



911

# FHA Task Force on Addressing the Crisis in Emergency Care

December 2005



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## FHA Task Force on

### Addressing the Crisis in Emergency Care Services

December 2005

#### EXECUTIVE SUMMARY

Florida is facing a crisis in providing emergency care to the citizens of Florida. Multiple challenges face our hospital emergency departments (EDs) on a daily, if not hourly, basis. These include providing on-call specialty care coverage, increased volumes and backlogs of patients requiring care, overcrowding that causes delays in patient care delivery, providing emergency obstetrical care, use of the ED for routine care, and the delays in care for emergency medical services (EMS) due to ambulance diversion and/or transfers.

To address the crisis in emergency care services, the Florida Hospital Association (FHA) convened a task force to explore the problems in the delivery of emergency care services and develop recommendations on how to solve those problems. Based on the task force findings, Florida's emergency care challenges stem from several things:

- **Increased patient volumes** both in the ED and the inpatient setting fueled by Florida's growing and aging population, significant number of tourists and retired, seasonal residents. Additionally, lack of community mental health services is placing an additional burden on Florida's acute care hospitals and EDs.
- **Lack of hospital capacity**, impacted by fewer hospital beds, sicker patients requiring specialized beds, fewer hospital EDs, and shortages of nurses and other health professionals to care for patients.
- **Shortages of physicians taking ED on-call coverage** due to physician supply not keeping up with demand, physicians no longer providing clinical care, physicians practicing in outpatient settings and no longer needing hospital privileges, stagnant medical school enrollment, medical students leaving the state for their residency programs, challenges in obtaining licenses, hospital privileges, and contracts with health plans. Shortages of specialists, such as ENT, neurosurgery, hand surgery, and orthopedic surgery, have reduced the supply of those willing to cover the ED.
- **Medical liability issues** impact the reluctance of physicians to take on-call coverage because of the increased risk of litigation.
- **Florida's growing uninsured and under-insured population** who rely on the ED as their "safety net" or source of primary care.
- **Use of the ED for non-emergencies** because of convenience, delays in getting appointments with physicians, and lack of alternative sites for after-hours, non-emergency care.
- **Effective use of EMS** constrained by state laws that require all patients be taken to the hospital ED if they request it, even if the patient might need minor treatment or could be treated in an alternative care site. The EMS community is also facing shortages of paramedics and emergency medical technicians (EMTs) as demand for their services increases.

- **Antiquated regulations at the state level**, which include lack of clarity in the hospital ED licensure laws for requirements for both service capability and a state exemption; EMS laws requiring transport of patients regardless of whether the patient actually requires emergency care and limiting the type of care paramedics may provide in the field; Baker Act receiving facilities being ineligible for reimbursement from the Department of Children and Families (DCF); and a lengthy process to file for a Limited License for those physicians interested in volunteering in clinics that serve the uninsured.
- **Regulatory ambiguity at the federal level** in the Emergency Medical Treatment and Active Labor Act (EMTALA) which discourages innovative ways to treat the patient. Hospitals are fearful of EMTALA violations despite data that show there are very few complaints and only a fraction of those are violations, most of which are documentation issues.

### **Recommendations**

After several meetings and conference calls, the FHA Task Force agreed upon the following recommendations as potential strategies for easing the problems in Florida's emergency care system.

