REPORT 1 OF THE COUNCIL ON MEDICAL SERVICE (I-26)
Transparency with the Term "Emergency Department"
(Reference Committee J)

EXECUTIVE SUMMARY

At the 2025 Interim Meeting, Resolution 226-I-25, Transparency with the Term "Emergency Department," was referred. It asked the following:

> RESOLVED, that our American Medical Association (AMA) advocates for the designation of "emergency department" or "emergency room" to be restricted to facilities with the presence of at least one physician on site and on-duty, who is responsible for the emergency department at all times; and be it further
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> RESOLVED, that our AMA recommends that facilities without physician staffing use alternative terminology, such as Acute Care Unit, as a matter of truth and transparency for patients, so that patients are not expecting care by a physician; and be it further
>
> RESOLVED, that our AMA work with the Joint Commission, Det Norske Veritas (DNV), and other authorities/regulators to educate them about this issue, and to encourage them to implement correct "emergency department" terminology designations to ensure truth and transparency at all times for our patients.

This report discusses emergency department staffing requirements, the Emergency Medical Treatment and Labor Act (EMTALA), emergency service payment, Critical Access Hospitals, Rural Emergency Hospitals, emergency department signage and advertising requirements, the American College of Emergency Physicians' accreditation program, the emergence of Urgent Care Centers, and includes several policy recommendations.

The Council on Medical Service recommends new policy supporting the development of standardized emergency department descriptors that clearly identify each facility's level of on-site physician coverage and available services; and recommends that facilities dedicated to emergency care without an on-site physician use standardized, real-time language that allows a prudent layperson to readily understand the level of physician presence and services available, thereby promoting truth and transparency for patients. The Council also recommends limiting the designations "emergency department" and "emergency room" to facilities that meet EMTALA requirements and allowing any EMTALA-covered facility that meets those requirements to be classified as an emergency place of service for billing purposes, regardless of its level of on-site physician coverage. Furthermore, the Council recommends requiring facilities without continuous on-site physician staffing to prominently disclose, through physical and online signage, that physicians are not continuously on duty and on site; and that our AMA support requiring advertisements for such facilities to include the same disclosure, consistent with Federal Trade Commission guidelines and community engagement to improve the education of patients. The Council also recommends reaffirming Policy H-130.929, which identifies an on-site physician whose primary duty is emergency department care as the AMA's preferred model; Policy D-35.976, which states that only physicians should supervise emergency care services in an emergency department; Policy D-130.958, which recognizes that staffing arrangements that do not allow physicians to properly provide emergency services are insufficient; Policy H-160.949, which opposes legislation allowing nonphysician groups to practice medicine without physician training or appropriate physician supervision; and Policy H-240.958, which recognizes the vital role of smaller, financially challenged facilities that provide emergency services.

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REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 1-I-26

Subject: Transparency with the Term "Emergency Department"

Presented by: A. Patrice Burgess, MD, Chair

Referred to: Reference Committee J

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> RESOLVED, that our American Medical Association (AMA) advocates for the designation of "emergency department" or "emergency room" to be restricted to facilities with the presence of at least one physician on site and on-duty, who is responsible for the emergency department at all times; and be it further
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This report discusses emergency department staffing requirements, the Emergency Medical Treatment and Labor Act, emergency service payment, Critical Access Hospitals, Rural Emergency Hospitals, emergency department signage and advertising requirements, the American College of Emergency Physicians' accreditation program, the emergence of Urgent Care Centers, and includes several policy recommendations.

BACKGROUND

Emergency departments (EDs) are a critical—and increasingly strained—gateway to care in the United States (US). In 2025, there were 155.4 million visits to the 5,751 EDs in the US with 17.8 million resulting in hospital admission, and 3.1 million resulting in admission to a critical care unit.[1,2] Nearly 1 in 4 patients aged 18-64 use the ED for non-urgent issues, which could otherwise be treated in an urgent care center (UCC) or primary care setting.[3] A small percentage of patients (4.5 percent to 8 percent) utilize the ED at least four times per year, but account for 21 percent to 28 percent of all ED visits.[4] Regional disparities for ED visits are significant, driven largely by healthcare access, the density of rural populations, and the prevalence of chronic health conditions.[5] For instance, in rural states healthcare providers are overwhelmingly concentrated in a few urban centers which leave geographic stretches with limited local primary care or UCCs.[6] Hospital deserts are widespread in the US: 691 of the nation's 3,142 counties (22 percent) lack a hospital, including 258 counties in highly vulnerable states where residents also face socioeconomic, housing, and transportation barriers to care.[7]

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Patient expectations for physician-led emergency care often collide with staffing realities, particularly in rural and low-volume hospitals. According to an American College of Emergency Physicians (ACEP) poll from 2021, 80 percent of patients state they most trust a physician to lead their ED medical care compared with a nurse, physician assistant (PA), or nurse practitioner (NP).[8] However, one in 13 EDs did not have one or more on-duty attending physicians at all times.[9] In several states, more than 30 percent of the EDs lacked constant physician leadership and, among them, 92 percent had low annual visit volumes, 89 percent were in critical access hospitals (CAHs), and 72 percent were rural.[10]

Gaps in round-the-clock emergency physician coverage vary significantly across states and reflect more than rural geography alone. Several factors are associated with the absence of continuous physician coverage, including annual visit volume under 10,000, workplace shortages, permissive state-level scope of practice laws, challenging hospital economics, and rural location.[11] Fifteen states—including many largely rural states—reported no EDs operating without a physician on-site 24 hours per day/7days per week (24/7).[12] Some of these states (e.g., Nevada, New Mexico, and West Virginia) are adjacent to states with comparatively high numbers of EDs without continuous physician coverage. In the Dakotas, for example, more than half of EDs operated without an attending physician, and in Montana, 43 percent lacked 24/7 attending physician coverage.[13] Nine states reported that at least 20 percent of EDs did not have 24/7 attending-physician coverage; these states are disproportionately located in the central US.[14] Most EDs (89 percent) without 24/7 physician coverage are designated as CAHs, 72 percent were rural, and 2 percent were freestanding.[15] However, more than a quarter (28 percent) of these EDs are located in metropolitan areas and the vast majority of which represent specialized freestanding emergency departments rather than traditional main hospital campuses.[16]

US hospital closures have risen sharply since the early 2000s. From 2017 through 2023, rural closures outnumbered openings 61 to 11, yielding a net loss of 50 hospitals; from 2005 through 2024, 193 rural hospitals closed.[17] Urban hospitals also close frequently, often because of financial pressures. In both settings, closures force residents to travel farther for care. Rural residents, for example, have preventable ED visit rates up to 45 percent higher than urban residents, largely because primary care shortages, longer travel distances for primary and specialty care, and geographic isolation allow conditions to worsen.[18] At the same time, annual visits to remaining EDs have increased by about 30 percent, worsening wait times and overcrowding. Closures are driven primarily by unsustainable financial losses and operational challenges; nearly half of rural hospitals operate at a negative margin. Major contributors include uncompensated care, low patient volume, billing and administrative burdens, regulatory requirements, and staffing shortages, with rural and socioeconomically disadvantaged communities facing the greatest effects.[19]

