ICEP Spring Symposium 2021

2021: Current State of Emergency Medicine

Gillian R. Schmitz, MD, FACEP

Disclosures

- No Financial Disclosures
- President-elect of ACEP

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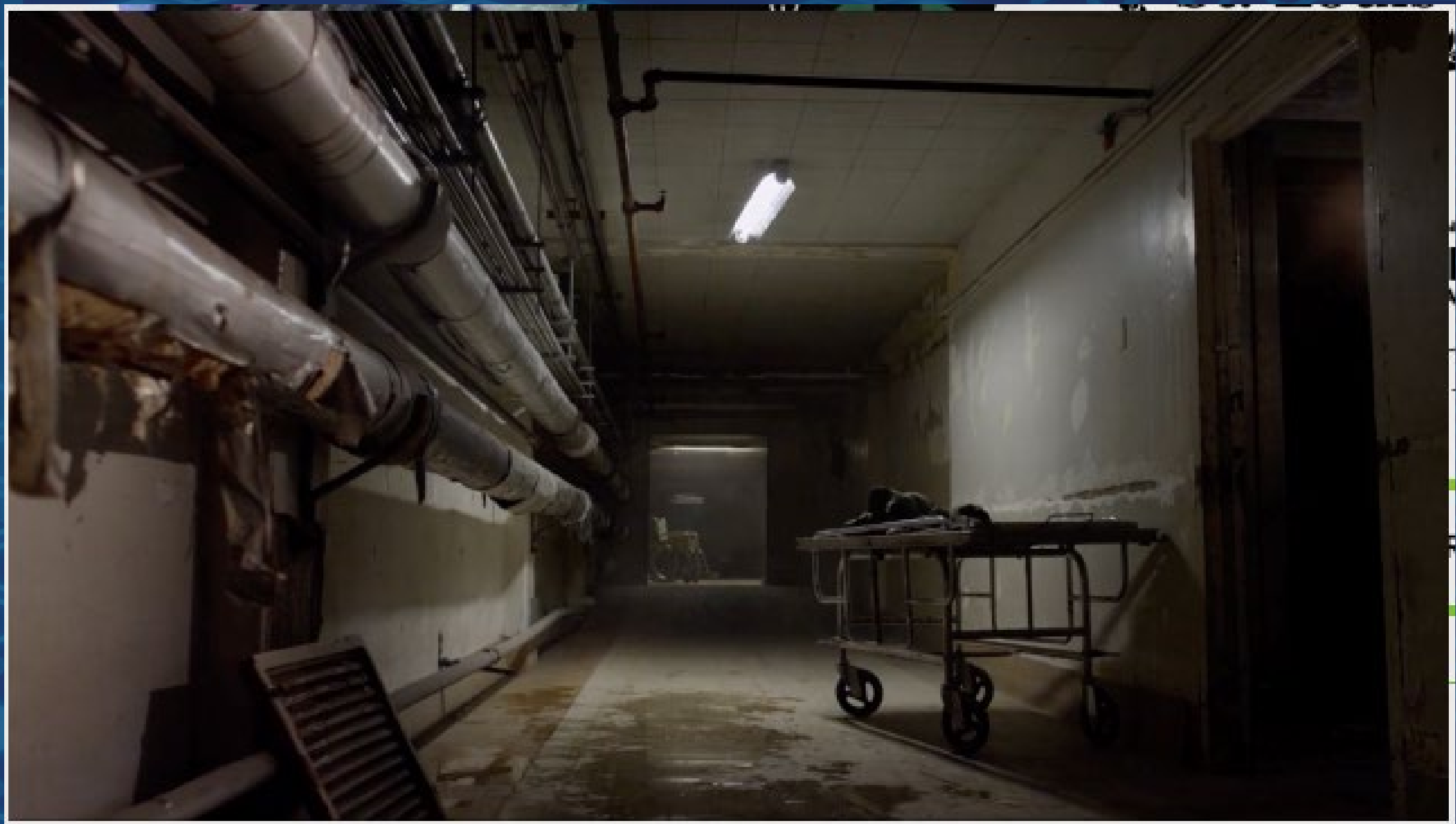

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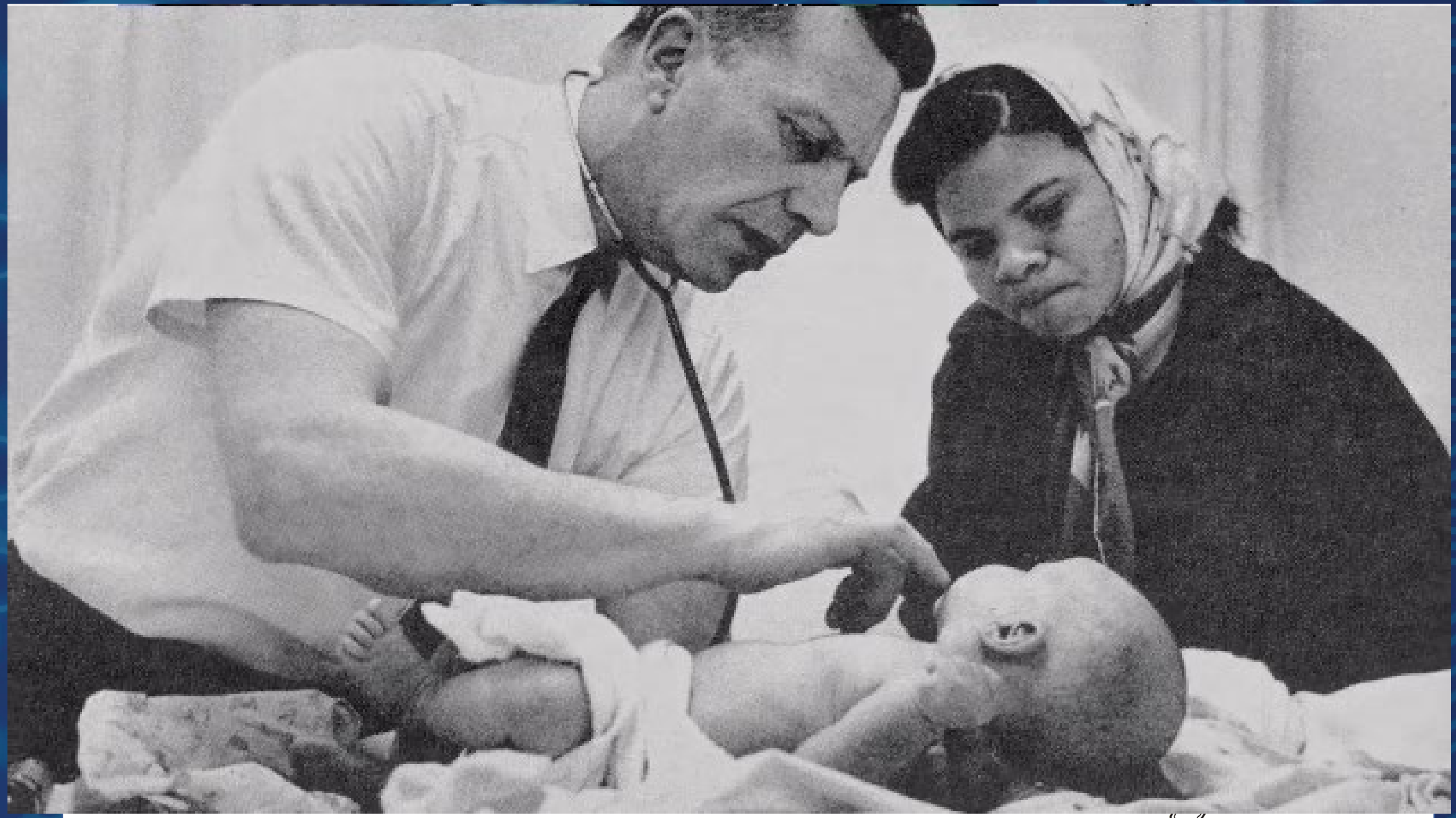

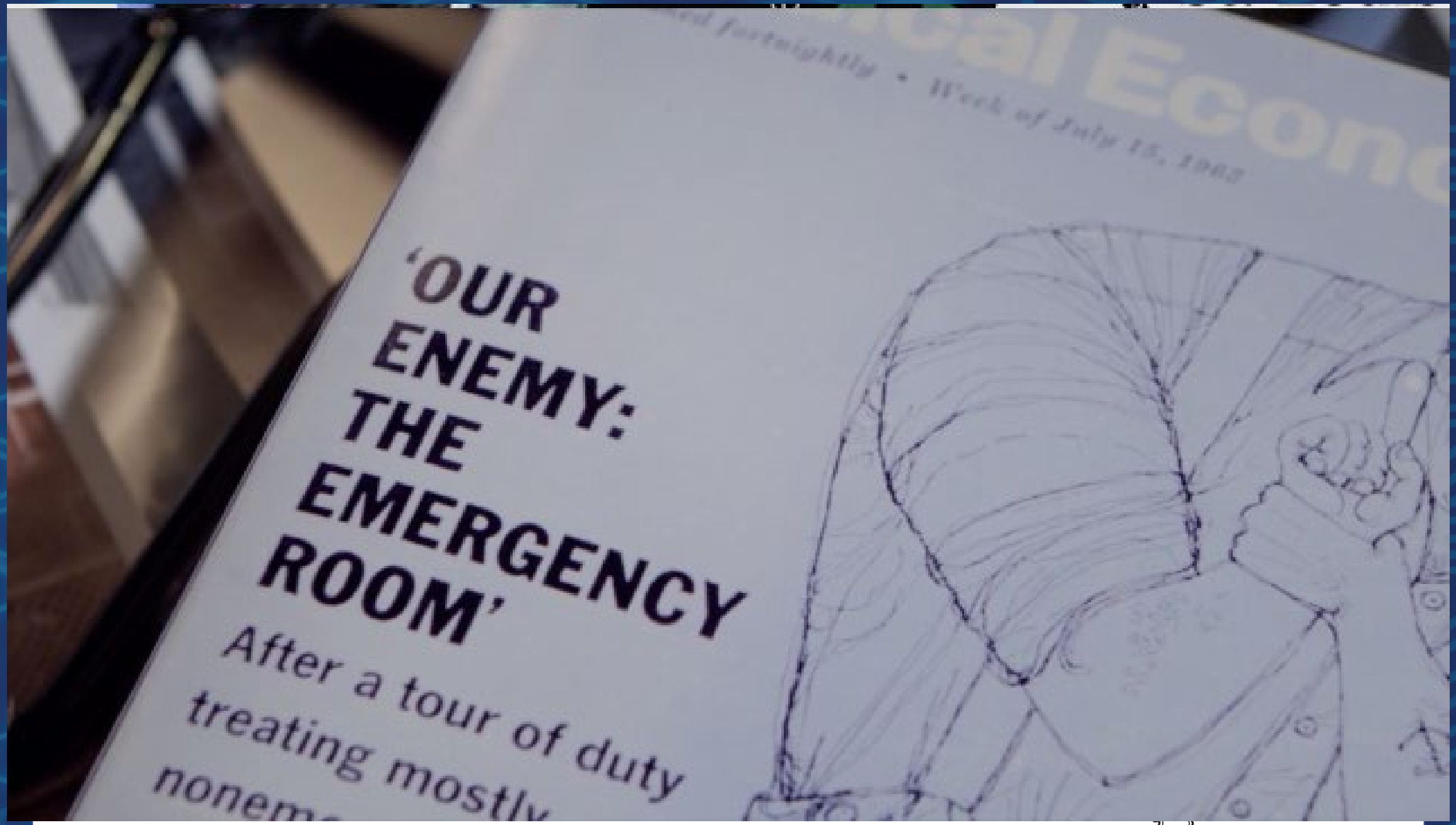
'OUR ENEMY: THE EMERGENCY ROOM'
After a tour of duty
treating mostly

