

May 17, 2023

The Honorable Ed Markey
Chair
Senate Health, Education, Labor, and
Pensions Committee
Subcommittee on Primary Health and
Retirement Security
430 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Roger Marshall, MD
Ranking Member
Senate Health, Education, Labor, and
Pensions Committee
Subcommittee on Primary Health and
Retirement Security
430 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Chairman Markey and Ranking Member Marshall,

On behalf of the American College of Emergency Physicians (ACEP) and our nearly 40,000 members, thank you for holding today's hearing, entitled, "A Crisis in Mental Health and Substance Use Disorder Care: Closing Gaps in Access by Bringing Care and Prevention to Communities." We appreciate the opportunity to share some of our experiences on the frontlines of our nation's mental health and substance use disorder (SUD) crises, and we look forward to continuing to work with you to improve access to the lifesaving care and treatment that our patients need and deserve.

As the health care safety net, the emergency department (ED) is often the first – and sometimes only – point of contact for individuals experiencing mental health crises or other behavioral health challenges, such as substance use disorder (SUD) or overdose. While the ED is the critical frontline safety net and the most appropriate setting for acute unscheduled care for individuals suffering from a mental health crisis, it is not ideal for long-term treatment of mental and behavioral health needs. However, due to the fragmented nature of the mental health care infrastructure in the U.S., persistent lack of sufficient resources, and longstanding shortages of mental and behavioral health professionals, far too many Americans have limited options for the longer-term follow-up treatment they need and deserve. These challenges contribute to long ED wait times and aggravate "boarding" issues, 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 they could be transferred. **Overcrowding and boarding are not failures of the ED; rather, they are symptoms of larger systemic issues that must be addressed to eliminate bottlenecks in health care delivery and reduce the burden on the already-strained health care safety net.**

Once again, ACEP is grateful for the Committee's attention to the mental and behavioral health challenges affecting millions of Americans. As you continue to examine this pressing public health issue, we urge you to consider several key issues. These include strengthening the mental/behavioral health workforce; increasing integration, coordination, and access to care; ensuring parity; furthering the use of telehealth; and improving access to behavioral health care for children and young people. We also continue strongly urge the Committee to include physician and provider mental health and burnout as necessary considerations in comprehensive mental health policy initiatives, especially in light of the significant mental health toll the COVID-19 pandemic and its lingering effects have taken on frontline health care providers. Improving and providing for the mental health and well-being of the health care workforce is a unique challenge, but one that is absolutely essential to ensure that patients have access to the full continuum of high-quality health care. Additionally, we hope you will examine the many innovative solutions that emergency physicians throughout the country have developed and successfully implemented to reduce emergency psychiatric patient boarding.

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Emergency Department Boarding

Patient “boarding” occurs when a patient continues to occupy an ED bed even after being seen and treated by a physician, while waiting to be admitted to an inpatient bed in the hospital, or transferred to psychiatric, skilled nursing, or other specialty facility. As our health care system becomes increasingly strained, these patients must stay in the ED for days or even weeks on end waiting for a bed to become available so they can be admitted or transferred. Patients being boarded in the ED limits the ability of ED staff to provide timely and quality care to all patients, forcing other newly arriving patients with equally important emergency conditions to wait in the ED waiting room for care, with wait times as long as eight or even twelve hours rapidly becoming a new norm, and patients even dying during these waits as staff struggle to keep up with an unsupportable volume of sick patients to care for.

Boarding has become its own public health emergency. Our nation’s safety net is on the verge of breaking beyond repair; EDs are gridlocked and overwhelmed with patients waiting – waiting to be seen, waiting for admission into an inpatient bed in the hospital, waiting to be transferred to psychiatric, skilled nursing, or other specialized facilities that have little to no available beds, or, waiting to simply return to their nursing home. And this breaking point is entirely outside of the control of highly skilled emergency physicians, nurses, and other ED staff doing their best to keep everyone attended to and alive.

Any emergency patient can find themselves boarded, regardless of their condition, age, insurance coverage, income, or geographic area. Even patients sick enough to need intensive care may board for hours in ED stretchers not set up for the extra monitoring they need. Those in mental health crises, often children or adolescents, board for *months* in chaotic EDs while waiting for a psychiatric inpatient bed to open anywhere. But boarding does not just affect those waiting to receive care elsewhere. When ED beds are already filled with boarded patients, other patients are decompensating and, in some cases, dying while in ED waiting rooms during their tenth, eleventh, or even twelfth hour of waiting to be seen by a physician.