EMERGENCY MEDICAL TREATMENT AND LABOR ACT

Ninety eight percent of EDs are subject to the Emergency Medical Treatment and Labor Act (EMTALA). EMTALA requires Medicare-participating hospitals with EDs to screen and treat emergency medical conditions regardless of a patient's insurance status or ability to pay.[20] EMTALA obligations are triggered when an individual "comes to the emergency department," including by arrival via Emergency Medical Services, is present anywhere on hospital property within 250 yards of the main building, or is sent via a transfer request from another hospital's ED.[21] Federal law requires hospitals to maintain an on-call list of physicians available to provide stabilizing treatment for emergency medical conditions, but it does not require ED care to be physician-led.[22] When an individual presents at a hospital ED for examination or treatment, the hospital must provide an appropriate medical screening examination (MSE) by qualified medical personnel (QMP), which may include a physician, PA, or NP.[23] Physicians may be on call for multiple hospitals at once, but hospitals must have policies to manage that arrangement, including backup community call plans when a physician is unavailable.[24]

Regulations define a "hospital with an emergency room" as a hospital with a dedicated ED, whether located on or off the main campus.[25] A dedicated ED is one that meets any one of the following three criteria: (1) it is licensed by the state as an emergency room (ER) or ED; (2) it is presented to the public—through its name, signage, advertising, or other means—as providing urgent care for emergency medical conditions without a scheduled appointment; or (3) during the prior calendar year, at least one-third of its visits were for urgent treatment of emergency medical conditions without a scheduled appointment, based on a representative sample.[26] This definition also includes units, such as labor and delivery or psychiatric intake or assessment units, where unscheduled ambulatory patients are routinely evaluated and treated for emergency medical conditions.[27]

Hospital policies must specify when a QMP must consult an on-site or on-call physician. If a QMP cannot confidently rule out an emergency medical condition, a physician must be involved.[28] The Centers for Medicare & Medicaid Services (CMS) also permits the required MSE be performed via telehealth, even when the physician is elsewhere on campus or off-site, so long as the remote examination is clinically sufficient to determine whether an emergency medical condition exists.[29] Under EMTALA, a telehealth provider performing a MSE does not have to be a physician as long as they qualify as a QMP.[30] If video or other remote data are inadequate, an in-person examination is required. Any remote provider performing MSEs must be fully credentialed and privileged by the hospital, and hospitals may use proxy credentialing to streamline telemedicine services.[31] If the treating ED physician determines that an in-person specialist assessment is needed to stabilize the patient, the on-call specialist must come to the hospital.[32]

Although uncommon, some ED-like settings are not subject to EMTALA. Facilities that do not accept Medicare or Medicaid payments may fall outside the scope of EMTALA. Military and Veterans Affairs hospitals are also exempt and operate under separate federal requirements. UCCs that are not owned or operated by a hospital typically are not covered, and off-campus hospital departments that do not primarily provide emergency services may not qualify as dedicated EDs. Once a patient is formally admitted as an inpatient, EMTALA obligations generally end and other CMS Conditions of Participation apply.

EMERGENCY SERVICE PAYMENT

Emergency service payment typically uses the Current Procedural Terminology (CPT®) codes 99281–99285 evaluation and management (E/M) codes (five levels based on complexity), supplemented by critical care CPT codes 99291–99292 and facility revenue codes 0450, 0451, or 0456.[33] Additional CPT codes include observation (99221–99223) for patients placed in observation status and common procedure codes such as laceration repair (12001–12011) and splint application (29125–29515).[34,35] For hospital inpatient or observation care services (including admission and discharge services) CPT codes 99234–99236 are used.[36] A modifier may be used to indicate a significant, separately identifiable E/M service performed by the same physician on the same day as a procedure.[37] Ambulance services are billed with Healthcare Common Procedure Coding System codes A0021–A0999 (e.g., Basic Life Support or Advanced Life Support).[38] Payment for these services does not depend on whether the care is delivered in a facility labeled an "emergency department" or "emergency room."

Place of Service (POS) codes are two-digit codes placed on healthcare professional claims to indicate the setting in which a service was provided. While there are numerous codes, POS 23 is designated for, "a portion of a hospital where emergency diagnosis and treatment of illness or injury is provided."[39] For emergency services provided via telehealth, POS 23 should be paired with -95 to indicate remote care.[40] There is no regulation, directive, or guidance by CMS that POS code 23 must be within a location called an "emergency room" or "emergency department."[41]

EMERGENCY DEPARTMENT STAFFING REQUIREMENTS

Staffing requirements vary by state and are set by state regulations and hospital licensing standards. State differences in ED physician-led care are driven, in part, by varying state regulations on the corporate practice of medicine, differing scope-of-practice laws, and the availability of local residency programs. While some states require continuous on-site physician coverage, most do not. Indiana, Virginia, and South Carolina require a physician to be on site and on duty 24/7, and several other states have considered similar legislation. Although this approach may serve as a model for other states, its success may depend upon most EDs in those states already being staffed in this way. In Virginia, for example, there was no ED without a physician present.[42] It is unclear whether South Carolina and Indiana were staffed similarly. California and New Jersey have long had comparable mandates. California requires a qualified physician to oversee a hospital's emergency services and ensure they are staffed by an experienced physician.[43] New Jersey requires at least one licensed physician to be present in the ED to manage emergencies.[44]

Most states, however, mandate flexible physician staffing requirements. Illinois, for example, classifies EDs as Comprehensive, Basic, or Standby. Comprehensive and Basic emergency treatment services require a physician on site 24/7, while standby services require a physician to be on call.[45] In Florida, state law requires every hospital offering emergency services to have its ED directed by a physician who is a member of the organized medical staff.[46] At least one physician must be available within 30 minutes through a required call roster, and two-way voice communication may be used for the initial consultation.[47] In New York, regulations provide that hospitals with fewer than 15,000 unscheduled ED visits per year do not need a supervising or attending physician on site, so long as one is available within 30 minutes of the patient's arrival.[48] States, however, universally require every licensed ED to appoint an explicit, state-licensed physician to serve as the Emergency Department Medical Director.[49] This individual is legally responsible for quality control, protocols, and provider credentialing.

Several factors can explain why a physician may not be present in an ED, including recruitment and retention challenges. Hospital administrators report difficulty attracting and retaining physicians to staff EDs, and workforce data support this concern. A 2020 study found that only eight percent of emergency physicians practiced in rural areas, and only two percent practiced in small rural areas.[50] Rural physicians also were, on average, significantly older than their urban counterparts and near retirement age, with most having completed training at least 20 years before 2020.[51] Although rural EDs may be more likely to employ physicians who are not specialty trained in emergency medicine, workforce research shows that fewer than one-quarter of clinically active family medicine-trained emergency physicians practice in rural areas.[52] Staffing challenges can also reinforce themselves; for example, rural hospitals may require new physicians to cover ED shifts multiple nights per week as a condition of employment, which may deter physicians who do not want to provide emergency services or work overnight hours.