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"WE'RE
No. 23!"

of Emergency Physicians

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the patient

Under the anti-dumping prov
sion, any hospital that has an emer

Emergency Room Acce

Con
uld Forbid Hospitals to 'Dump' the Poor, Uninsured

er Rich
Staff Writer

ng" provision ap-
ress would forbid
away emergency
"dump" them on
can't

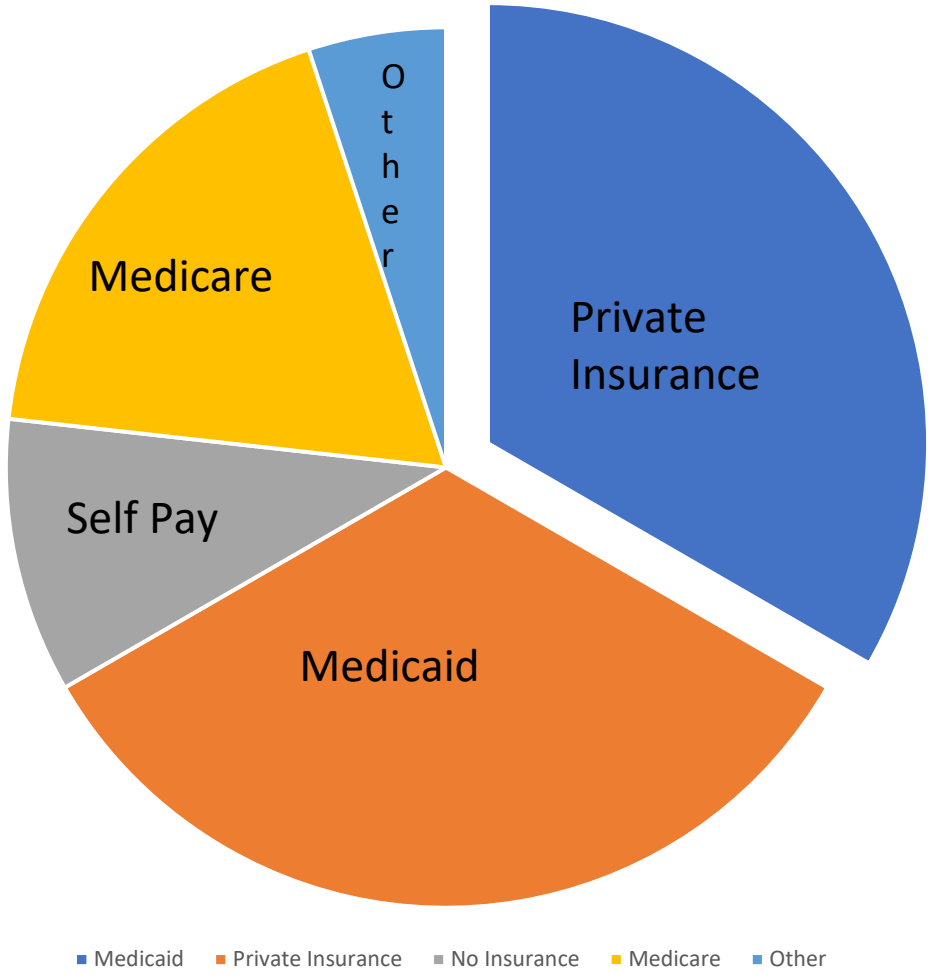
ance coverage for 18 months for
employes who are laid off and for
three years for the families of work-
ers who die. The laid-off worker or
the surviving family would have to
pay the premiums, but could do so
at the low group rate.

The anti-dumping provision
eeks to address a problem that has
creasing attention in re-
turning away

insurance continuation provision
Kennedy said that because ma
people do not have health ins
ance, "All across our country, em
gency patients are being kille
crippled because they cannot fi
hospital that will take them in
When one of our citizens arri
a hospital emergency room
potentially life-threatening
or injury, he deserves a c
and treatment, not a credi
a trip down the road."
dumping

of Emergency Physicians

Payor Mixes: All EDs



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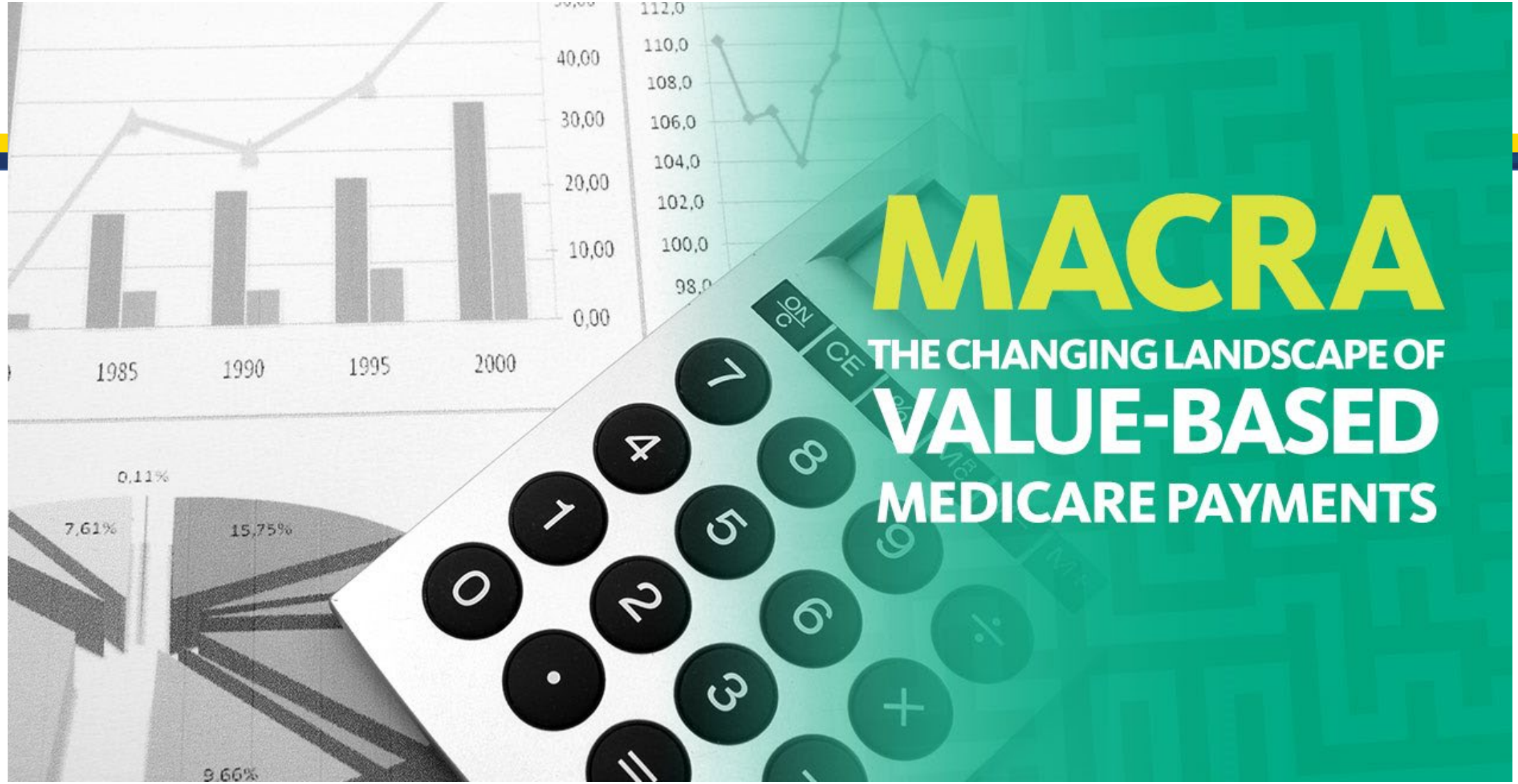

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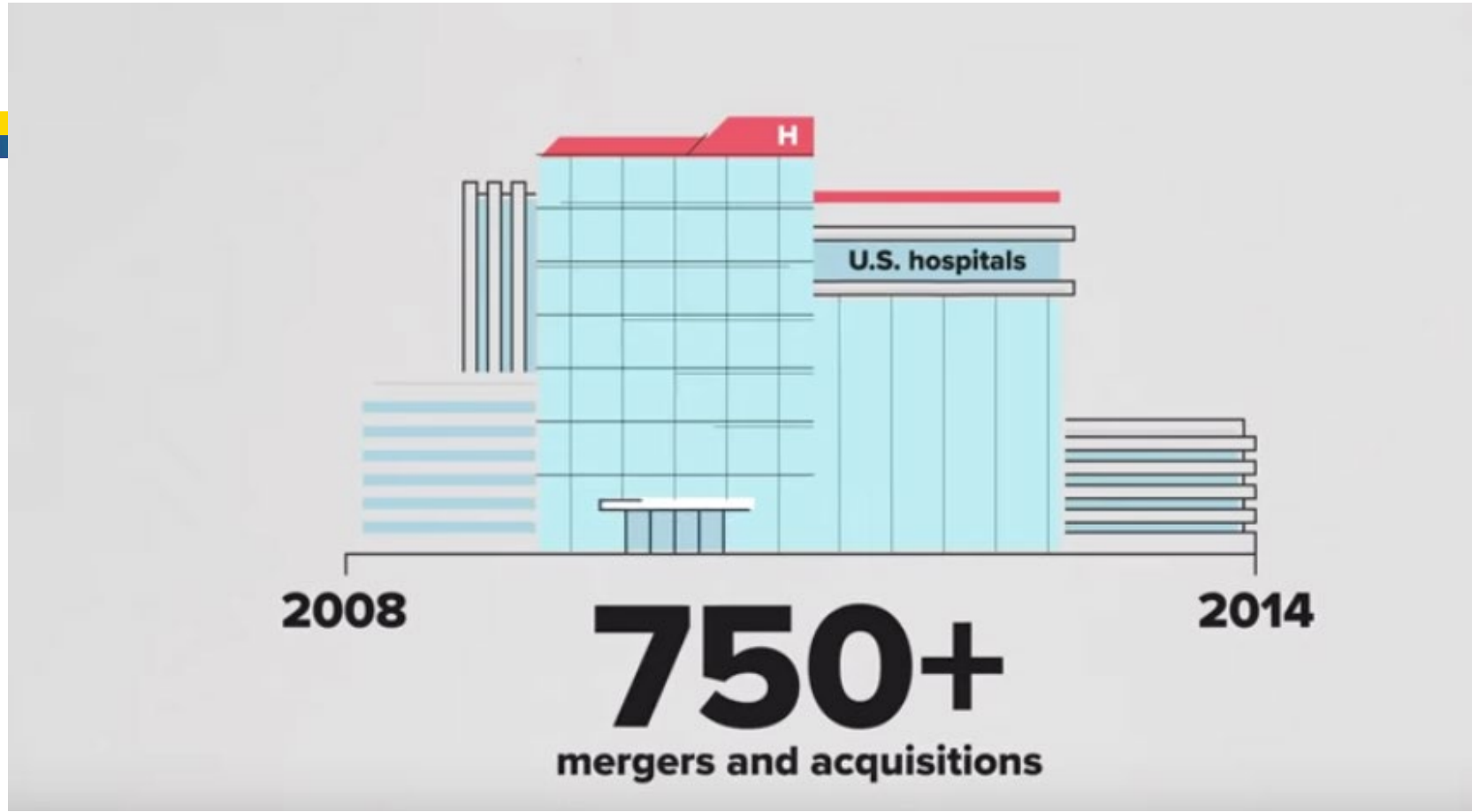

