

May 27, 2022

Dr. Victor Dzau, Co-Chair
Dr. Darrell Kirch, Co-Chair
Dr. Vivek Murthy, Co-Chair
Dr. Thomas Nasca, Co-Chair
National Academy of Medicine, Clinician Well-Being Collaborative
500 5th Street NW
Washington, D.C. 20001

Re: Draft National Plan for Health Workforce Well-Being

Dear Co-Chairs Dzau, Kirch, Murthy, and Nasca:

On behalf of our 40,000 members, the American College of Emergency Physicians (ACEP) appreciates the opportunity to provide input on the draft *National Plan for Health Workforce Well-Being*. Promoting the wellbeing of health workers is a critical priority for ACEP, and we thank the National Academy of Medicine (NAM) for addressing this important issue. ACEP would welcome the opportunity to partner with NAM on many of the recommendations included within the National Plan. For reference, ACEP has created a [website](#) dedicated to wellness, where we have produced a [repository of wellness resources](#), including the [ACEP Wellness & Assistance Program](#) and the [ACEP Wellness Guide](#). The ACEP Wellness & Assistance Program is a valuable ACEP member benefit, offering ACEP members exclusive access to three free counseling or wellness sessions. We are happy to meet with you to provide more information about our resources and initiatives.

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Comments on Chapter 1

Overall, ACEP supports much of the draft National Plan, but we would like to offer specific comments to strengthen the Plan. The Plan mentions that during the COVID-19 pandemic, “the public’s behaviors seemed to be driven by political ideologies that led to tensions over masks and distancing (Hardy et al., 2021) and, in some cases, as harassment and violence against health workers” (Page 3). However, the Plan does not include strategies to address workplace violence. ACEP recommends that NAM amend the Plan to clearly recommend the need for new policies and procedures to protect health workers from violent episodes and to impose penalties on perpetrators of these crimes.

Unfortunately, violence in health care is a common occurrence. An [ACEP survey from 2018](#) showed that nearly half of emergency physicians have experienced violence and 80 percent of emergency physicians said that violence was harming patient care. These trends have not improved, and we still continuously hear heart-wrenching stories about attacks or other violent episodes from health care workers across the country. In fact, since the onset of the pandemic, violence against hospital employees has markedly increased — and there is no sign it is receding. Studies

indicate that 44 percent of nurses report experiencing physical violence and 68 percent report experiencing verbal abuse during the pandemic. The frequency of violent attacks on nurses, physicians, and patients in our nation's hospitals is unconscionable and unacceptable. For medical professionals, being assaulted must no longer be tolerated as "part of the job." This persistent issue demands a response at the federal, state, and local levels. ACEP supports the "Workplace Violence Prevention for Health Care and Social Service Workers Act" (S.4182). This bipartisan effort takes critical steps to address emergency department (ED) violence by requiring the Occupational Safety and Health Administration (OSHA) to issue enforceable standards to ensure health care and social services workplaces implement violence prevention, tracking, and response systems. Similar legislation (H.R.1195) passed in the House of Representatives on April 16, 2021.

Another essential issue not addressed in the draft National Plan is overcrowding in the ED, a major contributor to burnout for all clinicians who work in EDs. Crowding in the ED has been an issue for years—in some cases causing ED "boarding," which can keep patients in the ED for days (or longer) due to the lack of available inpatient beds or space in other facilities where the patient could be transferred.

Unfortunately, ED boarding is at an all-time high. The reason for this is multi-factorial but mainly has to do with significant staffing shortages in hospitals and an influx of patients (both COVID- and non-COVID-related) who are extremely sick (potentially because some of them delayed care during the last two years).

[Ample research](#) supports the conclusion that ED crowding leads to increased cases of mortality related to downstream delays of treatment for both high- and low-acuity patients. Boarding can also lead to ambulance diversion, increased adverse events, preventable medical errors, lower patient satisfaction, violent episodes in the ED, and higher overall health care costs. ACEP met with Centers for Medicare & Medicaid Services (CMS) last October to talk about potential short and long-term solutions to help address the ED boarding crisis. We discussed potential tools to help mitigate boarding, such as increased CMS flexibilities and waivers, standards for prompt transfer out of the ED once a disposition decision by the treating emergency physician has been made, the development of a real-time bed tracking dashboard, and the ability to use alternative placement or home support for Medicare patients to help open beds. ACEP recommends that the Plan acknowledge this issue and urges NAM to consider inclusion of strategies to reduce ED boarding and overcrowding. Remediation of a major factor that directly causes burnout such as overcrowding in the ED will help alleviate burnout for clinicians in the future.

Comments on Chapter 5

ACEP does not support the Goal 5 recommendation included in chapter 5: "Enable health workers to practice at the top of their training and education; and permanently eliminate onerous scope-of-practice regulations to allow advanced practice providers (e.g., nurse practitioners, midwives) to practice independently" (Page 31). We are concerned about NAM's overall position regarding care delivered by non-physician practitioners, and ***strongly believe that non-physician practitioners should not perform independent unsupervised care in the ED or other health care settings.***

NAM should rely on fact-based resources, including a thorough review of the education and training of non-physician health care professionals and the impact on the overall cost and quality of care. NAM should also review the true impact of state scope of practice laws on access to care across the country.

As the most highly educated and trained health care professionals, we believe that physicians should lead the health care team. There is a vast difference in the education and training of physicians versus other health care professionals.

Patients agree and overwhelmingly want physicians leading their health care team. In fact, an [American Medical Association \(AMA\) survey](#) found that four out of five patients prefer a physician to lead their health care team and 86 percent of patients say patients with one or more chronic conditions benefit when a physician leads their health care team. Further, according to an [August 2021 public opinion survey](#) from ACEP and Morning Consult, nearly 80 percent of adults trust a physician to deliver their medical care in an emergency, compared to a nurse practitioner (9 percent), physician assistant (7 percent) or nurse (5 percent).

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.

A common argument for expanding the scope of practice of nonphysician professionals is that it will increase access to care. 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 are 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.

Overall, while all health care professionals play a critical role in providing care to patients, their skillsets are not interchangeable with that of fully trained physicians. The scope of practice of health care professionals should be commensurate with their level of education and training. **Patients deserve nothing less than to be cared for by physician-led health care teams.**

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,



Gillian R. Schmitz, MD, FACEP

ACEP President