EDs without an on-site physician often use alternative staffing models centered on advanced practice providers (APPs), such as PAs and NPs, to perform MSEs and stabilize patients. These models commonly pair APP staffing with remote physician oversight and rapid transfer protocols for higher-acuity cases. One approach is 24/7 APP coverage with an emergency physician continuously available off-site through real-time audiovisual technology to guide assessments, interpret diagnostics, and support critical decisions.[53] Another is autonomous APP staffing, in which PAs and NPs operate the ED with remote or on-call supervision from an off-site collaborating physician.[54] Some facilities use hybrid inpatient/ED models, with one experienced provider covering both the ED and inpatient unit during low-acuity or overnight periods.[55] A less common model uses specialized emergency paramedics, working under the attending APP's direct supervision, to support care through tasks such as IV placement, protocol-directed medication administration, and continuous vital-sign monitoring.[56]

The capabilities of EDs with and without continuous physician leadership differ significantly. With an attending physician, there is usually the capability to independently perform complex procedures like intubation, chest tube insertion, and emergency surgeries while immediate, autonomous decision-making is possible with an interpretation of imaging and lab results.[57] Furthermore, specialty coverage is a possibility with direct, on-site management of acute trauma, severe strokes, and multi-system organ failure and procedural sedation with full capacity to manage deep sedation for acute fracture reductions or cardioversion on-site.[58] Without a physician present, an initial assessment and triage is likely to occur with basic stabilization, telehealth consultation for lab results and treatment of complex conditions, basic diagnostics (e.g., lab work), and emergency transfer if trauma is severe.[59]

The practice requirements for APPs vary by state. All PAs must graduate from an accredited program, pass the national certification exam, obtain state licensure, and complete 100 continuing medical education hours every two years. Most states require physician supervision or collaboration, although eight—Iowa, Montana, New Hampshire, North Dakota, South Dakota, Maine, Utah, and Wyoming—allow eligible PAs to practice without a formal agreement.[60] PAs may prescribe in all states, Washington, D.C., and Guam, subject to local registration or delegation rules. Advanced practice registered nurses (APRNs), including NPs, clinical nurse specialists, nurse anesthetists, and nurse-midwives, practice under full, reduced, or restricted authority. Full practice permits independent evaluation, diagnosis, testing, treatment, and prescribing; reduced or restricted practice limits at least one function and may require collaboration, supervision, or delegation.[61] APRNs generally must hold an accredited graduate degree, national certification for their role and population focus, and state licensure.

Trauma capabilities also vary by facility. Every trauma center has an ED, but not every hospital with an ED is a trauma center. Trauma centers provide specialized care for critical injuries, with trauma surgeons, neurosurgeons, orthopedic specialists, and other teams available around the clock for emergency surgery.[62] State or regional authorities, not healthcare organizations, designate trauma centers using criteria that vary by state. Levels I through V reflect the resources available to treat traumatic injuries: Level I centers offer the most comprehensive care for severe injuries, while Level IV and V centers stabilize patients for transfer to higher-level facilities.[63] Adult and pediatric trauma centers receive separate designations. The American College of Surgeons (ACS) conducts a separate verification process to improve trauma care.[64] Whereas designation establishes a facility's trauma-center status, ACS verification confirms that it meets defined standards for preparedness, policies, resources, operations, and quality improvement.[65] Verification remains valid for three years.

CRITICAL ACCESS HOSPITALS & RURAL EMERGENCY HOSPITALS

Congress created the CAH designation in the Balanced Budget Act of 1997 after many rural hospitals closed in the 1980s and early 1990s.[66] The program is intended to preserve access to care in rural communities, reduce financial vulnerability, and keep essential services available.[67] Congress later established the Rural Emergency Hospital (REH) designation to help struggling rural hospitals avoid closure by converting to facilities that provide 24/7 emergency and outpatient services without inpatient care.[68] CAHs and REHs receive enhanced Medicare payments for certain outpatient services and, for REHs, additional monthly facility payments.[69] CAHs, rural acute care hospitals, tribally operated hospitals, and Indian Health Service hospitals with 50 or fewer beds that were open on December 27, 2020, may apply for REH status. To qualify, a hospital must be in a rural area or have an active rural classification under the Office of Management and Budget's Core Based Statistical Areas.[70]

REHs must provide 24-hour emergency and observation services and may choose to offer other outpatient services.[71] As with CAHs, an MD or DO physician, PA, NP, or clinical nurse specialist with emergency care training or expertise must be on-site or on-call and able to arrive within 30 minutes, or within 60 minutes if the facility meets certain frontier or remote-area criteria.[72] States may impose stricter

requirements, including minimum staffing hours or specific personnel standards.[73] CAHs also must meet federal Conditions of Participation and comply with applicable state and local laws.[74] If state law is more stringent—such as California's nurse-to-patient ratio standards or Indiana's on-site physician staffing requirement—the facility must follow the stricter state standard.[75] CAH and REH eligibility rules do not mandate use of the terms "emergency department" or "emergency room."

EMERGENCY DEPARTMENT SIGNAGE

No federal regulation requires facilities that provide immediate, unscheduled care, diagnostic services, and stabilization for seriously ill or injured patients to be labeled "emergency departments." There is also no financial barrier preventing an "emergency department" from adopting alternative names (e.g., "unscheduled care center" or "rural immediate care center"). EMTALA does require conspicuous signage that is easily visible to all individuals entering the ED, including at entrances, waiting rooms, registration, and treatment areas.[76] Hospitals with dedicated EDs that do not have a physician present 24/7 must post clear public signage disclosing that fact under Medicare Conditions of Participation and EMTALA-related requirements.[77] Hospitals with continuous, on-site, qualified physicians are not required to post a physician-absence notice. When an MD or DO is not present on-site 24/7, the sign must state that the hospital does not have a physician present 24/7, and explain how the hospital will meet the immediate needs of patients with emergency medical conditions when a physician is not physically present, such as calling on-call physicians, using telehealth, or transferring the patient.[78] The notice must be posted conspicuously where patients and visitors are likely to see it, including emergency department entrances, waiting rooms, admitting areas, and patient treatment or examination areas, readable from 20 feet away, and written in clear, simple, and accessible language.[79]

Furthermore, hospitals must post notices explaining patients' rights to emergency treatment and to file complaints.[80] Signs must also state that the hospital provides an appropriate MSE, necessary stabilizing treatment (including for stabilization of the fetus), and whether the hospital participates in Medicaid.[81] Posted information must be in the language(s) understood by the population served, written in clear, simple terms, and readable from 20 feet away.[82] Updated model signage includes a QR code for additional information to meet 42 CFR § 489.20(q) requirements.[83] In addition, public ED entrances must be clearly marked from outside and from surrounding roads, readily distinguishable from ambulance entrances, and illuminated for visibility at night or in poor weather.[84]

Some states impose additional ED signage requirements. For example, Massachusetts requires highly visible, illuminated—and in some cases reflective—signage directing patients to 24/7 care and clearly marking emergency entrances as "EMERGENCY."[85] Illinois requires additional ED notices, including information on Affordable Care Act exchange enrollment, human trafficking, and charges for services such as x-rays, ER services, and room fees.[86] Some cities also have added requirements; Chicago, for instance, mandates approved emergency lighting and exit signage that may differ from national codes and requires local inspections.[87]

EMERGENCY DEPARTMENT ADVERTISING

Although EDs without 24/7 on-site physician coverage must post clear public signage disclosing that fact under Medicare Conditions of Participation and EMTALA-related requirements, they are not required to include the same disclosure in advertising. Healthcare advertising is governed by federal law, state licensing boards, and healthcare marketing standards intended to protect patient safety, promote transparency about pricing and facility capabilities, and prevent deceptive practices. The Food and Drug Administration regulates pharmaceutical and medical device marketing to ensure information is accurate and not misleading.[88] State medical boards enforce jurisdiction-specific advertising rules, while the Federal Trade Commission (FTC) broadly regulates healthcare advertising by requiring claims to be

truthful, evidence-based, and not misleading.[89] For example, claims about wait times, equipment, or staff qualifications must be accurate. FTC enforcement focuses on deceptive practices under a three-part standard: the representation, omission, or practice must mislead or be likely to mislead consumers; the consumer's interpretation must be reasonable under the circumstances; and the misleading representation, omission, or practice must be material.[90] States (e.g., California, Georgia, and Indiana) increasingly restrict or penalize non-physician clinicians from using the title "doctor" in clinical and advertising settings if it misleads patients into believing they are physicians.[91,92]

FTC guidance on claim substantiation and consumer endorsements is particularly relevant to healthcare marketing. Advertisers must have support for all express and implied claims an advertisement is likely to convey to reasonable consumers before the advertisement runs.[93] For example, ED wait-time claims must be substantiated before publication. If the comparison relies on a national standard for certain trauma or condition-specific care, such as heart attacks or strokes, the advertisement should clearly disclose that qualification. Healthcare providers that advertise treatment outcomes must also be able to support those claims.[94] Comparisons to regional or national averages should be clearly stated, and advertisers should avoid success-rate claims when the data may be distorted by an unusual patient population, small case volume, or another statistical anomaly. Healthcare marketing should also consider how prospective patients are likely to interpret an advertisement.[95] A patient who sees a facility claims a much higher success rate than the national average may reasonably assume the difference reflects better care at that facility, rather than differences in patient population or case volume.