1. Ease overcrowding in hospital EDs:
  - a. Maximize the effective use of the hospital ED.
    - 1) Expand chapter 401, F.S., the EMS Scope of Practice, to permit EMTs and paramedics to treat patients not requiring hospital emergency care in the field.
    - 2) Modify chapter 401, F.S., to allow EMS to transport patients, under the supervision of the EMS medical director, to the most appropriate licensed setting for the patients' needs. These facilities must agree to treat all patients regardless of their ability to pay. Hospital-based ambulances would continue to comply with EMTALA regulations.
    - 3) Consider using physician assistants (PAs) or Advanced Registered Nurse Practitioners (ARNPs) in conjunction with EMS to treat patients not requiring emergency care.
    - 4) Encourage physicians, county health departments, and federally qualified community health centers (FQHCs) to offer extended office hours to their patients.
    - 5) Increase the availability of alternative sites for non-emergency care.
    - 6) Offer "bridge" antibiotic programs to avoid ED visits for medications.
    - 7) Educate the public and provide information regarding alternatives to the ED and the potential out-of-pocket cost differences.
    - 8) Educate physicians as to the availability of other care sites and incentivize them not to inappropriately use the ED.
    - 9) Work with health plans to educate their members on alternative sites of care for non-emergency conditions.
    - 10) Explore community case management programs through county health departments, hospitals, and EMS to better manage patients frequently using the hospital ED for nonemergent care.
    - 11) Identify a master list of urgent care centers.
2. Reduce backlogs in the ED:
  - a. Ensure that EMS patients are off-loaded to the hospital ED as quickly as possible.
    - 1) Encourage prompt off-load of EMS patients by designating a person in the ED to be responsible for ambulance receiving.
    - 2) Change the scope of practice to allow EMS to help with off-loading patients in the hospital ED subject to each hospital's protocol.
    - 3) Develop regional dispatch programs to better coordinate patient transportation.

- 4) Implement a real-time communication system which allows EMS, hospitals, and emergency physicians to know the availability of services, current capacity, and on-call specialties at each hospital.
  - b. Explore ways of improving the medical screening process.
    - 1) Educate hospitals on how registered nurses and other personnel could be used to provide medical screening exams in the ED.
  - c. Promote innovative strategies to increase patient throughput in the ED.
    - 1) Implement programs such as a hospital “bed czar” to oversee the demand and resource needs for the entire hospital.
    - 2) Identify processes to minimize ED patient wait times for admission to hospital or a critical care bed.
    - 3) Identify best practices for defining patients requiring critical care plans.
    - 4) Encourage each hospital to develop an “ED overcapacity crisis plan.”
    - 5) Use hospitalists, internists, and PAs to manage the inpatient stay.
    - 6) Work with medical staff to ensure timely patient discharge or transfers.
    - 7) Explore creating alternative areas in which to discharge patients no longer needing acute care.
    - 8) Evaluate standing orders for consults to determine appropriateness.
  - d. Ensure there is an adequate supply of nurses, paramedics, and allied health professionals to take care of Florida’s growing and aging population.
    - 1) Develop and implement equivalency measures to allow Florida to streamline the licensure process between states for nurses, paramedics, and other allied health professionals.
    - 2) Expand funding of Florida nursing school programs, nurse faculty positions, and allied health training programs such as radiology and ultrasound technologists.
3. Ease shortage of physicians willing to take ED call:
    - a. Increase the supply of physicians.
      - 1) Require the medical licensure boards to expand and enhance data on physicians to allow assessment of physician characteristics, medical specialty, and practice settings.
      - 2) Mandate that the Board of Medicine monitor gaps in the availability of specialties.
      - 3) Increase state funding for residency programs.
      - 4) Develop strategies, such as incentives or grants, to encourage Florida medical school graduates to stay in Florida.
      - 5) Consider using physicians with medical degrees without a Florida license as a “house” physician.
      - 6) Modify requirements for limited licenses to permit a more expedited application and licensure process for physicians wanting to volunteer to help the uninsured.
      - 7) Streamline hospital and health plan credentialing processes to expedite granting of privileges to newly licensed and out-of-state physicians interested in practicing in Florida.
    - b. Encourage licensed physicians to take ED call.
      - 1) Explore the option of community-based ED call coverage to determine the feasibility and whether antitrust exemptions are necessary to implement.
      - 2) Explore potential revenue sources to provide funding to those hospitals and physicians treating uninsured patients in the ED.
      - 3) Develop data to create a litigation immunity zone for emergency services to protect EMS, EMS medical directors, hospitals, and physicians.
  4. Modernize regulations to reflect the changing dynamics of healthcare:
    - a. Maintain state laws but modify to reduce some of the confusion with the Florida Access to Care laws.