“At peak times which occur up to 5 days per week we have more patients boarding than we have staffed beds. High numbers have include last week when our 22 bed emergency department had 35 boarders and an additional 20 patients in the waiting room...In addition, we have patients who unfortunately have died in our waiting room while awaiting treatment. These deaths were entirely due to boarding. Our boarding numbers have unfortunately skyrocketed in the wake of COVID as a consequence of increasing surgical volumes and decreasing inpatient nurse staffing.”

– anonymous emergency physician

To illustrate the stark reality of this crisis, ACEP asked its members to share [examples of the life-threatening](#) impacts of ED boarding. The stories paint a picture of an emergency care system already near collapse. While the causes of ED boarding are multifactorial, unprecedented and rising staffing shortages throughout the health care system have recently brought this issue to a crisis point, further spiraling the stress and burnout driving the current exodus of excellent physicians, nurses, paramedics, and other health care professionals.

We need a health care system that can accurately track available beds and other relevant data in real-time, appropriate metrics to measure ED throughput and boarding, contingency plans and “load balancing” plans for boarding/crowding scenarios, and fewer regulatory or other “red tape” burdens that delay necessary care. Recognizing all EDs are different and there is no one-size-fits-all solution to this multifactorial problem, ACEP is in the process of developing a broad range of potential legislative and regulatory solutions that will alleviate the burdens and overall strain on EDs caused by patient boarding. As we finalize these recommendations and policy solutions, we will share more broadly with you and your staff in the coming weeks. Further, we strongly urge Congress to direct its attention to this critical issue and work with us and other stakeholders through roundtables, hearings, and legislation to provide both short- and long-term solutions to this public health crisis.

Violence Against Emergency Physicians and Health Care Workers

Violence in the emergency department is a serious and growing concern, causing significant stress to emergency department staff and to patients who seek treatment in the emergency department (ED). According to a [survey conducted by ACEP in 2022](#), two-thirds of emergency physicians report being assaulted in the past year alone, while more than one-third of respondents say they have been assaulted more than once. Nearly 85 percent of emergency physicians say the rate of ED violence has increased within the last year.

Beyond the immediate physical impacts and injuries, the risk of violence increases the difficulty of recruiting and retaining qualified health care professionals and contributes to greater levels of physician burnout. In fact, 87% of emergency physicians report a loss of productivity from the physician or staff as a result, and 85% of emergency physicians report emotional trauma

and an increase in anxiety because of ED violence. Most importantly, patients with medical emergencies deserve high-quality care in a place free of physical dangers from other patients or individuals, and care from staff that is not distracted by individuals with behavioral or substance-induced violent behavior.

And unlike the significantly more visible violence against airline employees and other travelers that has become more ubiquitous over the last several years, violence against health care workers often is not seen or addressed because of inadequate reporting and tracking of violent incidents, and other systemic barriers that do not hold violent individuals accountable for their actions. As a result of the inability to prosecute those who are arrested, many health care workers are discouraged from even pressing charges and being forced to accept that it's "just part of the job." Violence is not accepted in any other workplace, and it must not be accepted especially in a setting focused on improving the health and well-being of individuals.

There are many factors contributing to the increase in ED and hospital violence, we recognize there is no one-size-fits-all solution to this issue either. In fact, one of the challenges is that the types of violence one ED typically experiences can be significantly different from another ED, even in the same town. Therefore, ensuring there are adequate resources to help identify best practices and outfitting facilities with resources appropriate to their specific needs is imperative. Overall, employers and hospitals should develop workplace violence prevention and response procedures that address the needs of their particular facilities, staff, contractors, and communities, as those needs and resources may vary significantly.