State medical boards oversee ED advertising primarily to protect public health by preventing false, deceptive, or misleading claims.[96] Because emergency care is time-sensitive, boards scrutinize advertisements that could manipulate vulnerable patients or delay lifesaving treatment. Key compliance concerns include misrepresenting a facility's services, capabilities, licensing, or staff credentials.[97] For example, a practice or freestanding facility should not advertise itself as an "emergency room" or "emergency department" unless it has the required state license, trauma designation, and 24/7 capabilities.[98] Similarly, an ED should not claim to be "fully staffed by emergency specialists" if shifts are routinely covered by clinicians who lack the stated qualifications or required supervision.[99] Advertised wait times—whether displayed on billboards, websites, or apps—also must be based on legitimate, reliable data.[100] A board may investigate a hospital that presents door-to-triage time as total wait time rather than measuring the time until evaluation by a qualified medical professional. The ACEP advises prominent disclaimers explaining that published wait times do not apply to life-threatening emergencies, which receive immediate priority.[101] If a patient with a serious condition, such as a heart attack, delays care because of a posted wait time, a board may assess whether the advertisement created a public health risk.[102] State licensing boards also restrict fear-based or high-pressure marketing that exaggerates health threats or exploits patient panic to steer individuals toward a particular hospital network.[103] Although medical boards regulate individual professional licenses, they often coordinate with other agencies on ED advertising violations. Misleading, inaccurate, or unsafe marketing can result in public reprimands, financial penalties, practice restrictions, or suspension or revocation of the licenses of responsible physicians or medical directors.

AMERICAN COLLEGE OF EMERGENCY PHYSICIANS' ACCREDITATION PROGRAM

The ACEP Emergency Department Accreditation Program (EDAc) is a voluntary national program recognizing EDs that meet defined standards for quality, safety, and clinical excellence and could be a roadmap to evaluate and distinguish EDs with and without continuous physician coverage. Its 33 multidisciplinary benchmarks address quality improvement, boarding policies, pediatric readiness, workplace fairness, performance monitoring, and resources such as ultrasound, interpreter services, and staff safety protocols.[104] EDAc evaluates facilities across four levels based on capabilities such as advanced imaging, social services, and, most importantly, staffing models. Gold Level I, the highest

designation, requires comprehensive staffing, a qualified emergency or pediatric emergency physician be physically on-site 24/7 365 days per year, advanced imaging, and on-site social services.[105] Silver Level II applies strong but less stringent staffing with integrated physician-led care and advanced diagnostic access but permits flexible on-call scheduling or slightly altered supervisor-to-midlevel (APP) staffing ratios.[106] Bronze Level III reflects compliance with the 33 foundational standards and focuses heavily on the structural administrative baseline and requires foundational advanced imaging and strict physician-led supervision frameworks but mandates fewer dedicated ancillary staff lines like standalone ED social workers.[107] Lastly, the Rural and Critical Access designation uses streamlined criteria for federally designated Rural Emergency Hospitals and Critical Access Hospitals.[108] Participating hospitals use EDAc to show they follow evidence-based policies and provide high-quality emergency care.

URGENT CARE CENTERS

While EDs address immediate, life-threatening emergencies, UCCs are free-standing same-day clinics for patients who need expedient, non-critical care. UCCs emerged in the 1970s as a convenient alternative to EDs for noncritical, acute illnesses.[109] In the 1980s, there was skepticism of their role due to a perceived lack of quality control which led to a decline in popularity.[110] However, they are now seen as an essential part of the healthcare system. Over the past two decades, they have expanded due to the high cost of ED visits, insurance company encouragement, and the need for immediate, non-scheduled care.[111, 112] From 2016 to 2025, UCCs have grown from 9,000 to 15,398 with 89.4 percent of the US population within a 20-minute drive.[113] Approximately, 185 million patients were cared for in an UCC setting in 2025.[114]

UCCs are largely physician-led with 94 percent of facilities employing at least one full-time physician.[115] Most UCCs legally require a physician for medical oversight, with a physician employed or contracted by the facility even if they are not physically in the building. Approximately 80 percent of UCCs employ a combination of physicians, PAs, and NPs.[116] The remaining 20 percent employ only physicians.[117] Sixty percent of UCCs are independent/private while 30 percent are hospital-owned.[118] Of the physicians practicing in UCCs, about 48 percent are family medicine physicians, 30 percent are emergency medicine physicians, and 8 percent are internal medicine physicians.[119] In 22 states and the District of Columbia, NPs have full practice authority and can practice without direct physician supervision. However, even in states with relaxed rules, corporate practice of medicine laws and insurance enrollment policies often require a physician on the business or licensing framework, making completely physician-free corporate urgent care structures extremely rare. Physician employment tends to attract physicians wishing to work part-time hours and those looking to transition into retirement.

There is a diverse, rapidly growing variability in the care, services, and staffing between UCCs and EDs.[120] While designed for immediate, non-life-threatening needs, UCC capabilities range from basic, NP-led care to advanced, hospital-affiliated facilities with specialized diagnostics.[121] Services vary, but they often include on-site x-rays, casting, and suturing.[122] However, only 14 percent had computed tomography scanners and 18.6 percent had ultrasound on site.[123] There also might be potential for high rates of discordant diagnoses compared to EDs, with some studies finding that 64 percent of patients transferred from a UCC to the ED had a discordant diagnosis.[124] This discrepancy may reflect limited services at some UCCs, less experience with advanced diagnostic interpretation, and care provided by APPs rather than physicians specializing in emergency medicine.[125] Some UCCs focus on primary care or occupational medicine, while others prioritize acute, low-acuity cases and increasing patient volume.[126] UCCs in cities with hospitals may have different patient demographics (younger) and shorter wait times, while corporate-owned or hospital-affiliated centers may offer different service menus than independent ones.[127]

RECENT REGULATORY ACTIVITY

Several states have mandated that a physician be present in the ED 24/7. Signed into law on May 4, 2023, Indiana's Senate Bill 400 (SB 400) requires that all hospital EDs in the state have a licensed physician on-site, on-duty, and responsible for the ED at all times. This legislation aims to ensure physician-led care in emergency settings. The law was driven by efforts to standardize care quality and ensure high-level training is available, particularly following concerns about solely staffing EDs with non-physician practitioners. Starting July 1st, 2025, Virginia law (Senate Bill 392) requires all hospital EDs to have a physician physically on site, on-duty, and responsible for the ED 24/7. Passed by the Virginia General Assembly and signed into law, the mandate ensures physician-led care for emergency patients, specifically enhancing care in rural locations. Previously, the law mandated there must be a physician on-call, but not physically present. South Carolina passed legislation in May 2025 (H. 4067) that requires all hospitals with EDs to always have at least one physician physically on-site while the department is open. This applies to all hospitals with EDs, regardless of their classification – rural, urban, public, or private.