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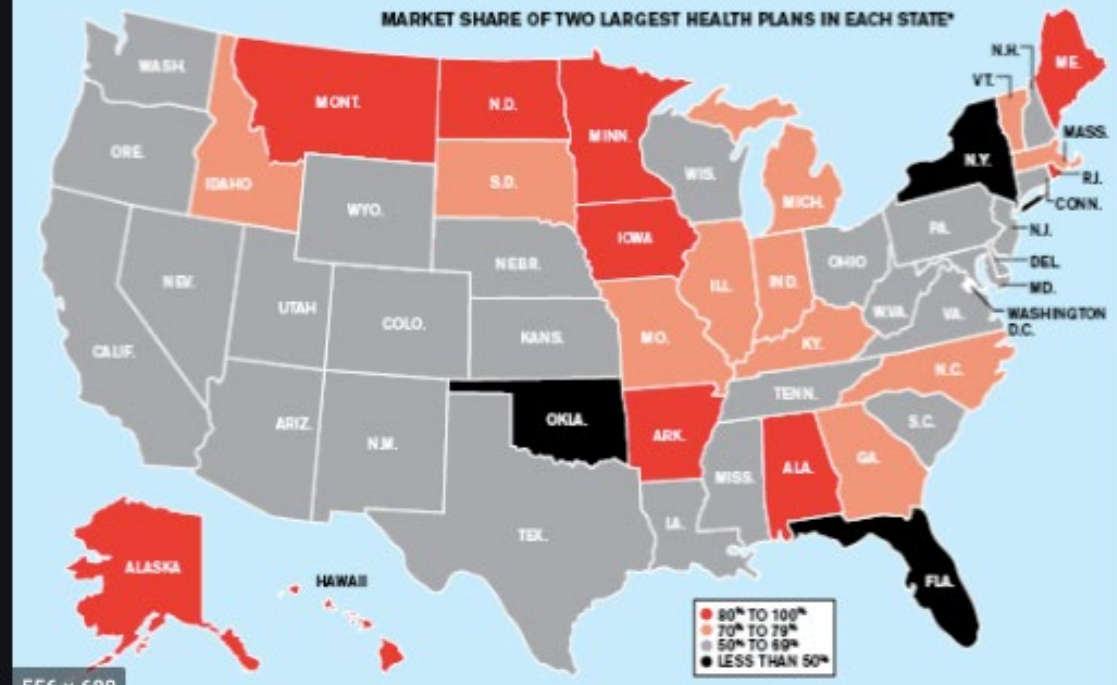
WHERE COMPETITION IS IN SHORT SUPPLY

In many states, just one or two players command the health-insurance market:

STATE	LARGEST INSURER	MARKET SHARE
Alabama	Blue Cross Blue Shield AL	83%
Rhode Island	Blue Cross Blue Shield R.I.	79%
Hawaii	Blue Cross Blue Shield HI	78%
Maine	WellPoint	78%
Vermont	Blue Cross Blue Shield VT	77%
Montana	Blue Cross Blue Shield MT	75%
Arkansas	Blue Cross Blue Shield AR	75%



556 × 688

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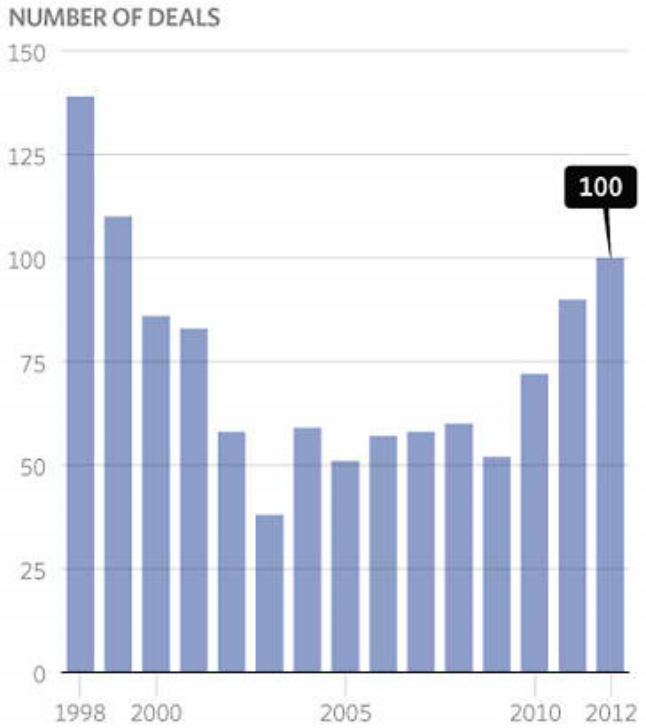
CHART 1

Hospital Mergers on the Rise

In 2012, there were 100 hospital mergers and acquisitions. Since 1998, there have been 1,113 such deals, averaging about 74 per year.



Source: American Hospital Association, "Trends Affecting Hospitals and Health Systems," *Trendwatch Chartbook 2012*, http://www.aha.org/research/reports/tw/chartbook/index.shtml (accessed June 18, 2014).

BG 2928 heritage.org

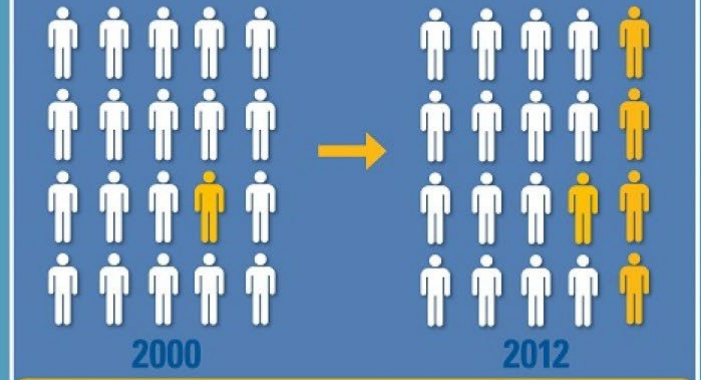
Provider Consolidation

LESS COMPETITION AND HIGHER COSTS

TIME FOR AFFORDABILITY.

Research demonstrates that when hospitals consolidate, either merging with other hospitals or buying up physician practices, health care costs go up. Provider consolidation gives hospitals greater negotiating strength and limits competition, resulting in higher prices for services, higher costs for patients, and no improvement in the quality of care delivered.

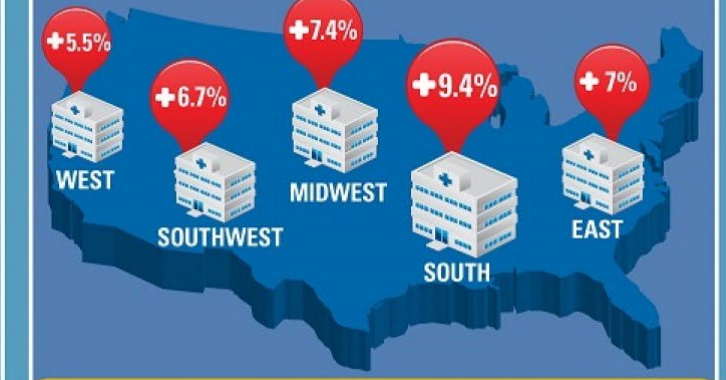
Physicians Are Becoming Hospital Employees[1]



"Last year, a 15-minute visit to a doctor in private practice cost $69...That same visit to a hospital-employed physician cost $124."

-Orlando Sentinel

Increasing Market Concentration Leads to Higher Prices for Consumers[2]



"Research suggests that hospital consolidation in the 1990s raised prices by at least five percent and likely significantly more. Prices increase 40 percent or more when merging hospitals are closely located."

-Robert Wood Johnson Foundation

1. Jameson, Marni. "As Hospitals Take over Doctors' Practices, Fees Rise." Orlando Sentinel. N.p., 15 Sept. 2012. Web. <http://articles.orlandosentinel.com/2012-09-15/health/os-hospitals-buy-physicians-20120915_1_hospital-executives-hospital-employee-physician-practices?pagewanted=all>.
2. Vogt, William B., Ph.D., and Robert Town, Ph.D. How Has Hospital Consolidation Affected the Price and Quality of Hospital Care? Rep. N.p., Feb. 2006. Web. <http://www.rwjf.org/content/rwjf/en/research-publications/find-rwjf-research/2006/02/how-has-hospital-consolidation-affected-the-price-and-quality-of.html>.

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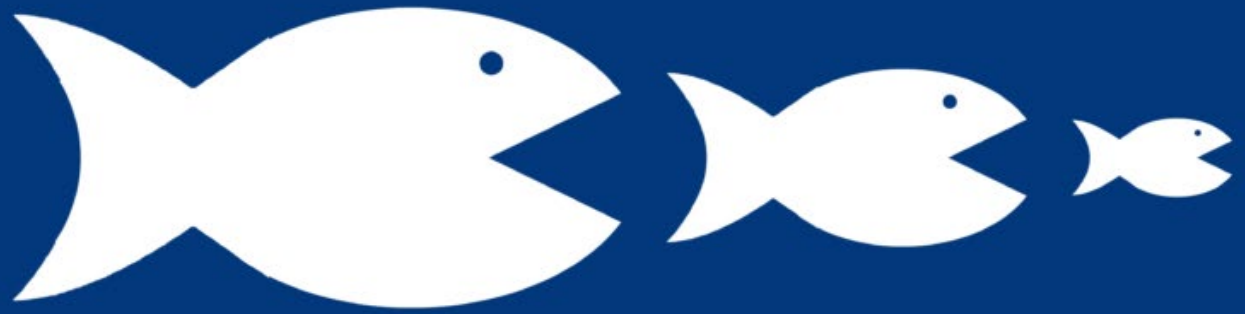
HEALTH CARE
CONSOLIDATION TRENDS,



IS BIGGER BETTER?