- 1) Educate hospitals on the current capability, exemption, and complaint requirements under state law.
  - 2) Modify the Agency for Health Care Administration (AHCA) form for exemptions to change the requirement to seek local community transfer agreements from hospitals in a 50-mile radius to either the five closest hospitals or all hospitals within a 10-mile range.
  - 3) Analyze the state's inpatient database to determine the extent of hospitals' problems with providing services on an emergency basis.
  - 4) Evaluate the impact of the current public policy that encourages more specialties to function outside the hospital and not be available for ED coverage.
  - 5) Expand the Baker Act to allow private hospitals to be eligible for reimbursement from DCF.
  - 6) Develop guidelines for crisis stabilization units (CSUs) to require a mental health and medical screening exam prior to leaving the CSU and to call ahead to the ED to make arrangements prior to transfer to a hospital ED.
  - 7) Increase funding of community mental health services to minimize the reliance on acute care hospitals to treat these patients.
- b. EMTALA Interpretative Guidelines should be modified to reflect the current healthcare environment.
- 1) Modify the EMTALA Interpretative Guidelines to either encourage, or at least not discourage, hospitals that want to create innovative on-call coverage.
  - 2) Reevaluate the original intent of the law and allow more flexibility in where patients are treated, including facilities outside the hospital.
  - 3) Change the 23/90-day termination process to permit more due process before threatening to publicize the alleged violation or withdrawing Medicare certification based on the alleged violation.

## **INTRODUCTION**

Florida is facing a crisis in providing emergency care to its citizens. Multiple challenges face our hospital emergency departments (EDs) on a daily, if not hourly, basis. These include providing on-call specialty care coverage, increased volumes of patients requiring care, overcrowding that causes delays in patient care delivery, providing emergency obstetrical care, use of the ED for routine care, a shortage of qualified nursing and support staff, and the delays in access to care from emergency medical services (EMS) due to ambulance diversion, delays at the ED, and transfers.

Emergency medical care is the most critical access point to our healthcare delivery system. Floridians want assurance that trained, medical experts are available 24 hours a day, seven days a week. Many lives would be lost without the availability of emergency and trauma care in local communities. EMS and EDs serve as the first line of response in a natural or man-made disaster and ensure guaranteed access for all those who need care, regardless of their ability to pay.

While the challenge of providing emergency care services is a national issue, the problem in Florida is particularly acute given the medical liability climate, the growing number of uninsured and underinsured, the increased demand for emergency services due to a growing and aging population, the nursing shortage, and the lack of hospital capacity. Solving or easing these problems requires a coordinated approach from all the stakeholders involved in providing, regulating or paying for emergency care services.

## FHA TASK FORCE

To address the crisis in emergency care services, the Florida Hospital Association (FHA) convened a task force to explore the problems in the delivery of emergency care services and to develop recommendations on how to solve those problems. The task force included representatives from each of the key stakeholder groups. The individual members of the task force include:

### **Task Force Chair:**

Chris Finton, MD Health First, Melbourne

### **Agency for Health Care Administration:**

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Jeffrey N. Gregg Bureau Chief of Health Facility Regulation

### **Emergency Medical Services:**

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Joe Nelson, DO Department of Health-State EMS Medical Director  
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Rick Slevinski, MD Sacred Heart Health System

### **Florida Academy for Healthcare Attorneys:**

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### **Florida College of Emergency Physicians:**

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### **Florida Emergency Nurses Association:**

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### **Florida Medical Association:**

Fred Whitson Florida Medical Association

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Roger Howell, DO Lee Memorial Hospital, Ft. Myers  
David Katzin, MD Tenet HealthSystem  
Mark Vaalar, MD St. Joseph's Hospital, Tampa