AMA POLICY

Policy H-130.929 recognizes that the preferred model of emergency care is the on-site presence of a physician in the ED whose primary duty is to provide care in that ED and supports state medical associations in developing appropriate rural exceptions to such a requirement if, based on the needs of their states, the association chooses to pursue certain alternative supervision models for care provided in EDs in remote rural areas that cannot meet such a requirement.

Policy D-35.976 advocates for the establishment and enforcement of legislation and/or regulations that ensure only physicians supervise the provision of emergency care services in an ED.

Policy H-160.949 opposes legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision, encourages state medical societies to oppose state legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision, and vigorously supports and advocates for the requirement of appropriate physician supervision of non-physician clinical staff in all areas of medicine.

Policy H-130.976 reaffirms its policy endorsing the concept of appropriate medical direction of all prehospital emergency medical services and asserts that physician supervision of prehospital services is essential to ensure that the critical decision to resuscitate in the field or to transfer the patient rapidly is made swiftly and correctly.

Policy H-35.973 supports the formulation of clearer definitions of the scope of practice of physician extenders to include direct appropriate physician supervision and recommended guidelines for physician supervision to ensure quality patient care.

Policy H-35.989 broadly outlines that the PA should function under the direction of and supervision by a duly qualified licensed physician and that the care provided by the PA be in concert and guidance by the physician.

Policy H-160.947 presents the guidelines developed by the AMA for guiding an appropriately developed physician/PA practice and that the AMA will develop a plan for identifying and lobbying against laws that allow advanced practice nurses to provide medical care without the supervision of a physician.

Policy H-160.888 supports any individual, company, or other entity that establishes and/or operates UCCs adhere to principles which, in part, suggests that UCCs should be prohibited from using the word "emergency" or "ED" in their name, any of their advertisements, or to describe the type of care provided.

Policy D-130.958 seeks federal legislation or regulation prohibiting staffing ratios that do not allow for proper physician supervision of non-physician practitioners in the ED and supports all ED be staffed 24/7 by a qualified physician.

Policy D-35.985 outlines the advocacy of the AMA for physician led team-based care.

DISCUSSION

The Council recognizes that physician-led emergency care differs in scope, complexity, and depth from care provided by non-physician practitioners such as PAs and NPs. It also acknowledges that a growing number of EDs are not physician-led or lack on-site physician coverage around the clock. Rural and under-resourced facilities often face financial, recruitment, and retention challenges that make continuous physician coverage difficult. These pressures are contributing to facility closures, further limiting patients' access to care. Nonetheless, transparency remains essential. Patients seeking care at an ED should be clearly informed when a physician is not providing their care and when transfer to another hospital may be necessary for more complex treatment. Accordingly, the Council supports standardized ED descriptors that clearly identify each facility's level of on-site physician coverage and available services. It also recommends that facilities dedicated to emergency care without an on-site physician use standardized, real-time language that enables a prudent layperson to readily understand the physician coverage and services available. To further promote transparency, the Council supports requiring facilities without continuous on-site physician staffing to prominently disclose this fact through physical and online signage and in advertisements, consistent with FTC guidelines. The Council also supports community engagement and patient education to improve understanding of ED coverage and services and to help healthcare teams promote efficient, site-appropriate care. Finally, the Council recognizes the complexities of site-of-service payment, including the risk that emergency care may be improperly paid regardless of a facility's level of on-site physician coverage, and that facility terminology may confuse patients. To address these concerns, the Council supports limiting the terms "emergency department" and "emergency room" to facilities that meet EMTALA requirements and classifying any qualifying EMTALA-covered facility as an emergency place of service for billing purposes, regardless of its level of on-site physician coverage.

The AMA has longstanding policy on key aspects of this issue, and the Council recommends reaffirming several policies to reassert its position. Because emergency medicine is complex, the preferred model is full-time, on-site physician presence, which should be pursued whenever possible and feasible. However, the Council recognizes that workforce shortages and financial constraints may warrant limited rural exceptions, and that alternative models may be necessary to meet some communities' needs. Accordingly, the Council recommends reaffirming Policy H-130.929, which recognizes the AMA's preferred model of on-site physician presence in the ED whose primary duty is to provide care in that ED and supports state medical associations in developing appropriate limited rural exceptions. Additionally, the Council recognizes that an increasing number of facilities, including EDs, are substituting physicians with non-physician practitioners. The Council views this trend as concerning because physician-led care provides a level of training, scope, and clinical judgment that differs from care provided by non-physicians. As such, the Council recommends reaffirming Policy H-160.949, which opposes legislation allowing non-physician groups to engage in the practice of medicine without physician training or appropriate physician supervision, encourages state medical societies to oppose state legislation allowing non-physician groups to engage in the practice of medicine without physician training or appropriate physician supervision, vigorously supports and advocates for the requirement of appropriate physician supervision of non-

physician clinical staff in all areas of medicine, and states that the AMA will continue to work with constituent societies to educate the public regarding the differences in the scopes of practice and education of physicians and non-physician healthcare workers.

Furthermore, the Council recognizes the important role of physicians in the supervision of emergency care. Therefore, the Council recommends reaffirming Policy D-35.976, which advocates for the establishment and enforcement of legislation and/or regulations that ensure only physicians supervise the provision of emergency care services in an ED, and Policy D-130.958, which seeks federal legislation or regulation prohibiting staffing ratios that do not allow for proper physician supervision of non-physician practitioners in the ED. Lastly, the Council recognizes the vital role of smaller, financially challenged facilities that provide emergency services and does not seek to undermine their viability. Accordingly, the Council recommends reaffirming Policy H-240.958, which advocates prohibiting insurers from denying or reducing payment for medically necessary procedures based solely on the site of service, provided the procedure can be safely performed in that location.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed:

1. That our American Medical Association (AMA) support the development of standardized emergency department (ED) descriptors that reflect a facility's level of on-site physician coverage and available services, easily discernible by the prudent layperson. (New HOD Policy)

2. That our AMA recommend that emergency care facilities without a dedicated on-site physician utilize these standardized ED descriptors to promote truth and transparency for patients. (New HOD Policy)

3. That our AMA support:
    a. limiting the designations "emergency department" and "emergency room" to facilities that meet Emergency Medical Treatment and Labor Act (EMTALA) requirements and provide 24/7 coverage by a qualified physician who is immediately available in-person.
    b. allowing any EMTALA-covered facility that meets EMTALA requirements to be classified as an emergency place of service for billing purposes. (New HOD Policy)

4. That our AMA support requiring facilities without continuous on-site physician staffing to prominently disclose, through physical and online signage, that physicians are not continuously on duty and on-site; and that our AMA support requiring advertisements for such facilities to include the same disclosure, consistent with Federal Trade Commission guidelines. (New HOD Policy)

5. That our AMA support community engagement to improve the education of patients and allow other healthcare team members to promote efficient and site appropriate care. (New HOD Policy)

6. That our AMA reaffirm Policy H-130.929, which recognizes that the AMA's preferred model of emergency care is the on-site presence of a physician in the ED whose primary duty is to provide care in that ED and supports state medical associations in developing limited appropriate rural exceptions. (Reaffirm HOD Policy)

7. That our AMA reaffirm Policy D-35.976, which advocates for the establishment and enforcement of legislation and/or regulations that ensure only physicians supervise the provision of emergency care services in an ED. (Reaffirm HOD Policy)

8. That our AMA reaffirm Policy H-160.949, which opposes legislation allowing non-physician groups to engage in the practice of medicine without physician training or appropriate physician supervision, encourages state medical societies to oppose state legislation allowing non-physician groups to engage in the practice of medicine without physician training or appropriate physician supervision, vigorously supports and advocates for the requirement of appropriate physician supervision of non-physician clinical staff in all areas of medicine, and states that the AMA will continue to work with constituent societies to educate the public regarding the differences in the scopes of practice and education of physicians and non-physician healthcare workers. (Reaffirm HOD Policy)