ACEP supports multi-pronged legislative efforts to address various aspects of health care workplace violence prevention, including the "[Workplace Violence Prevention for Health Care and Social Service Workers Act](#)," (H.R. 2663/S. 1176), introduced by Sen. Tammy Baldwin (D-WI) (and by Reps. Joe Courtney (D-CT), Don Bacon (R-NE), and others in the House); as well as the "[Safety From Violence for Healthcare Employees \(SAVE\) Act](#)," (H.R. 2584) introduced by Reps. Larry Bucshon (R-IN) and Madeline Dean (D-PA). The Workplace Violence Prevention for Health Care and Social Service Workers Act would ensure that health care workplaces implement violence prevention plans and techniques and are prepared to respond to acts of violence, while the SAVE Act would establish federal legal penalties for individuals who knowingly and intentionally assault or intimidate health care workers and provide grants to help hospitals and medical facilities establish and improve workplace safety, security, and violence prevention efforts.

Access to Mental Health Care

The emergency department is not only a safety net for those with physical care needs, but also for individuals suffering from a mental health crisis or acute psychiatric emergency. However, it is not ideal for long-term treatment of mental and behavioral health needs. Due to the fragmented nature of the mental health care infrastructure in the U.S., persistent lack of sufficient resources, and longstanding shortages of mental and behavioral health professionals, far too many Americans have limited options for the longer-term follow-up treatment they need and deserve. These challenges also contribute to the long ED wait times and aggravate ED boarding issues detailed above. In fact, 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.

Improving coordination of care across the health care continuum must be one of the highest priorities for any mental health reform effort. The ED serves as the critical health care safety net not only for acute injuries, but for psychiatric emergencies as well. However, most EDs are not ideal facilities to provide longer-term care for patients experiencing a mental health crisis – they are often hectic, noisy, and particularly disruptive for behavioral health patients.

Across the country, communities have adopted innovative alternative models to improve emergency psychiatric care and reduce psychiatric patient boarding. These include Behavioral Health Emergency Rooms (BHERs), separate areas of the ED that specialize in caring for patients experiencing a behavioral health crisis; Emergency Psychiatric Assessment Treatment and Healing (EmPath) Units, a separate, hospital-based setting solely for psychiatric emergencies with the safe, calming, homelike environment of a community mental health crisis clinic but with the ED's ability to care for any patient presenting for treatment; and Psychiatric Emergency Service (PES) models, a "hub-and-spoke" model with a dedicated psychiatric ED serving as a central hub with bidirectional spokes going out to a wide variety of mental, behavioral, and physical care, as well as social services.

- **Behavioral Health Emergency Rooms (BHERs).** BHERs are separate areas of the ED that specialize in proactive rapid-assessment, stabilization, and treatment of patients in experiencing a behavioral health crisis. Care is delivered via a multidisciplinary team of emergency physicians, psychiatrists, psychiatric nurses, and social workers. This service is operational 24 hours a day, 7 days a week, 365 days a year. These dedicated spaces provide patients with a safer, private, and more peaceful setting in which to deescalate and receive specialized care.

By initiating proactive assessments in a BHER, 40-50 percent of patients can be safely discharged home, reducing ED boarding time. Additionally, optimizing transition of care through Integrated Outpatient Care clinics ensures ongoing high-quality medical and behavioral health care follow-up with convenient and comprehensive treatment options for patients.

- **EmPath (Emergency Psychiatric Assessment Treatment and Healing) Units.** The EmPath unit is a separate, hospital-based setting solely for psychiatric emergencies with the safe, calming, homelike environment of a community mental health crisis clinic with the ED's ability to take care of any patient who presents for treatment. This unit accepts all suitable patients regardless of the severity of their illness, legal status, dangerousness, substance use intoxication or withdrawal, or co-morbid medical problems, as these patients are typically excluded from community programs and thus would likely experience boarding in an ED in the traditional medical system.

EmPath units provide immediate access to individualized care from a comprehensive mental health care team of psychiatrists, psychologists, mental health nurses, social workers, and other licensed mental health care professionals. This team partners directly with patients and their families to address the immediate mental crisis and to develop a longer-term care plan through appropriate follow-up services. In some instances, EmPath Units have reduced regional ED boarding by 80 percent, and have also reduced the need for -- and incidence of -- coercive measures (such as physical restraints), episodes of agitation, and psychiatric hospitalization.