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Growth in ER Visits Relative to U.S. Population Growth

Year	U.S. Population	Growth	ER Visits	Growth
2014	318,301,008		137,803,068	
2015	320,635,163	0.7%	143,464,093	4.1%
2016	322,941,311	0.7%	144,832,278	1.0%
2017	324,985,539	0.6%	144,812,097	0.0%
2020	332,639,102	2.4%	149,043,305	2.9%*
2030	355,100,730	6.8%	**162,724,227**	12.4%*

Note: 2014-2018 population data come from U.S. Census Bureau Population Estimates. 2020-2030 population data come from U.S. Census Bureau Population Projections. 2014-2017 ER Visits come are estimates from 2014-2017 NEDS data. 2020-2030 ER Projected visits are the product of 2017 NEDS utilization rates and 2020-2030 population projections.

- The growth listed for 2020 and 2030 represent the growth from 2017

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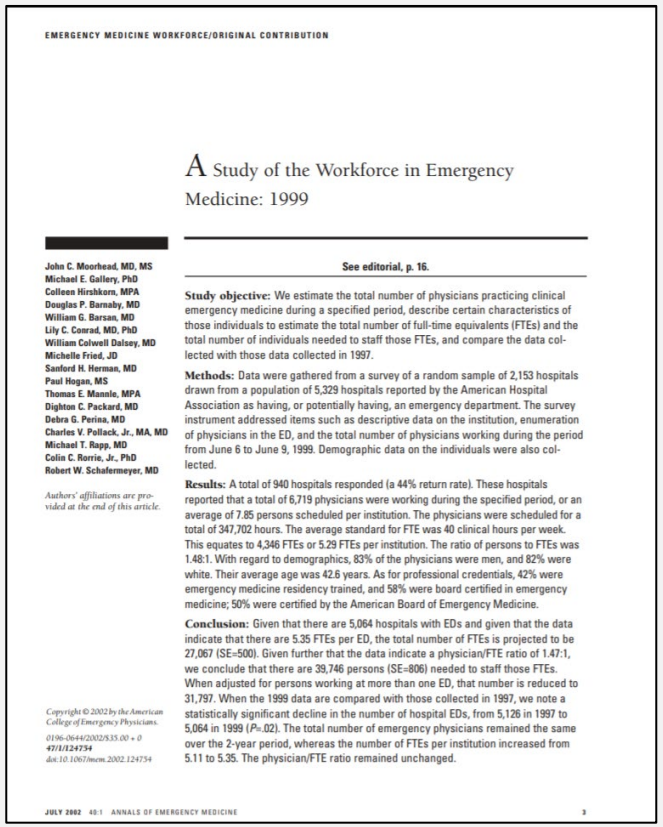

EMERGENCY MEDICINE WORKFORCE/ORIGINAL CONTRIBUTION

A Study of the Workforce in Emergency Medicine: 1999

John C. Moorhead, MD, MS
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Colleen Hirshkorn, MPA
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William G. Barsan, MD
Lily C. Conrad, MD, PhD
William Colwell Dalsey, MD
Michelle Fried, JD
Sanford H. Herman, MD
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Dighton C. Packard, MD
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0196-0644/2002/$35.00 + 0
47:1:124754
doi:10.1067/mem.2002.124754

See editorial, p. 16.

Study objective: We estimate the total number of physicians practicing clinical emergency medicine during a specified period, describe certain characteristics of those individuals to estimate the total number of full-time equivalents (FTEs) and the total number of individuals needed to staff those FTEs, and compare the data collected with those data collected in 1997.

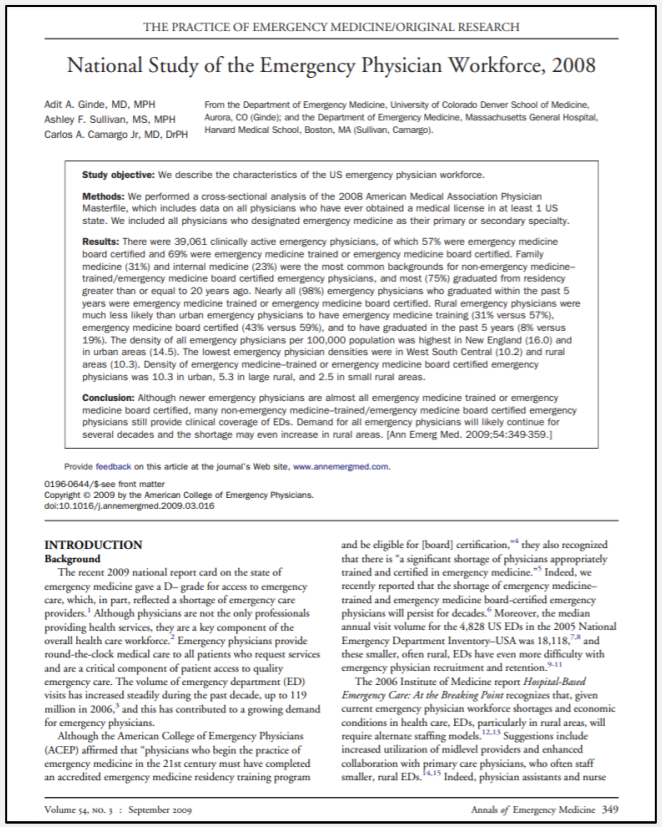
Methods: Data were gathered from a survey of a random sample of 2,153 hospitals drawn from a population of 5,329 hospitals reported by the American Hospital Association as having, or potentially having, an emergency department. The survey instrument addressed items such as descriptive data on the institution, enumeration of physicians in the ED, and the total number of physicians working during the period from June 6 to June 9, 1999. Demographic data on the individuals were also collected.

Results: A total of 940 hospitals responded (a 44% return rate). These hospitals reported that a total of 6,719 physicians were working during the specified period, or an average of 7.85 persons scheduled per institution. The physicians were scheduled for a total of 347,702 hours. The average standard for FTE was 40 clinical hours per week. This equates to 4,346 FTEs or 5.29 FTEs per institution. The ratio of persons to FTEs was 1.48:1. With regard to demographics, 83% of the physicians were men, and 82% were white. Their average age was 42.6 years. As for professional credentials, 42% were emergency medicine residency trained, and 58% were board certified in emergency medicine; 50% were certified by the American Board of Emergency Medicine.

Conclusion: Given that there are 5,064 hospitals with EDs and given that the data indicate that there are 5.35 FTEs per ED, the total number of FTEs is projected to be 27,067 (SE=500). Given further that the data indicate a physician/FTE ratio of 1.47:1, we conclude that there are 39,746 persons (SE=806) needed to staff those FTEs. When adjusted for persons working at more than one ED, that number is reduced to 31,797. When the 1999 data are compared with those collected in 1997, we note a statistically significant decline in the number of hospital EDs, from 5,126 in 1997 to 5,064 in 1999 (P=.02). The total number of emergency physicians remained the same over the 2-year period, whereas the number of FTEs per institution increased from 5.11 to 5.35. The physician/FTE ratio remained unchanged.

2002

- 5,064 EDs
- 27,067 EPs (Est)
- 31,797 EPs needed
- 144 Residencies
- 895 Graduates/Yr
- Rural EDs lack EPs
- Board Certification



National Study of the Emergency Physician Workforce, 2008

Adit A. Ginde, MD, MPH
Ashley F. Sullivan, MS, MPH
Carlos A. Camargo Jr, MD, DrPH

From the Department of Emergency Medicine, University of Colorado Denver School of Medicine, Aurora, CO (Ginde); and the Department of Emergency Medicine, Massachusetts General Hospital, Harvard Medical School, Boston, MA (Sullivan, Camargo).

Study objective: We describe the characteristics of the US emergency physician workforce.

Methods: We performed a cross-sectional analysis of the 2008 American Medical Association Physician Masterfile, which includes data on all physicians who have ever obtained a medical license in at least 1 US state. We included all physicians who designated emergency medicine as their primary or secondary specialty.

Results: There were 39,061 clinically active emergency physicians, of which 57% were emergency medicine board certified and 69% were emergency medicine trained or emergency medicine board certified. Family medicine (31%) and internal medicine (23%) were the most common backgrounds for non-emergency medicine–trained/emergency medicine board certified emergency physicians, and most (75%) graduated from residency greater than or equal to 20 years ago. Nearly all (98%) emergency physicians who graduated within the past 5 years were emergency medicine trained or emergency medicine board certified. Rural emergency physicians were much less likely than urban emergency physicians to have emergency medicine training (31% versus 57%), emergency medicine board certified (43% versus 59%), and to have graduated in the past 5 years (8% versus 19%). The density of all emergency physicians per 100,000 population was highest in New England (16.0) and in urban areas (14.5). The lowest emergency physician densities were in West South Central (10.2) and rural areas (10.3). Density of emergency medicine–trained or emergency medicine board certified emergency physicians was 10.3 in urban, 5.3 in large rural, and 2.5 in small rural areas.

Conclusion: Although newer emergency physicians are almost all emergency medicine trained or emergency medicine board certified, many non-emergency medicine–trained/emergency medicine board certified emergency physicians still provide clinical coverage of EDs. Demand for all emergency physicians will likely continue for several decades and the shortage may even increase in rural areas. [Ann Emerg Med. 2009;54:349-359.]

Provide feedback on this article at the journal's Web site, www.annemergmed.com.

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doi:10.1016/j.annemergmed.2009.03.016

INTRODUCTION

Background

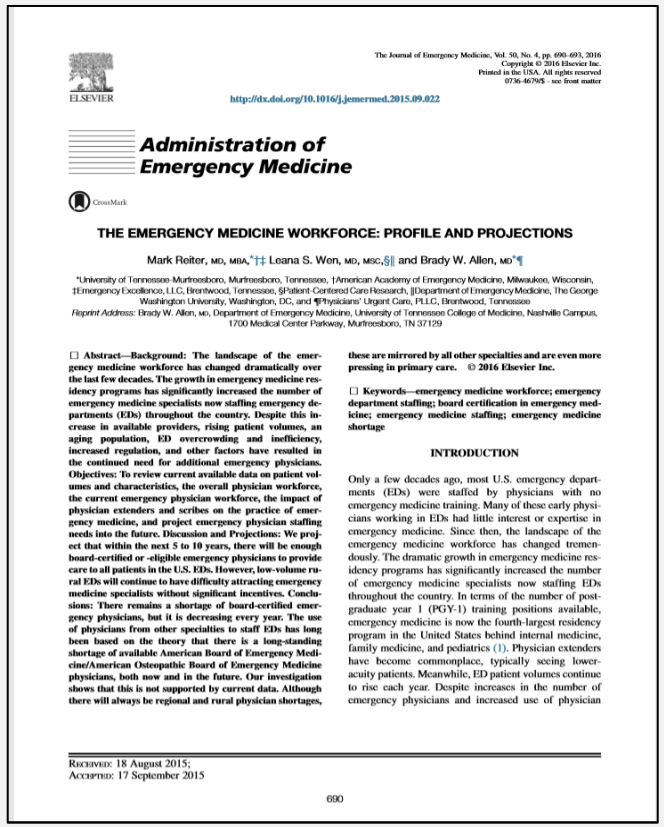
The recent 2009 national report card on the state of emergency medicine gave a D– grade for access to emergency care, which, in part, reflected a shortage of emergency care providers.[1] Although physicians are not the only professionals providing health services, they are a key component of the overall health care workforce.[2] Emergency physicians provide round-the-clock medical care to all patients who request services and are a critical component of patient access to quality emergency care. The volume of emergency department (ED) visits has increased steadily during the past decade, up to 119 million in 2006,[3] and this has contributed to a growing demand for emergency physicians.