9. That our AMA reaffirm Policy D-130.958, which seeks federal legislation or regulation prohibiting staffing ratios that do not allow for proper physician supervision of non-physician practitioners in the ED and supports all EDs be staffed 24 hours per day/7days per week by a qualified physician. (Reaffirm HOD Policy)

10. That our AMA reaffirm Policy H-240.958, which advocates to prohibit insurers from denying or reducing payment for a procedure based solely on the site of service in which it was performed, provided that the procedure is medically necessary and can safely be performed in that location. (Reaffirm HOD Policy)

Fiscal Note: Minimal

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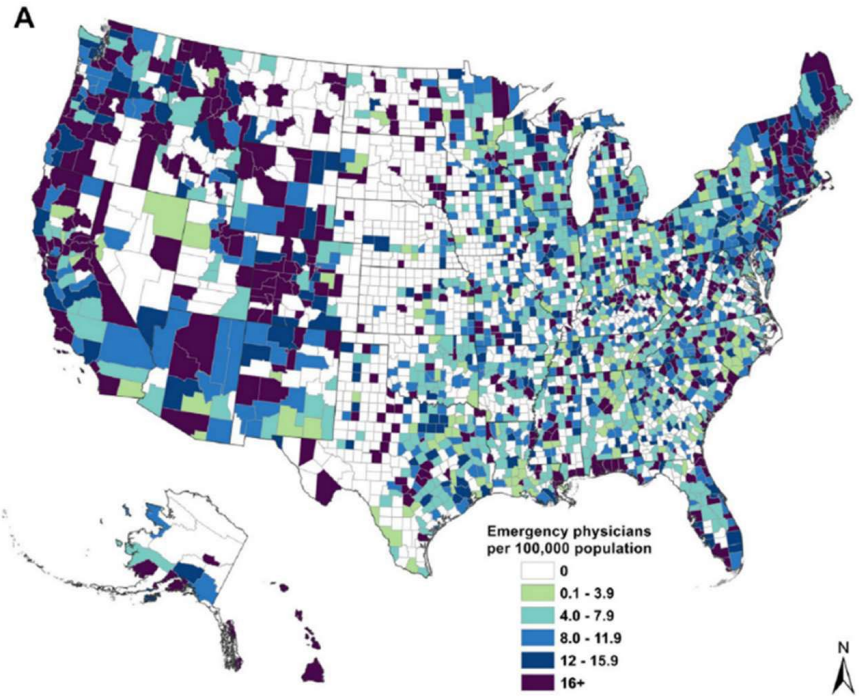
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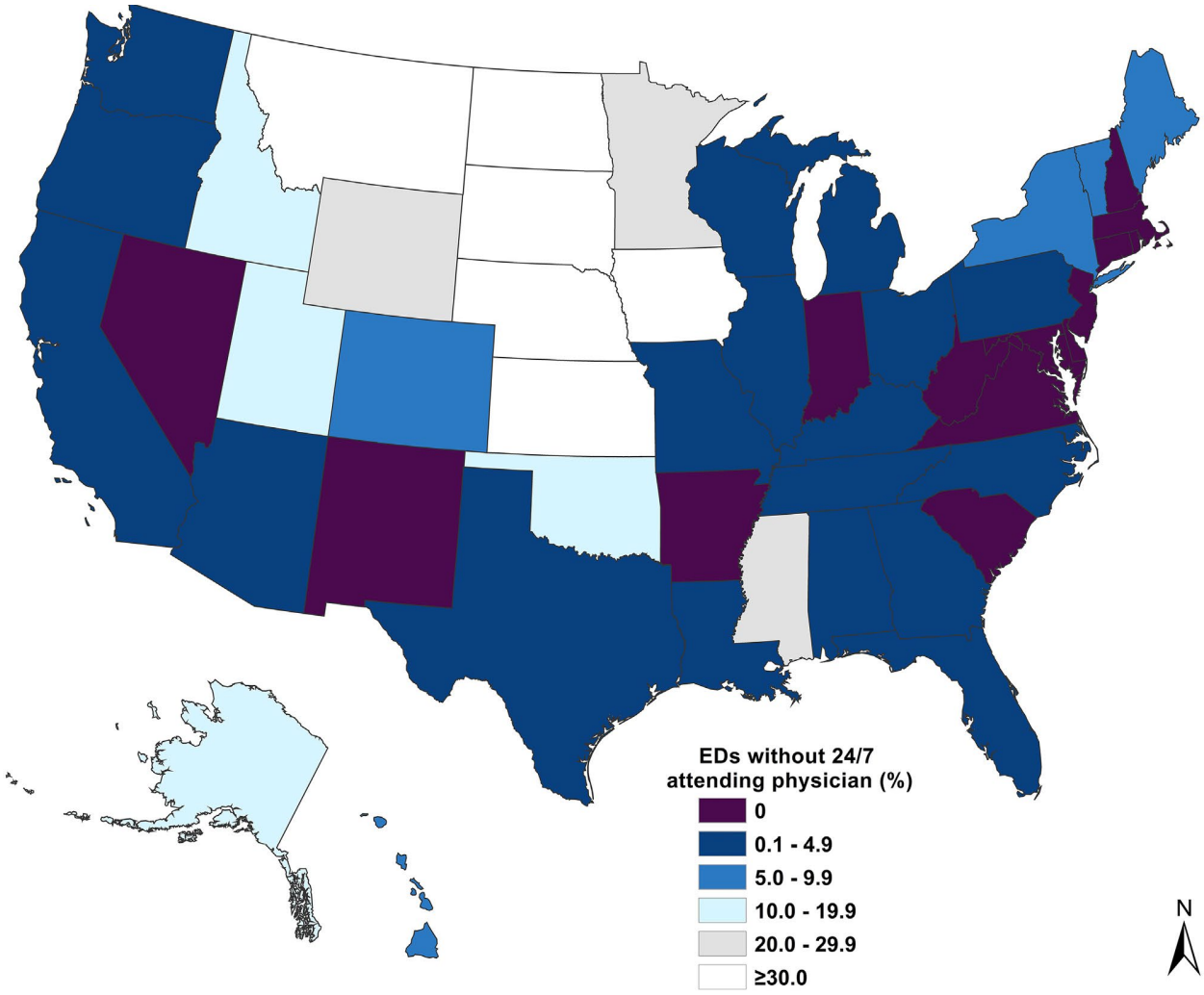
Appendix A

Density of emergency physicians across the country—emergency physicians per 100,000 population—includes physicians who are residency-trained or certified in emergency medicine and physicians trained in a nonemergency specialty. (*Supra* 47)



Appendix B

Percentage of US emergency departments without 24/7 attending physician coverage by state, 2022. (*Supra* 8)



Council on Medical Service Report 1-I-26
Transparency with the Term "Emergency Department"
Policy Appendix

On site Physician Requirements for Emergency Departments H-130.929

1. Our American Medical Association recognizes that the preferred model of emergency care is the on site presence of a physician in the emergency department (ED) whose primary duty is to provide care in that ED, and support state and federal legislation or regulation requiring that a hospital with an ED must have a physician on site and on duty who is primarily responsible for the emergency department at all times the emergency department is open.
2. Our AMA, in the pursuit of any legislation or regulation requiring the on site presence of a physician who is primarily responsible for care in the emergency department (ED), supports state medical associations in developing appropriate rural exceptions to such a requirement if, based on the needs of their states, the association chooses to pursue certain alternative supervision models for care provided in EDs in remote rural areas that cannot meet such a requirement due to workforce limitations, ensuring that exceptions only apply where needed. These exceptions shall preserve 24/7 physician supervision of the ED and provide for the availability of a physician to provide on site care.