- **Psychiatric Emergency Service (PES).** The PES model is a multipronged approach for emergency psychiatric patients treated in the ED based on increased availability of psychiatrists and dedicated case managers who focus on psychiatric patients. This model is referred to as a “hub-and-spoke” model with a dedicated psychiatric ED serving as a central hub with bidirectional spokes going out to a wide variety of mental, behavioral, and physical care, as well as social services. Recognizing that psychiatric patients have vastly different needs and circumstances affecting their overall health, this model helps address the patient's immediate mental health needs and swiftly directs them to the most appropriate follow-up services, which helps alleviate the overall load on the mental health care system. These two-way spokes may also serve to reconnect patients with the psychiatric ED should they require acute stabilization while receiving follow-up services, potentially avoiding an inpatient hospitalization and ensuring the patient receives the most appropriate care and treatment throughout the mental health care continuum.

These innovative approaches have helped communities improve coordination of emergency psychiatric care and they can serve as models for other communities to implement and build upon. **However, what is clear from experience is that the ultimate success of any model hinges on the availability of resources, whether monetary, staffing, or access to follow-up services and patient access to long-term mental and behavioral health care.** One of the persistent challenges in emergency medicine is that “one emergency department is one emergency department” – i.e., the needs of each community and the resources available to local EDs, hospitals, and other facilities vary widely, and a model that is successful in one community may not be the best fit for another community.

For example, in 2017, Oregon implemented a dedicated psychiatric ED model in Portland based closely on the Alameda Model (California), but the transition has been marked by challenges for both the dedicated psychiatric ED and surrounding facilities. The dedicated psychiatric ED that was intended to reduce the burden on individual EDs is frequently at capacity or overcrowded, but emergency physicians at other facilities have noted that they are still seeing the same number of acute psychiatric patients in their own EDs. Additionally, the dedicated psychiatric ED has struggled to transfer patients to long-term follow-up treatment at Oregon State Hospital, contributing to long wait times, crowding, and poor outcomes for patients. Despite these challenges, stakeholders have been working to address the shortcomings of the system and adapt the model to better meet the needs of the Portland community, but the experience has highlighted that new care models are not necessarily “plug-and-play” and do not guarantee immediate results.

To ensure that communities can implement models that best fit their needs, ACEP supports the bipartisan “[Improving Mental Health Access from the Emergency Department Act](#)” (S. 1346), led by Sens. Shelley Moore Capito (R-WV) and Maggie Hassan (D-NH). This legislation would provide critical funding to help communities implement and expand programs to expedite transition to post-emergency care through expanded coordination with regional service providers, assessment, peer navigators, bed availability tracking and management, transfer protocol development, networking infrastructure development, and transportation services; increase the supply of inpatient psychiatric beds and alternative care settings; and, expand approaches to providing psychiatric care in the ED, including telepsychiatry, peak period crisis clinics, or dedicated psychiatric emergency service units. During the 117th Congress, this legislation (H.R. 1205) was passed by the House of Representatives in a voice vote but was not considered by the Senate. We urge Congress to consider and pass this important legislation.

Another longstanding barrier to providing adequate mental health treatment services is the Medicaid Institutions for Mental Disease (IMD) exclusion that prohibits the federal government from providing Medicaid reimbursement to states for care provided to most patients in an inpatient psychiatric or SUD facility with more than 16 beds. Though this longstanding policy was intended to reduce the number of people committed to long-term psychiatric treatment facilities without receiving appropriate care, it has perpetuated the problem of disparate treatment of mental health and has stood as a major barrier in the effort to provide necessary non-hospital inpatient psychiatric care options.

As a limited workaround, states have been able to apply for Section 1115 Medicaid waivers to receive matching federal funds for short-term residential treatment services in an IMD. Congress also recently took steps to address some of the challenges posed by the IMD exclusion in the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act (P.L. 115-271), creating a limited new exception to allow states to provide Medicaid coverage for beneficiaries with at least one SUD in certain IMDs.

The IMD exclusion may also threaten the ability of communities to provide a continuum of crisis stabilization services that includes call centers, mobile crisis units, and crisis stabilization programs. Crisis stabilization programs are a resource distinct from traditional residential treatment facilities for mental health and SUD treatment. These provide individuals with additional immediate-access treatment options, helping them avoid settings detrimental to their condition such as jails, homeless shelters, or the streets. Unfortunately, the IMD exclusion was established before crisis stabilization beds were developed, and the 16-bed limitation for facilities severely restricts the ability of these services to meet the needs of communities with vulnerable Medicaid populations and high demand for such services. We agree with legislators' [bipartisan efforts](#) urging CMS to ensure Medicaid reimbursement for crisis stabilization beds and to ensure these programs are not adversely affected by the IMD exclusion.