Although the American College of Emergency Physicians (ACEP) affirmed that "physicians who begin the practice of emergency medicine in the 21st century must have completed an accredited emergency medicine residency training program and be eligible for [board] certification,"[4] they also recognized that there is "a significant shortage of physicians appropriately trained and certified in emergency medicine."[5] Indeed, we recently reported that the shortage of emergency medicine–trained and emergency medicine board-certified emergency physicians will persist for decades.[6] Moreover, the median annual visit volume for the 4,828 US EDs in the 2005 National Emergency Department Inventory–USA was 18,118,[7,8] and these smaller, often rural, EDs have even more difficulty with emergency physician recruitment and retention.[9-11]

The 2006 Institute of Medicine report *Hospital-Based Emergency Care: At the Breaking Point* recognizes that, given current emergency physician workforce shortages and economic conditions in health care, EDs, particularly in rural areas, will require alternate staffing models.[12,13] Suggestions include increased utilization of midlevel providers and enhanced collaboration with primary care physicians, who often staff smaller, rural EDs.[14,15] Indeed, physician assistants and nurse

2009

- 4,828 EDs (2005)
- 39,061 EPs
- 40,030 EPs needed
- 149 Residencies
- 1,350 Graduates/Yr
- Rural EDs lack EPs
- Gender



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Administration of Emergency Medicine

THE EMERGENCY MEDICINE WORKFORCE: PROFILE AND PROJECTIONS

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□ **Abstract—Background: The landscape of the emergency medicine workforce has changed dramatically over the last few decades. The growth in emergency medicine residency programs has significantly increased the number of emergency medicine specialists now staffing emergency departments (EDs) throughout the country. Despite this increase in available providers, rising patient volumes, an aging population, ED overcrowding and inefficiency, increased regulation, and other factors have resulted in the continued need for additional emergency physicians. Objectives: To review current available data on patient volumes and characteristics, the overall physician workforce, the current emergency physician workforce, the impact of physician extenders and scribes on the practice of emergency medicine, and project emergency physician staffing needs into the future. Discussion and Projections: We project that within the next 5 to 10 years, there will be enough board-certified or -eligible emergency physicians to provide care to all patients in the U.S. EDs. However, low-volume rural EDs will continue to have difficulty attracting emergency medicine specialists without significant incentives. Conclusions: There remains a shortage of board-certified emergency physicians, but it is decreasing every year. The use of physicians from other specialties to staff EDs has long been based on the theory that there is a long-standing shortage of available American Board of Emergency Medicine/American Osteopathic Board of Emergency Medicine physicians, both now and in the future. Our investigation shows that this is not supported by current data. Although there will always be regional and rural physician shortages, these are mirrored by all other specialties and are even more pressing in primary care.** © 2016 Elsevier Inc.

□ **Keywords—emergency medicine workforce; emergency department staffing; board certification in emergency medicine; emergency medicine staffing; emergency medicine shortage**

INTRODUCTION

Only a few decades ago, most U.S. emergency departments (EDs) were staffed by physicians with no emergency medicine training. Many of these early physicians working in EDs had little interest or expertise in emergency medicine. Since then, the landscape of the emergency medicine workforce has changed tremendously. The dramatic growth in emergency medicine residency programs has significantly increased the number of emergency medicine specialists now staffing EDs throughout the country. In terms of the number of postgraduate year 1 (PGY-1) training positions available, emergency medicine is now the fourth-largest residency program in the United States behind internal medicine, family medicine, and pediatrics (1). Physician extenders have become commonplace, typically seeing lower-acuity patients. Meanwhile, ED patient volumes continue to rise each year. Despite increases in the number of emergency physicians and increased use of physician

Received: 18 August 2015;
Accepted: 17 September 2015

2016

- 4,552* EDs
- 45,140 EPs (2014)
- 5-10 yrs enough EPs?
- 208 Residencies (2015)
- 2,050 Graduates/Yr
- Rural EDs lack EPs
- Physician Extenders

National Study of the Emergency Physician Workforce, 2020

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*Corresponding Author. E-mail: ccamargo@partners.org, Twitter: @cleebennett.

Study objective: We describe the current US emergency physician workforce.

Methods: We analyzed the 2020 American Medical Association Physician Masterfile data set. All physicians who designated emergency medicine as their primary or secondary specialty were included; nonactive physicians, residents, primarily research or teaching faculty, or those primarily involved in administration or nonclinical work were excluded. We calculated emergency physician population density, using 2018 Census Bureau estimates of the US population; urban-rural assignments were based on Urban Influence Codes. We compared 2020 results with our previous analysis of the 2008 emergency physician workforce. Again, we were unable to account for American Osteopathic Board of Emergency Medicine certification.

Results: There were 48,835 clinically active emergency physicians in 2020. The median age was 50 years (interquartile range [IQR] 41 to 62 years) and 28% were women. Overall density of emergency physicians per 100,000 population was 14.9. Most emergency physicians were in urban areas (92%), whereas 2,730 (6%) were in large rural areas and 1,197 (2%) in small rural areas. Urban emergency physicians were younger (median age 50 years; IQR 41 to 61 years) than those in large rural areas (median age 58 years; IQR 47 to 67 years) or small rural areas (median age 62 years; IQR 51 to 68 years), and more likely to be women (29%, 20%, and 19%, respectively). Most emergency physicians in small rural areas (71%) completed their medical training more than 20 years ago. Compared with 2008, the total number of clinically active emergency physicians has increased by 9,774, but, per 100,000 US population in 2020, emergency physician density decreased in both large rural (−0.4) and small rural (−3.7) areas.

Conclusion: Urban emergency physicians in 2020 remain substantially younger than rural emergency physicians, with many rural ones near the US retirement age. We did not observe a continued increase in the percentage of female physicians among emergency physicians. Given the ongoing demand for physicians in all US emergency departments, this analysis provides essential information for understanding the current emergency physician workforce and the challenges ahead. [Ann Emerg Med. 2020;■:1-14.]

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

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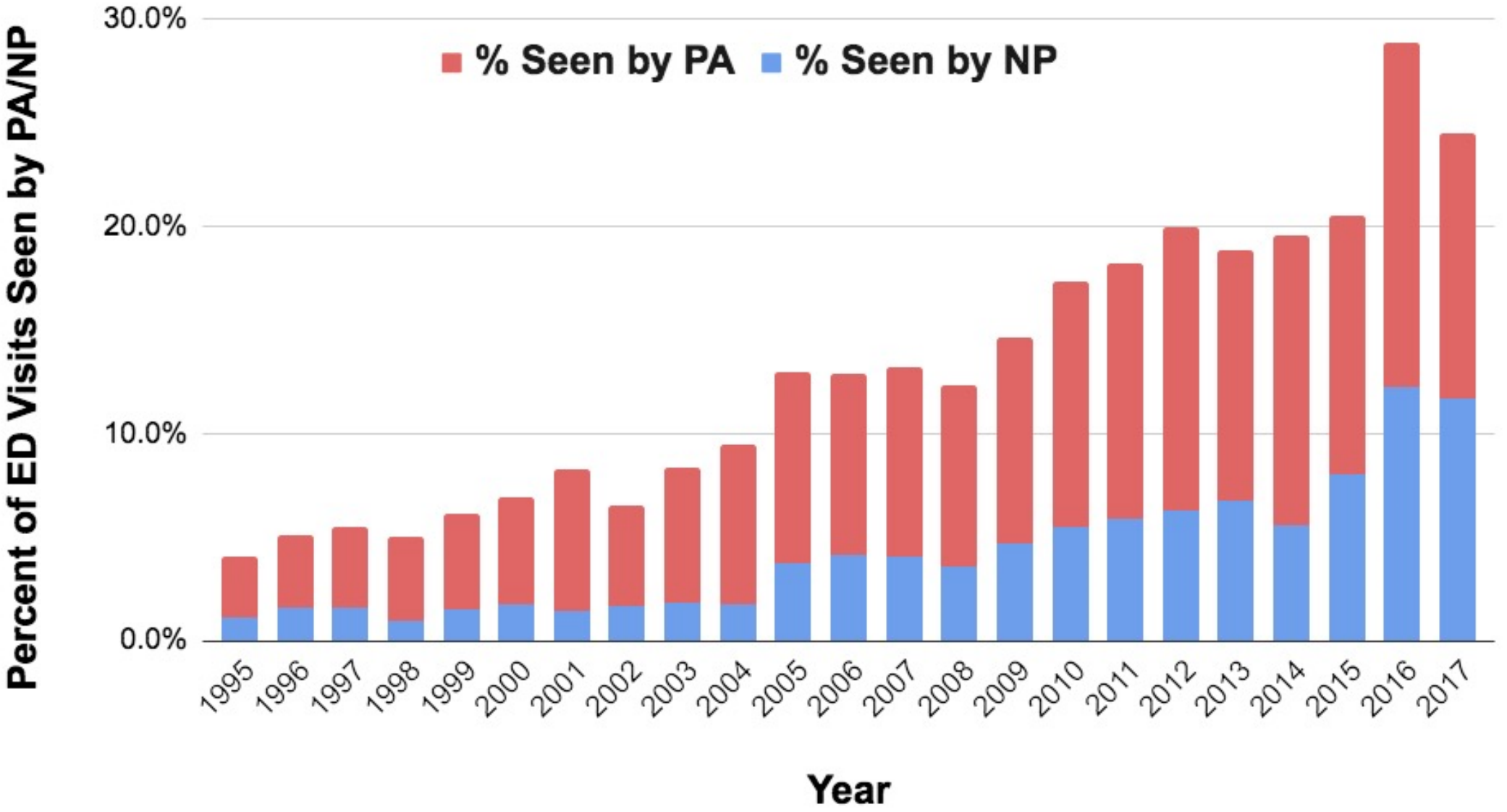