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Marcia Gomez, MD Humana, Inc.  
Steve Lee, MD Humana, Inc.  
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Denise Barnett Charlotte Regional Medical Center  
Ken Bradley Florida Hospital Winter Park  
Rick Brown Doctor's Memorial Hospital, Perry  
Wayne Chutkan Mt. Sinai Medical Center, Miami Beach  
Paul Clark Munroe Regional Medical Center, Ocala  
Tony Degina Plantation General Hospital, Plantation  
Diane Godfrey Florida Hospital  
Val Jackson Columbia Hospital, West Palm Beach  
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Zeff Ross Memorial Hospital West, Pembroke Pines

**FHA Staff**

Bill Bell  
Kim Streit

**FCEP Staff**

Beth Brunner

General Counsel  
VP/Health Care Research and Information Services

Chief Executive Officer

The objectives of the task force were to:

1. Identify the problems and challenges impacting hospital EDs in Florida;
2. Examine and make recommendations for standardizing the AHCA process for granting exemptions for specialty care coverage, including reevaluating or auditing exemptions;
3. Recommend potential changes to the Emergency Medical Treatment and Active Labor Act (EMTALA), the Florida Access to Care law, and other regulations that might need to be addressed to ease the problem;
4. Evaluate what additional data might need to be collected to gain a better understanding of the problem/issues;
5. Explore what hospitals in Florida and other parts of the country have done to address the issues of providing emergency care;
  - a. What worked
  - b. What didn't work and why
6. Develop and disseminate best practices on specialty care coverage and efficient ED care;
7. Discuss methods for educating the public on the appropriate use of the ED and proper use of 911/EMS;
8. Evaluate medical staff bylaws regarding exemptions from ED on-call coverage; and
9. Explore public funding (tax revenues, fines/penalties) for ED on-call coverage.

The task force held three meetings and five conference calls to identify potential strategies to address the problems facing emergency medical care in Florida. This report describes the scope of the problems facing Florida's EDs and potential solutions for easing those problems.

## **TASK FORCE FINDINGS**

The task force identified and discussed the problems affecting the delivery of emergency care in Florida. Understanding the underlying problems was an important component of identifying potential strategies. Based on the task force findings, Florida's ED issues stem from several things:

- Increased volume of patients
- Lack of hospital capacity
- Shortages of nursing, EMS, and other health professionals
- Shortages of physicians taking on-call coverage
- Effective use of EMS
- Medical liability issues
- Growing number of uninsured and under-insured Floridians
- Use of the ED for non-emergencies
- Lack of available alternative care sites
- Antiquated and ambiguous regulations – state and federal

Additional references on these issues can be found in the Appendix.

## Increased Volume of Patients

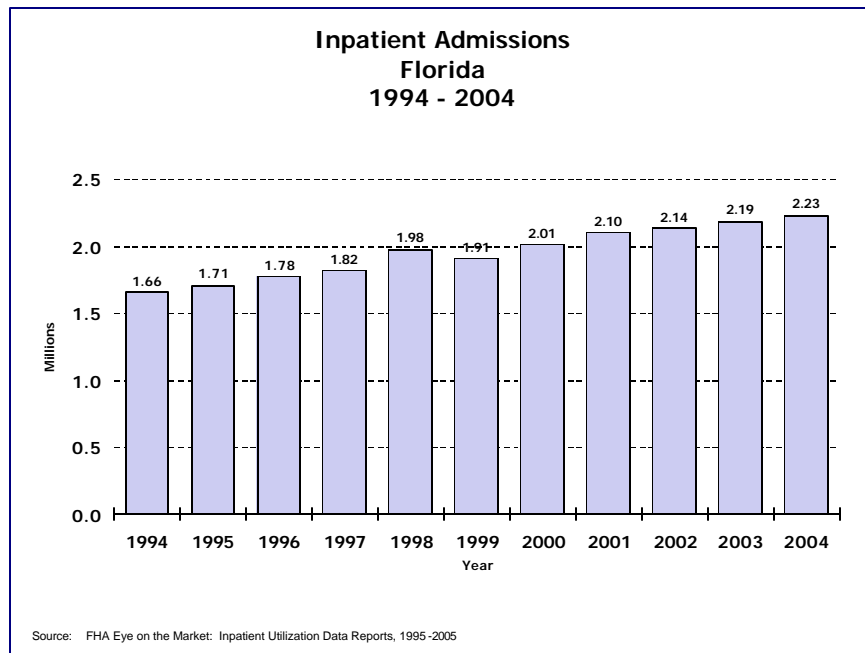
Florida is the fourth largest state and continues to be one of the fastest growing in the nation. Since 2000, Florida's population grew 12 percent and is expected to grow another 10 percent between 2005 and 2010. Almost one-fifth of Florida's population, or three million residents, is 65 years or older. Florida has the highest percentage of elderly than any state in the nation.

