions, please contact Jeffrey Davis, ACEP's Director of Regulatory and External Affairs, at jdavis@acep.org.

Sincerely,

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ACEP President