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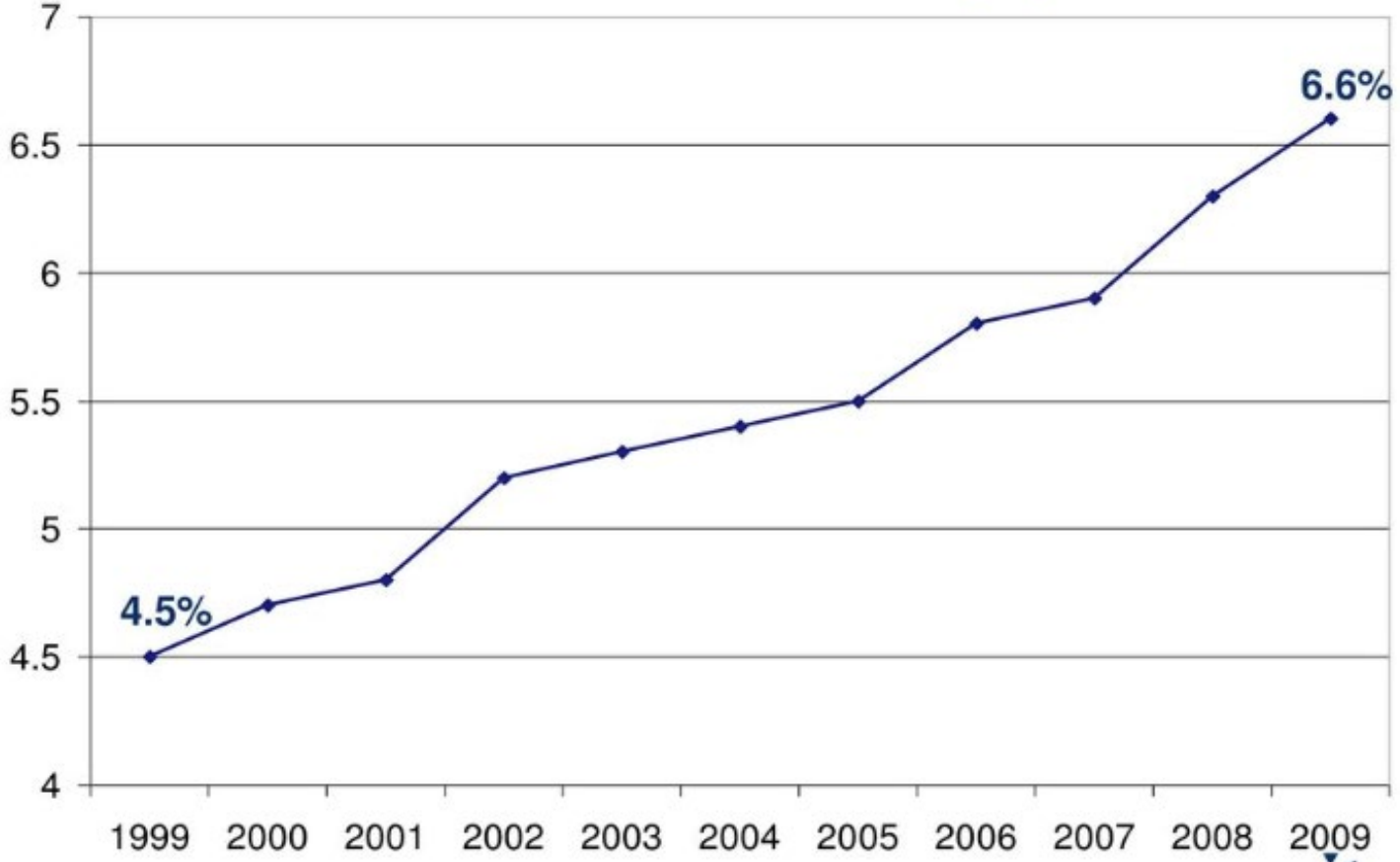
Emergency Medicine's Share of Positions Offered in NRMP Has Risen Sharply 1999-2009



Source: NRMP Data;
Prepared by Center for Workforce Studies 4-09

AAMC

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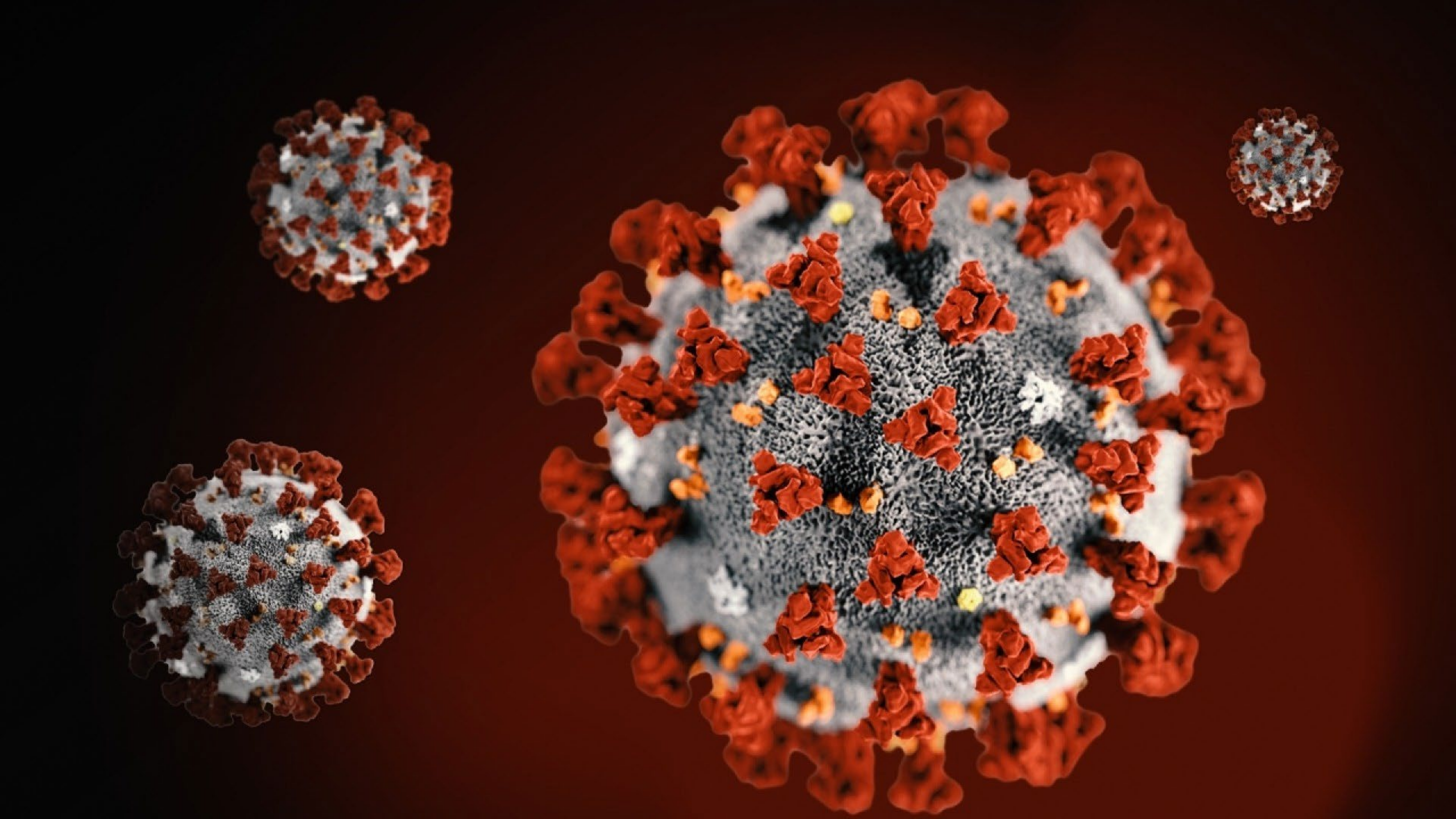
Historical Trends in Graduates of ACGME and AOA Residency Programs, 2008-2020

- *Note:* Total number of graduates in 2020-2023 is estimated based on new entrants in 2017-2020.

Year	Historical (ACGME + AOA)	Growth rate
2008	1464	
2009	1544	5.4%
2010	1633	5.7%
2011	1660	1.7%
2012	1762	6.2%
2013	1806	2.5%
2014	1905	5.5%
2015	1953	2.5%
2016	2038	4.4%
2017	2190	7.4%
2018	2281	4.2%
2019	2286	0.2%
2020	2357	3.1%
2021	2571	9.1%
2022	2634	2.5%
2023	2696	2.3%


TRAUMA CENTER



Range of Outcomes Under Different Scenarios

- Of 36 possible outcomes with different combinations of scenarios:
  - 4 of 36 show a shortage of EM physicians; 32 show more EM physicians than likely demand
  - The range of outcomes: a shortage of 2,855 to a surplus of 16,505
  - Under the most likely scenario: a supply exceeds demand by 9,413

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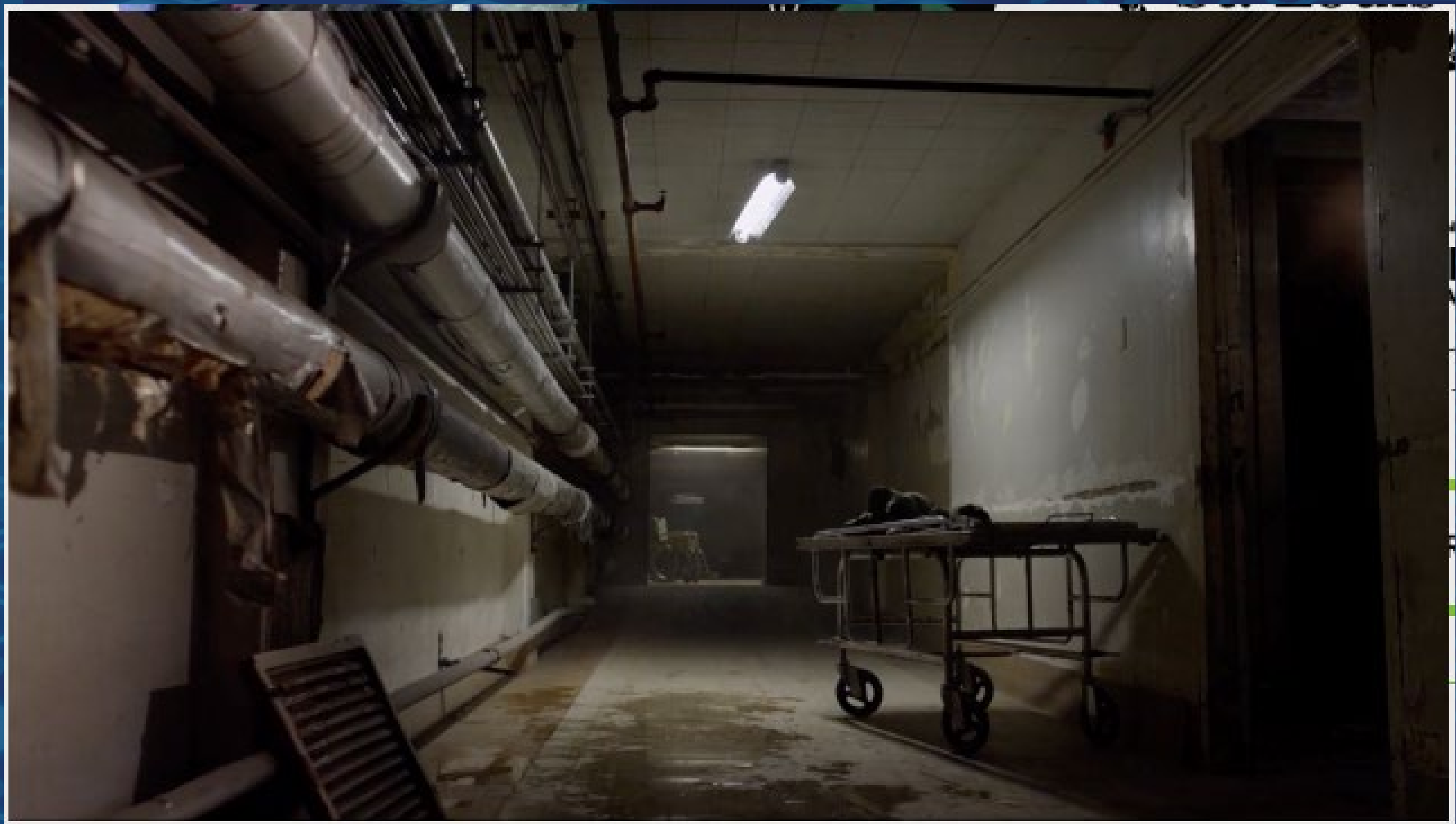