ACEP has long advocated for full repeal of the IMD exclusion and strongly urges Congress to rescind this harmful policy either as a standalone effort or as a cornerstone of any comprehensive mental health reform legislation.

Ensuring Parity Between Behavioral and Physical Health Care

Limited access to appropriate coverage, narrow provider networks, lack of federal enforcement mechanisms for parity law violations, and low reimbursement for mental health services remain barriers to achieving parity between mental and physical health care.

In recent years, Congress has taken important steps to improve parity between mental and physical health care by requiring insurers to provide the same level of coverage for mental health and substance use disorder treatment as they do for physical care. **But despite federal law, there is no mechanism for the federal government to enforce compliance against plans that continue to violate parity requirements and discriminate against patients with mental health conditions or SUD.** ACEP supports providing the Department of Labor (DOL) with the ability to issue civil monetary penalties (CMPs) for violations of the "Mental Health Parity and Addiction Equity Act" (MHPAEA; P.L. 110-343) by group health plan sponsors, plan administrators, or issuers. ACEP supports legislative efforts to give the DOL the authority to issue CMPs.

Without enforcement penalties and more explicit parity requirements, we will continue to see insurers attempting to find their way around the law and limit the coverage available to beneficiaries experiencing mental health crisis. As a recent example, Optum in Maryland issued a policy several years ago establishing that only certain provider types (specialty mental health providers) are eligible to bill when the only diagnosis is a psychiatric issue, including homicidal ideation and suicidal ideation, precluding payment for an ED physician's evaluation and management services. This policy ignores the significant challenges emergency physicians are experiencing in seeing and treating mental health needs in the ED and has disproportionate impacts on hospitals with high Medicaid populations. Though Optum ultimately issued an updated provider alert that resolved this matter, it was not without significant confusion and substantial delays that affected patient care.

We also believe this is yet another example of insurers attempting to disregard the Prudent Layperson Standard (PLP), a longstanding and critical policy that protects patients from retroactive denials of insurance coverage for emergency department visits that are ultimately determined to be non-emergent. Patients who believe they are experiencing a medical emergency should not be discouraged from seeking treatment out of fear that their ED visit will not be covered by their insurer.

Ensuring parity for behavioral health care also requires appropriate treatment of substance use and opioid use disorders (SUD/OD). Individuals with SUD/OD often seek care in the emergency department, and one of the most effective means emergency physicians have to aid these patients is by using buprenorphine as part of a medications for opioid use disorder (MOUD) protocol. As one of three drugs approved by the U.S. Food & Drug Administration (FDA) for the treatment of opioid dependence, buprenorphine is a very safe and efficacious medication. Strong enough to reduce withdrawal symptoms and

cravings but not enough to cause euphoria, it can allow individuals with OUD to more effectively engage in treatment as they pursue recovery. But despite the passage of the MAT Act and subsequent removal of the X-waiver, significant barriers to the use of buprenorphine persist, including limited access to the treatment due to Drug Enforcement Administration (DEA) set quantity limits, which flag pharmacy and hospital purchases of these required SUD/OUD treatments as suspicious orders. In fact, both prescribers and patients across the nation are still experiencing difficulty in obtaining buprenorphine prescriptions. According to a recent study that surveyed more than 5,000 pharmacies, less than half stocked buprenorphine.¹ Additionally, a separate survey found that one-fifth of pharmacies were not willing to fill buprenorphine prescriptions.² A survey of addiction treatment providers also revealed that 84 percent of their patients experienced a delay in accessing their buprenorphine, which can be life-threatening for those undergoing treatment for opioid use disorder.³ We urge Congress to ensure that health insurance plans appropriately cover SUD/OUD treatments, and further to ensure that patients are not hindered by unnecessary federal barriers on their path to recovery through arbitrary limitations on the medications they need.

Improving Access to Behavioral Health Care for Children and Young People

The full effects of the COVID-19 pandemic are not limited to the staggering toll on American lives or the long-term physical health challenges from which many recovering patients still suffer. We are still collectively struggling to comprehend the true scope of the pandemic's impact on the mental health and well-being of millions of Americans, particularly on children and younger Americans.