(BOT Rep. 02, I-24; Reaffirmed in lieu of: Res. 213, A-25)

Promoting Supervision of Emergency Care Services in Emergency Departments by Physicians D-35.976

Our American Medical Association will advocate for the establishment and enforcement of legislation and/or regulations that ensure only physicians supervise the provision of emergency care services in an emergency department.
(Res. 218, A-23; Reaffirmed in lieu of: Res. 213, A-25)

Practicing Medicine by Non-Physicians H-160.949

1. Our American Medical Association urges all people, including physicians and patients, to consider the consequences of any health care plan that places any patient care at risk by substitution of a non-physician in the diagnosis, treatment, education, direction and medical procedures where clear-cut documentation of assured quality has not been carried out, and where such alters the traditional pattern of practice in which the physician directs and supervises the care given;
2. Our AMA continues to work with constituent societies to educate the public regarding the differences in the scopes of practice and education of physicians and non-physician health care workers.
3. Our AMA continues to actively oppose legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision.
4. Our AMA continues to encourage state medical societies to oppose state legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision.
5. Our AMA, through legislative and regulatory efforts, vigorously support and advocate for the requirement of appropriate physician supervision of non-physician clinical staff in all areas of medicine.
6. Our AMA opposes special licensing pathways for "assistant physicians" (i.e., those who are not currently enrolled in an Accreditation Council for Graduate Medical Education training program, or have not completed at least one year of accredited graduate medical education in the U.S).

(Res. 317, I-94; Modified by Res. 501, A-97; Appended: Res. 321, I-98; Reaffirmation A-99; Appended: Res. 240, Reaffirmed: Res. 708 and Reaffirmation A-00; Reaffirmed: CME Rep. 1, I-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: Res. 208, I-10; Reaffirmed: Res. 224, A-11; Reaffirmed: BOT Rep. 9, I-

11; Reaffirmed: Res. 107, A-14; Appended: Res. 324, A-14; Modified: CME Rep. 2, A-21; Reaffirmed in lieu of: Res. 213, A-25)

On site Emergency Care H-130.976
(1) The AMA reaffirms its policy endorsing the concept of appropriate medical direction of all prehospital emergency medical services. (2) The following factors should be considered by prehospital personnel in making the decision either to provide extended care in the field or to evacuate the trauma victim rapidly: (a) the type, severity and anatomic location of the injury; (b) the proximity and capabilities of the receiving hospital; (c) the efficiency and skill of the paramedic team; and (d) the nature of the environment (e.g., rural or urban). (3) Because of the variability of these factors, no single methodology or standard can be applied to all accident situations. Trauma management differs markedly between locales, settings, and types of patients receiving care. For these reasons, physician supervision of prehospital services is essential to ensure that the critical decision to resuscitate in the field or to transfer the patient rapidly is made swiftly and correctly.
(BOT Rep. N, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: CSAPH Rep. 01, A-17)

Scopes of Practice of Physician Extenders H-35.973
Our American Medical Association supports the formulation of clearer definitions of the scope of practice of physician extenders to include direct appropriate physician supervision and recommended guidelines for physician supervision to ensure quality patient care.
(Res. 213, A-02; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: BOT Rep. 7, A-21)

Physician Assistants H-35.989
1. Our American Medical Association opposes legislation to increase public funding for programs to train physician assistants and supports a careful reevaluation of the need for public funding at the time that present legislative authorities expire.
2. A physician assistant should provide patient care services only in accord with the medical practice act and other applicable state law, and such law should provide that the physician assistant's utilization by a physician or group of physicians be approved by the medical licensing board. A licensed physician or group of physicians seeking to utilize a physician assistant should submit to the medical licensing board an application for utilization that identifies: the qualifications and experience of the physician assistant, the qualifications and experience of the supervising physician and a description of their practice, and a description of the manner and the health care settings in which the assistant will be utilized, and the arrangements for supervision by the responsible physician. Such an application should also specify the number of physician assistants that the physician or group of physicians plans to employ and supervise. A physician assistant should be authorized to provide patient care services only so long as the assistant is functioning under the direction and supervision of a physician or group of physicians whose application for utilization has been approved by the medical licensing board. State medical licensing boards, in their review of applications for utilization of a physician assistant, should take special care to insure that the proposed physician assistant functions not be of a type which:
    a. would unreasonably expand the professional scope of practice of the supervising physician;
    b. cannot be performed safely and effectively by the physician assistant, or
    c. would authorize the unlicensed practice of medicine.
3. The physician assistant should function under the direction of and supervision by a duly qualified licensed physician. The physician must always maintain the ultimate responsibility to assure that high quality care is provided to every patient. In discharging that responsibility, the physician should exercise that amount of control or supervision over a physician assistant which is appropriate for the maintenance of quality medical care and in accord with existing state law and the rules and regulations of the medical licensing authority. Such supervision in most settings includes the personal

presence or participation of the physician. In certain instances, such as remote practice settings, where the physician assistant may function apart from the supervising physician, such remote function (if permitted by state law) should be approved by the state medical licensing board on an individual basis. Such approval should include requirements for regular reporting to the supervising physician, frequent site visits by that physician, and arrangements for immediate communication with the supervising physician for consultation at all times. The physician assistant may serve the patients of the supervising physician in all types of health care settings, including but not limited to: physician's office, ambulatory or outpatient facility, clinic, hospital, patient's home, long-term care facility or nursing home. The state medical licensing board should determine on an individual basis the number of physician assistants that a particular physician may supervise or a group of physicians may employ.

4. While it is preferable and desirable that the physician assistant be employed by a physician or group of physicians so as to ensure appropriate physician supervision in the interests of the patient, where a physician assistant is employed by a hospital, the physician assistant must provide patient care services in accordance with the rules and procedures established by the organized medical staff for utilization of physician-employed physician assistants functioning in that institution, and under the direction and supervision of a designated physician who has been approved by the state medical licensing board to supervise that physician assistant in accordance with a specific utilization plan and who shall be directly responsible as the attending physician for the patient care services delegated to their physician assistant.
5. Our AMA opposes legislation or proposed regulations authorizing physician assistants to make independent medical judgments as to the drug of choice for an individual patient.
6. In view of an announced interest by HHS in considering national legislation which would override state regulatory systems for health manpower, the AMA recommends that present Association policy supporting state prerogatives in this area be strongly reaffirmed.
7. Our AMA opposes legislation or regulation that allows physician assistant independent practice.

(BOT/CME/CMS Joint Rep., I-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmation A-99; Reaffirmed: CME Rep. 2, A-09; Reaffirmed: BOT Rep. 9, I-11; Appended: Res. 230, I-17; Reaffirmed: BOT Rep. 12, A-23; Reaffirmed: Res. 208, I-23; Modified: Speakers Rep. 02, I-24)

Physician Assistants and Nurse Practitioners H-160.947
Our American Medical Association will develop a plan to assist the state and local medical societies in identifying and lobbying against laws that allow advanced practice nurses to provide medical care without the supervision of a physician.