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RAISING THE BAR

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SCOPE OF PRACTICE

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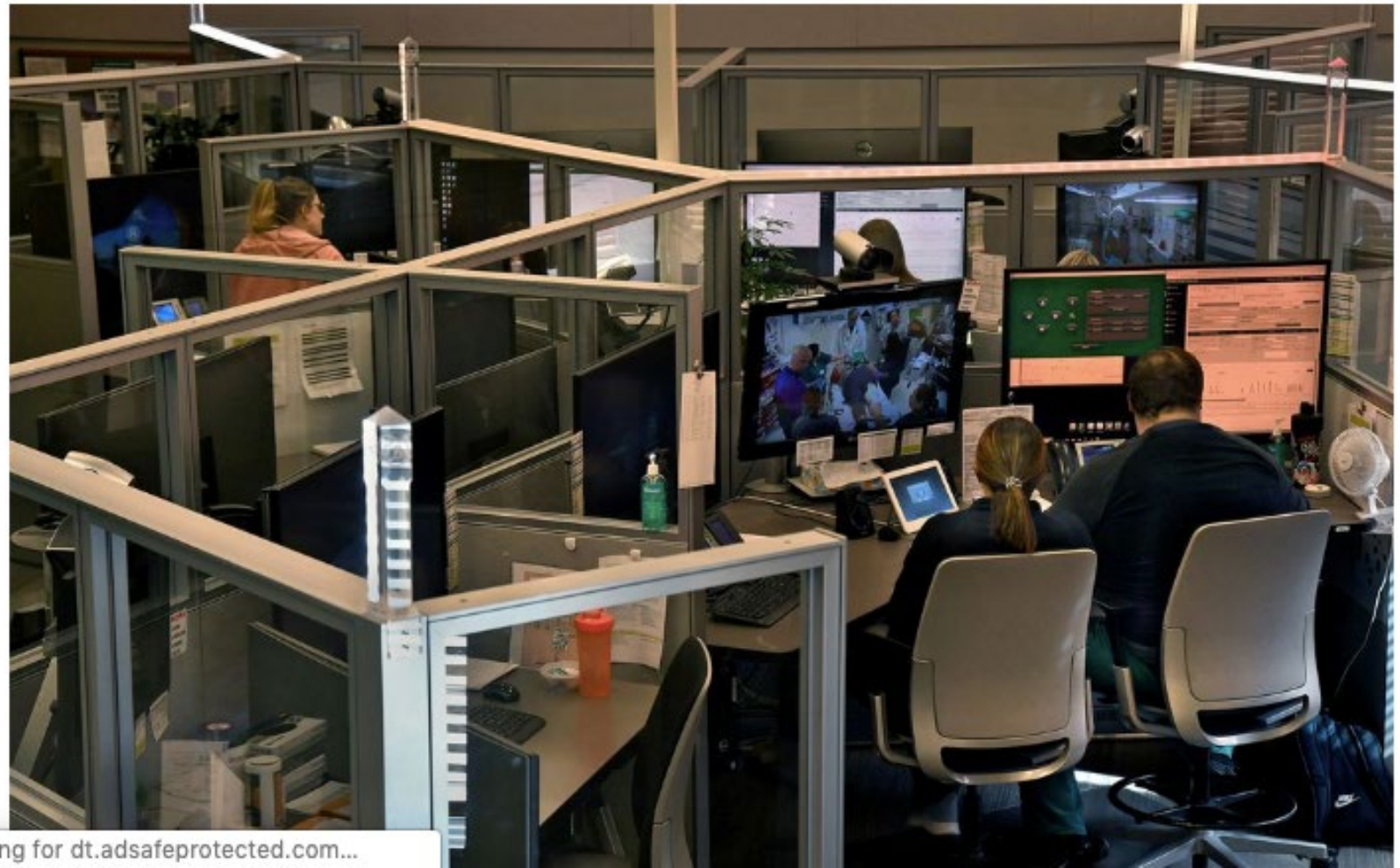
EMERGENCY
AMBULANCE
EMERGENCY
Entrance
Ambulances
Only

National

The most remote emergency room: Life and death in rural America



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FSEDs/ Hybrid Models

Full Spectrum Emergency Room

EMERGENCY 24 hr SERVICES

One Location...Two Options

The Rim Urgent Care

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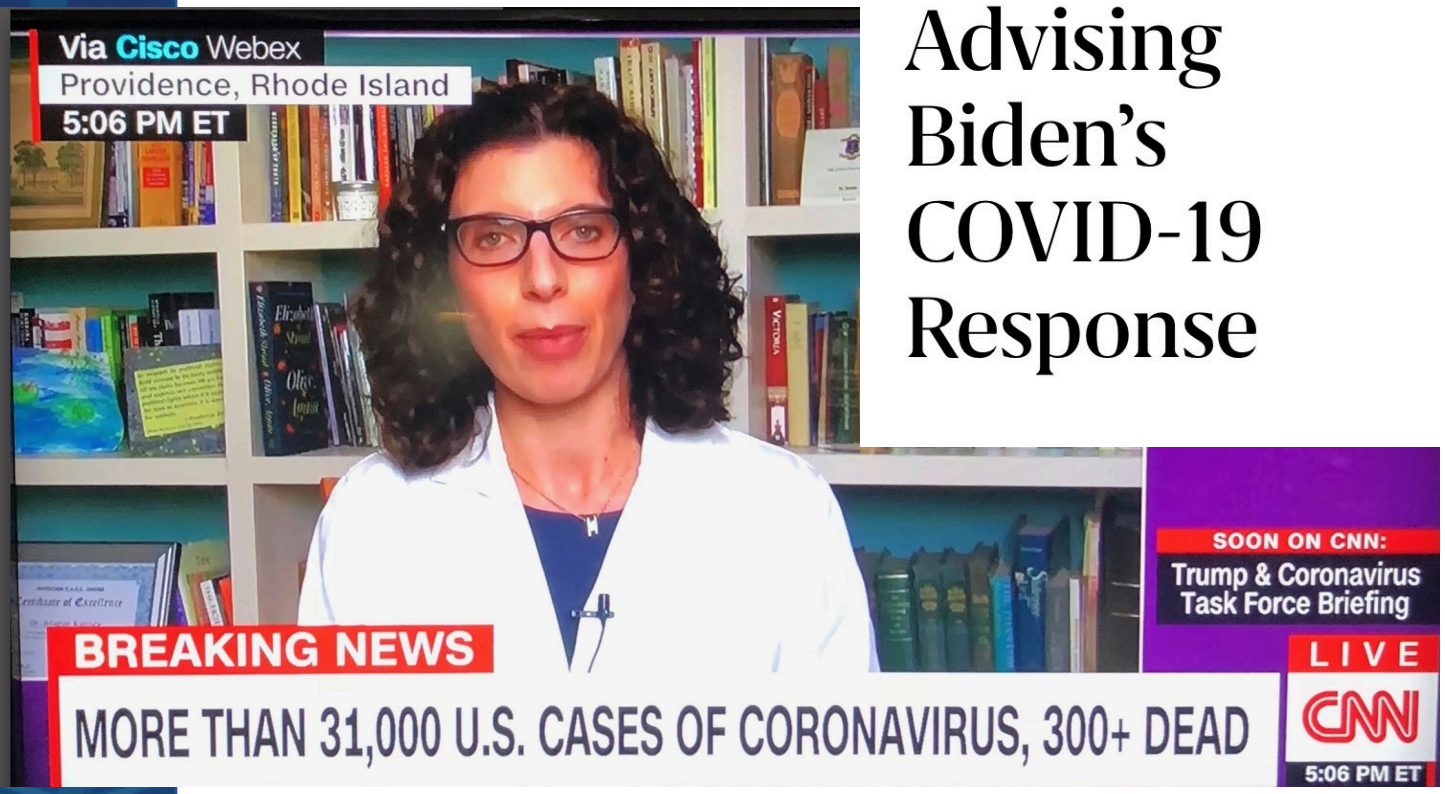

NEWS

This ER Doctor and Brownsville Native Is Advising Biden's COVID-19 Response

Dr. Robert Rodriguez at work at the University of California San Francisco, where he's a professor of emergency medicine.