As the recent U.S. Department of Education report, "[Supporting Child and Student Social, Emotional, Behavioral, and Mental Health Needs](#)" notes, children have experienced isolation, bereavement, depression, worry, and other issues throughout the pandemic, leading to reports of anxiety, mood, and eating disorders, as well as increased self-harm behavior and suicidal ideation at nearly twice the rate of adults. **Pediatric ED visits related to mental health significantly increased during the pandemic – a 24 percent increase for children 5-11 years of age, and 31 percent for children 12-17.** These stressors affect children's development and ability to learn in both the immediate and long-term with lasting consequences should their mental health needs not be adequately addressed.

Adding to these long-term considerations are the mental health stresses associated with the loss of a caregiver. According to a recent pre-publication study in the October 2021 issue of the American Academy of Pediatrics journal, *Pediatrics*, more than 140,000 U.S. children under the age of 18 lost a primary or secondary caregiver due to COVID-19 between April 1, 2020 and June 30, 2021.⁴ The consequences of the pandemic's disproportionate impact on racial and ethnic minorities, exacerbated by longstanding systemic inequalities, manifest here as well given that children of racial and ethnic minorities account for 65 percent of children who lost a primary caregiver (compared to 39% of the total population). The authors note the significant long-term impacts that orphanhood and caregiver loss have on the health and well-being of children, ranging from mental health problems and increased risks of suicide violence, sexual abuse, and exploitation, to disruptions in family circumstances such as housing instability and lack of nurturing support. Especially given the Committee's considerable attention to gaps in equity and longstanding disparities in health care, we urge you to examine the far-reaching effects of pandemic on historically underserved populations and we stand ready to work with you to provide the perspective and experience of emergency physicians to help develop effective and durable policy solutions.

Our health care system is not currently well-equipped to address the long-term effects of the significant trauma so many young Americans have experienced over the course of the last year. **Given the substantial strains on the health care and social safety nets that existed long before the pandemic hit, it is clear that EDs, child welfare systems, the child and adolescent mental health workforce, and other related services will need considerable investments and significantly expanded resources in order to appropriately address this unprecedented challenge.** As policymakers and stakeholders evaluate suggestions to improve mental and behavioral health access, these proposals and any new treatment models must be considered through the lens of pediatric care in order to prioritize the most vulnerable of the vulnerable.

¹ Hill, L. G., Loera, L. J., Torrez, S. B., Puzantian, T., Eroy, K. E., Ventricelli, D. J., Eukel, H. N., Peckham, A. M., Chen, C., Ganetsky, V. S., Yeung, M. S., Zagorski, C. M., & Reveles, K. R. (2022). Availability of buprenorphine/naloxone films and naloxone nasal spray in community pharmacies in 11 U.S. states. *Drug and alcohol dependence*, 237, 109518. <https://doi.org/10.1016/j.drugalcdep.2022.109518>

² Kazerouni, N. J., Irwin, A. N., Levander, X. A., Geddes, J., Johnston, K., Gostanian, C. J., Mayfield, B. S., Montgomery, B. T., Graalum, D. C., & Hartung, D. M. (2021). Pharmacy-related buprenorphine access barriers: An audit of pharmacies in counties with a high opioid overdose burden. *Drug and Alcohol Dependence*, 224. <https://doi.org/10.1016/j.drugalcdep.2021.108729>

³ American Society of Addiction Medicine. (2022). Reducing Barriers to Lifesaving Treatment: Report on the Findings from ASAM's Pharmacy Access Survey. https://sitefinitystorage.blob.core.windows.net/sitefinity-production-blobs/docs/default-source/advocacy/reports/asam-pharmacy-access-survey-report-final-11.7.22.pdf?sfvrsn=6da97680_3

⁴ [COVID-19-Associated Orphanhood and Caregiver Death in the United States \(aappublications.org\)](#)

Once again, thank you for the opportunity to provide our comments and suggestions on how to improve access to mental health and substance use disorder care for our patients and their families. We look forward to working with you on these important efforts. Should you have any questions or require any further information, please do not hesitate to contact Ryan McBride, ACEP's Congressional Affairs Director, at rmcbride@acep.org.

Sincerely,

A handwritten signature in black ink, appearing to read "Chris Kang", written in a cursive style.

Christopher S. Kang, MD, FACEP
ACEP President