The suggested Guidelines for Physician/Physician Assistant Practice are adopted to read as follows (these guidelines shall be used in their entirety):

1. The physician is responsible for managing the health care of patients in all settings.
2. Health care services delivered by physicians and physician assistants must be within the scope of each practitioner's authorized practice, as defined by state law.
3. The physician is ultimately responsible for coordinating and managing the care of patients and, with the appropriate input of the physician assistant, ensuring the quality of health care provided to patients.
4. The physician is responsible for the supervision of the physician assistant in all settings.
5. The role of the physician assistant in the delivery of care should be defined through mutually agreed upon guidelines that are developed by the physician and the physician assistant and based on the physician's delegatory style.
6. The physician must be available for consultation with the physician assistant at all times, either in person or through telecommunication systems or other means.

7. The extent of the involvement by the physician assistant in the assessment and implementation of treatment will depend on the complexity and acuity of the patient's condition and the training, experience, and preparation of the physician assistant, as adjudged by the physician.
8. Patients should be made clearly aware at all times whether they are being cared for by a physician or a physician assistant.
9. The physician and physician assistant together should review all delegated patient services on a regular basis, as well as the mutually agreed upon guidelines for practice.
10. The physician is responsible for clarifying and familiarizing the physician assistant with their supervising methods and style of delegating patient care.

(BOT Rep. 6, A-95; Reaffirmed: Res 240 and Reaffirmation A-00; Reaffirmed: Res. 213, A-02; Modified: CLRPD Rep. 1, A-03; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: Joint CME-CMS Rep., I-12; Reaffirmed: BOT Rep. 16, A-13; Reaffirmed: Res. 206, I-22; Reaffirmed: CMS Rep. 09, A-23; Modified: Speakers Rep. 02, I-24; Reaffirmed in lieu of: Res. 213, A-25)

Guidelines for Integrated Practice of Physician and Nurse Practitioner H-160.950

Our American Medical Association endorses the following guidelines and recommends that these guidelines be considered and quoted only in their entirety when referenced in any discussion of the roles and responsibilities of nurse practitioners:

1. The physician is responsible for the supervision of nurse practitioners and other advanced practice nurses in all settings.
2. The physician is responsible for managing the health care of patients in all practice settings.
3. Health care services delivered in an integrated practice must be within the scope of each practitioner's professional license, as defined by state law.
4. In an integrated practice with a nurse practitioner, the physician is responsible for supervising and coordinating care and, with the appropriate input of the nurse practitioner, ensuring the quality of health care provided to patients.
5. The extent of involvement by the nurse practitioner in initial assessment, and implementation of treatment will depend on the complexity and acuity of the patients' condition, as determined by the supervising/collaborating physician.
6. The role of the nurse practitioner in the delivery of care in an integrated practice should be defined through mutually agreed upon written practice protocols, job descriptions, and written contracts.
7. These practice protocols should delineate the appropriate involvement of the two professionals in the care of patients, based on the complexity and acuity of the patients' condition.
8. At least one physician in the integrated practice must be immediately available at all times for supervision and consultation when needed by the nurse practitioner.
9. Patients are to be made clearly aware at all times whether they are being cared for by a physician or a nurse practitioner.
10. In an integrated practice, there should be a professional and courteous relationship between physician and nurse practitioner, with mutual acknowledgment of, and respect for each other's contributions to patient care.
11. Physicians and nurse practitioners should review and document, on a regular basis, the care of all patients with whom the nurse practitioner is involved. Physicians and nurse practitioners must work closely enough together to become fully conversant with each other's practice patterns.

(CMS Rep. 15 - I-94; BOT Rep. 6, A-95; Reaffirmed: Res. 240, A-00; Reaffirmation A-00; Reaffirmed: BOT Rep. 28, A-09; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: Joint CME-CMS Rep., I-12; Reaffirmed: BOT Rep. 16, A-13; Reaffirmed: BOT Rep. 09, A-23)

Support for Physician Led, Team Based Care D-35.985

1. Our American Medical Association reaffirms, will proactively advance at the federal and state level, and will encourage state and national medical specialty societies to promote policies H-35.970, H-

35.973, H-35.974, H-35.988, H-35.989, H-35.992, H-35.993, H-160.919, H-160.929, H-160.947, H-160.949, H-160.950, H-360.987, H 405.969 and D-35.988.

2. Our AMA will identify and review available data to analyze the effects on patients? access to care in the opt-out states (states whose governor has opted out of the federal Medicare physician supervision requirements for anesthesia services) to determine whether there has been any increased access to care in those states.
3. Our AMA will identify and review available data to analyze the type and complexity of care provided by all non-physician providers, including CRNAs in the opt-out states (states whose governor has opted out of the federal Medicare physician supervision requirements for anesthesia services), compared to the type and complexity of care provided by physicians and/or the anesthesia care team.
4. Our AMA will advocate to policymakers, insurers and other groups, as appropriate, that they should consider the available data to best determine how non-physicians can serve as a complement to address the nation's primary care workforce needs.
5. Our AMA will continue to recognize non-physician providers as valuable components of the physician-led health care team.
6. Our AMA will continue to advocate that physicians are best qualified by their education and training to lead the health care team.
7. Our AMA will call upon the Robert Wood Johnson Foundation to publicly announce that the report entitled, "Common Ground: An Agreement between Nurse and Physician Leaders on Interprofessional Collaboration for the Future of Patient Care" was premature; was not released officially; was not signed; and was not adopted by the participants.

(BOT Rep. 9, I-11; Reaffirmed: CMS Rep. 1, A-12; Reaffirmed: CMS Rep. 07, A-17; Reaffirmed: CMS Rep. 10, A-19; Reaffirmed: CMS Rep. 6, A-21)

Staffing Ratios in the Emergency Department D-130.958

1. Our American Medical Association will seek federal legislation or regulation prohibiting staffing ratios that do not allow for proper physician supervision of non-physician practitioners in the Emergency Department.
2. Our AMA supports that all Emergency Departments be staffed 24-7 by a qualified physician.

(Res. 204, A-24; Reaffirmed in lieu of: Res. 213, A-25)

Urgent Care Centers H-160.888

1. Our American Medical Association supports that any individual, company, or other entity that establishes and/or operates urgent care centers (UCCs) adhere to the following principles:
    a. UCCs must help patients who do not have a primary care physician or usual source of care to identify one in the community.
    b. UCCs must transfer a patient’s medical records to their primary care physician and to other health care providers, with the patient’s consent, including offering transfer in an electronic format if the receiving physician is capable of receiving it.
    c. UCCs must produce patient visit summaries that are transferred to the appropriate physicians and other health care providers in a meaningful format that prominently highlight salient patient information.
    d. UCCs should work with primary care physicians and medical homes to support continuity of care and ensure provisions for appropriate follow-up care are made.
    e. UCCs should use local physicians as medical directors or supervisors and they should be clearly identified and posted.
    f. UCCs should have a well-defined scope of clinical services, communicate the scope of services to the patient prior to evaluation, provide a list of services provided by the center, provide the qualifications of the on site health care providers prior to services being rendered, describe the degree of physician supervision of any non-physician practitioners, and include in any marketing materials the qualifications of the on site health care providers.

g. UCCs should be prohibited from using the word “emergency” or “ED” in their name, any of their advertisements, or to describe the type of care provided.

2. Our AMA will work with interested stakeholders to improve attribution methods such that a physician is not attributed to spending for services that a patient receives at an UCC if the physician could not reasonably control or influence that spending.
3. Our AMA supports patient education including notifying patients if their physicians are providing extended hours care, including weekends, informing patients what to do in urgent situations when their physician may be unavailable, informing patients of the differences between an urgent care center and an emergency department, asking for their patients to notify their physician or usual source of care before seeking UCC services, and encouraging patients to familiarize themselves with their anticipated out-of-pocket financial responsibility for UCC services.

(CMS Rep. 6, A-21; Modified: Speakers Rep. 02, I-24)