Noah Berger

In early July, as COVID-19 cases surged in the Rio Grande Valley and hospital beds filled with patients

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Pioneer New Pricing and Payment Models

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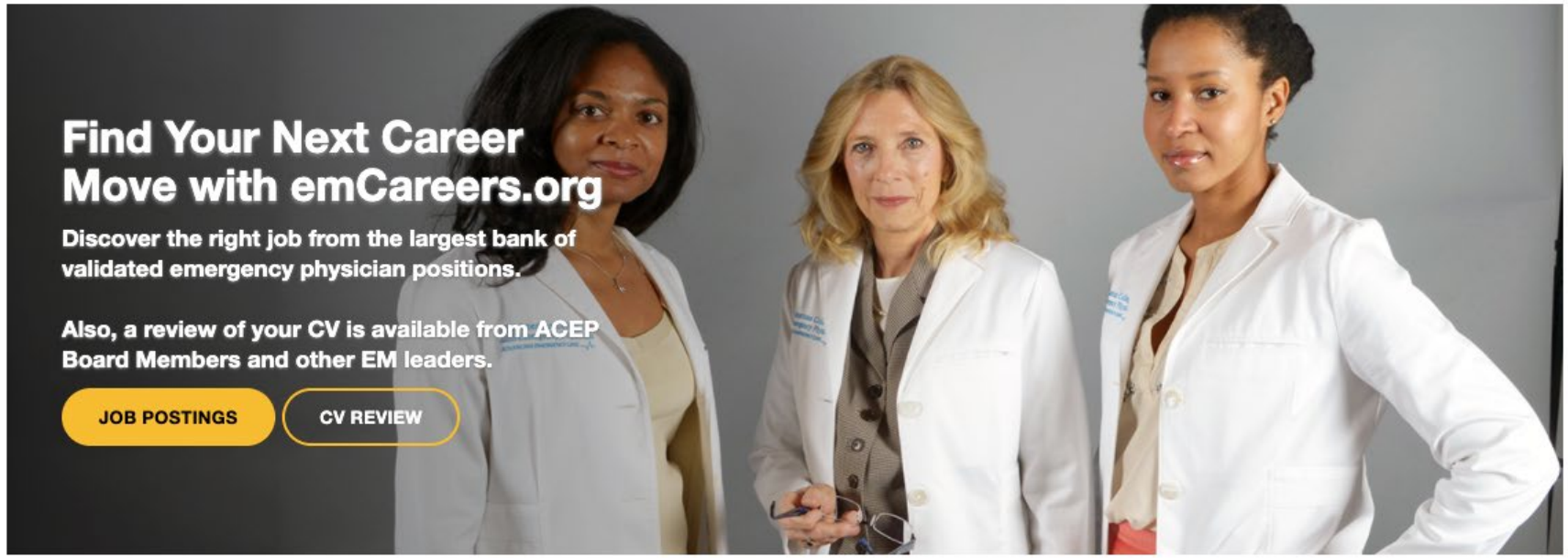
Career Center



Job Hunt Resources

I Need a Job: Getting Hired in a Pandemic

EMRA: Virtual Interview Tips

Legal & Financial Support for Members

Compensation Reports

Prep to be an ED Director with ACEP's EDDA

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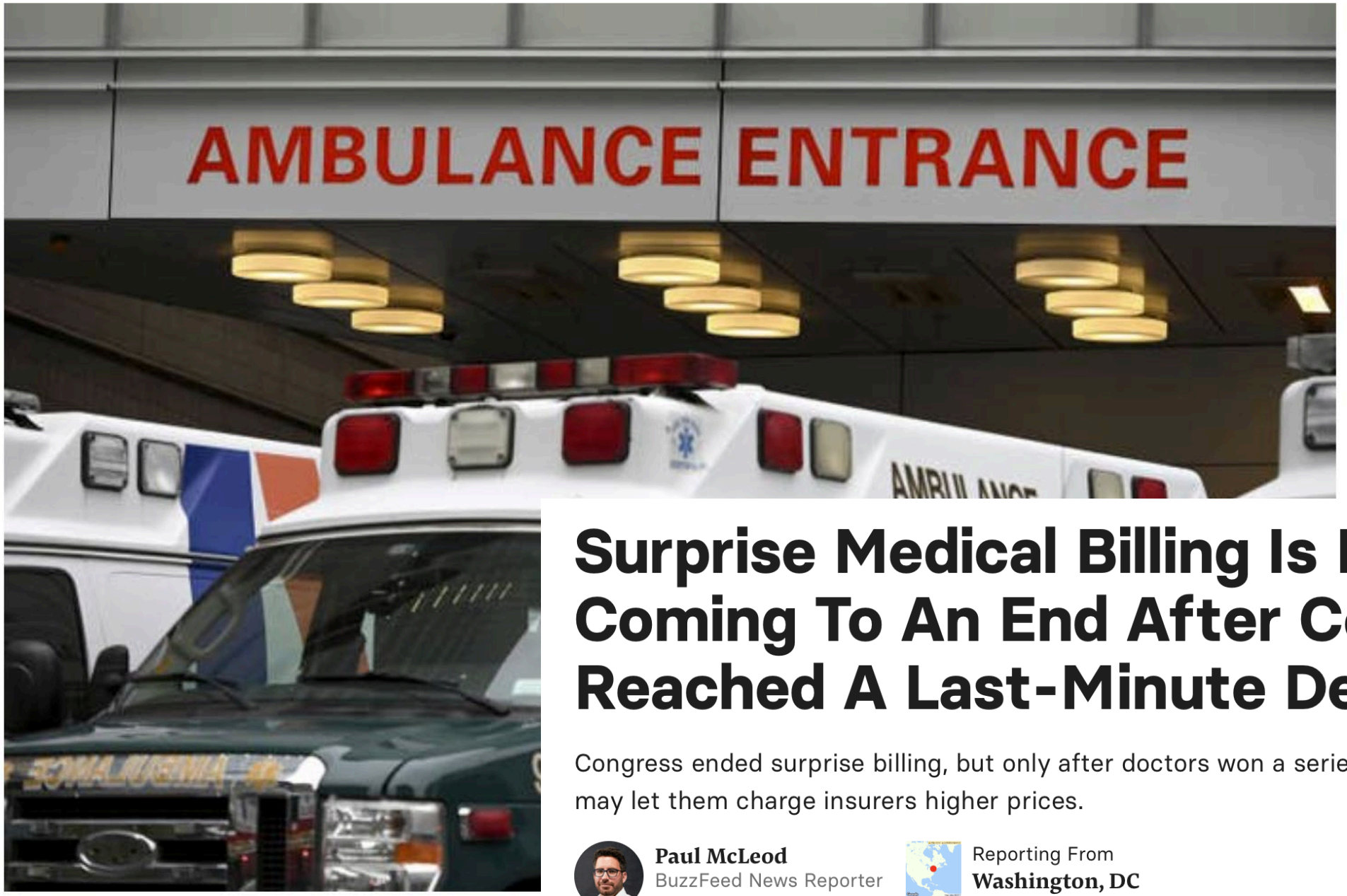
After several years of advocacy work, we were successful in getting the burdensome X waiver removed for medication-assisted treatment for opioid use disorder (OUD). This is a huge win for our patients and the number of emergency physicians who helped make this happen.

EMERGENCYPHYSICIANS.ORG

1-14-21 ACEP Applauds Removal of X-waiver, Expanding Medication-assisted Treatment for Opioid Use Disorder



Surprise Medical Billing Is Finally Coming To An End After Congress Reached A Last-Minute Deal

Congress ended surprise billing, but only after doctors won a series of concessions that may let them charge insurers higher prices.

Paul McLeod
BuzzFeed News Reporter

Reporting From
Washington, DC

Posted on December 22, 2020, at 5:43 p.m. ET

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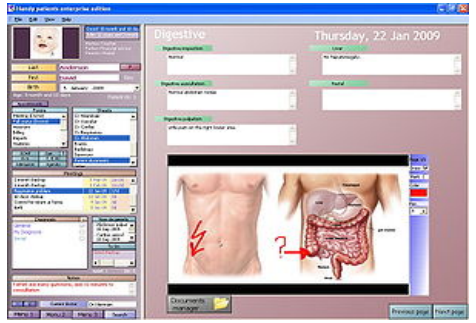
advocacy

to change "what is"
into "what should be"

What's Your Problem?

SCOPE OF PRACTICE




Coverall

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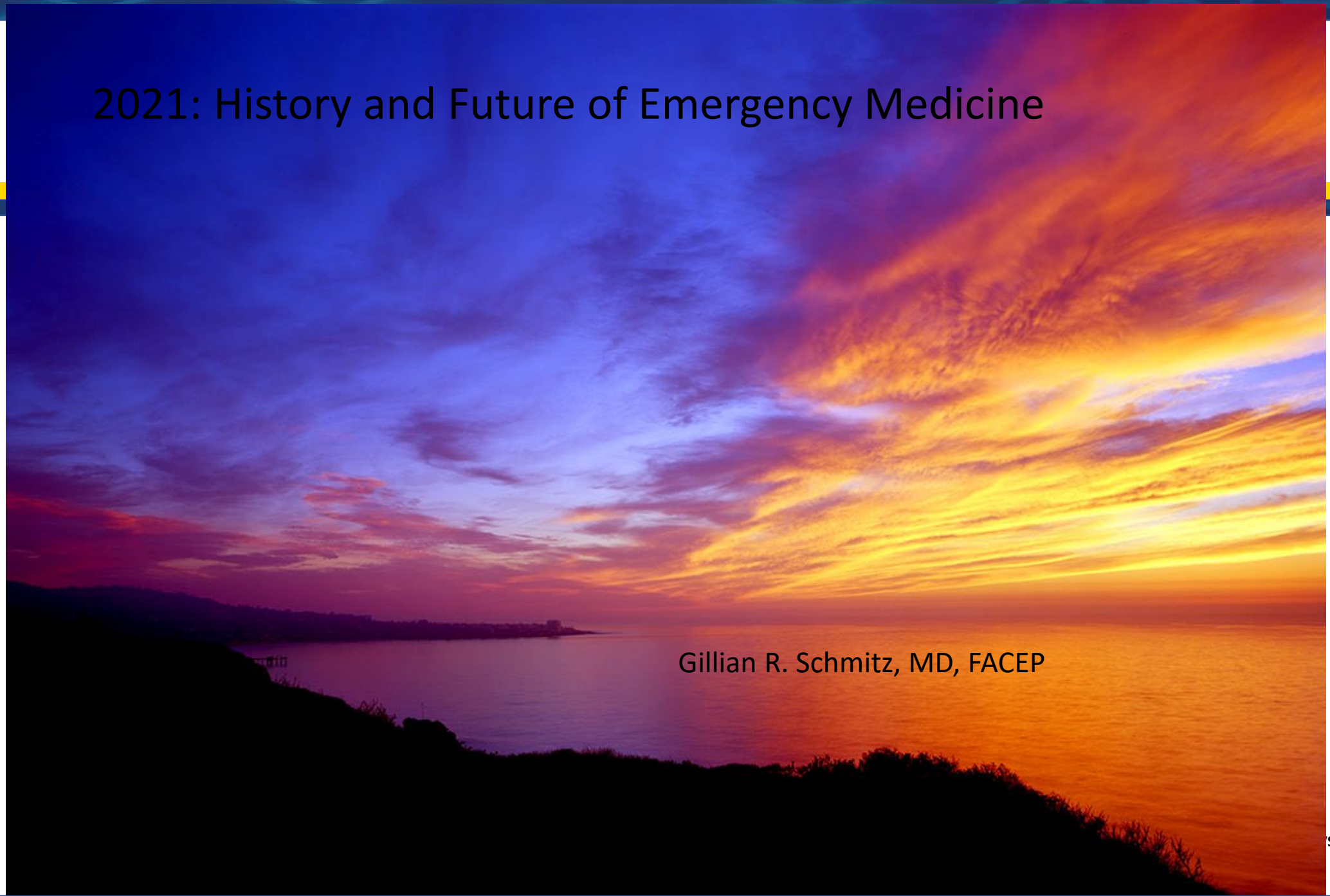
THANK YOU
HEALTHCARE
WORKERS


SPAIN APPLAUD
HEALTH WORKERS
VIDEO GO VIRAL

2021: History and Future of Emergency Medicine



Gillian R. Schmitz, MD, FACEP

sicians

Evaluation & CME

To receive your CME certificate for the Symposium, log on to

icep.org/evaluation2021

Complete the online form at the conclusion of the program or by Monday, March 1st

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