Publicly available population estimates do not include the number of seasonal residents, mostly retirees, who live in Florida for part of the year. In addition to Florida's growing population and the seasonal residents, approximately 79.8 million tourists visit the state each year.<sup>1</sup>

### More People are Using the Hospitals

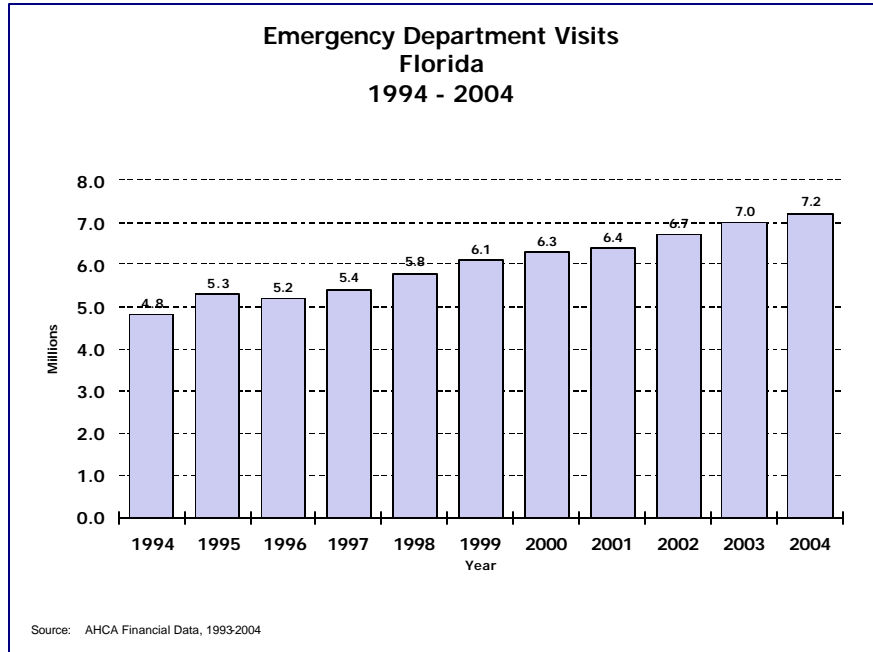
With 17.9 million residents, the highest percentage of elderly in the country, the large tourist population, foreign visitors and the seasonal residents, the demand for healthcare services in Florida continues to grow. Florida's elderly population places additional demands on Florida's healthcare system as people tend to use more healthcare services as they get older.

In 2004, Florida hospitals treated over 2.2 million inpatients, an increase of 34 percent since 1994.<sup>2</sup> In addition to total population growth accounting for increased hospital admissions, the data also show that the use of hospital inpatient services has increased. Over the past ten years, admissions per thousand grew five percent to 127.3 in 2004. These numbers only reflect patients that were "admitted to the hospital" Those that are in the hospital for "observation" but not officially admitted place additional demands on hospital resources. Unfortunately, there are no public data on the number of observation patients so the total demands on hospital staff and beds cannot be provided.



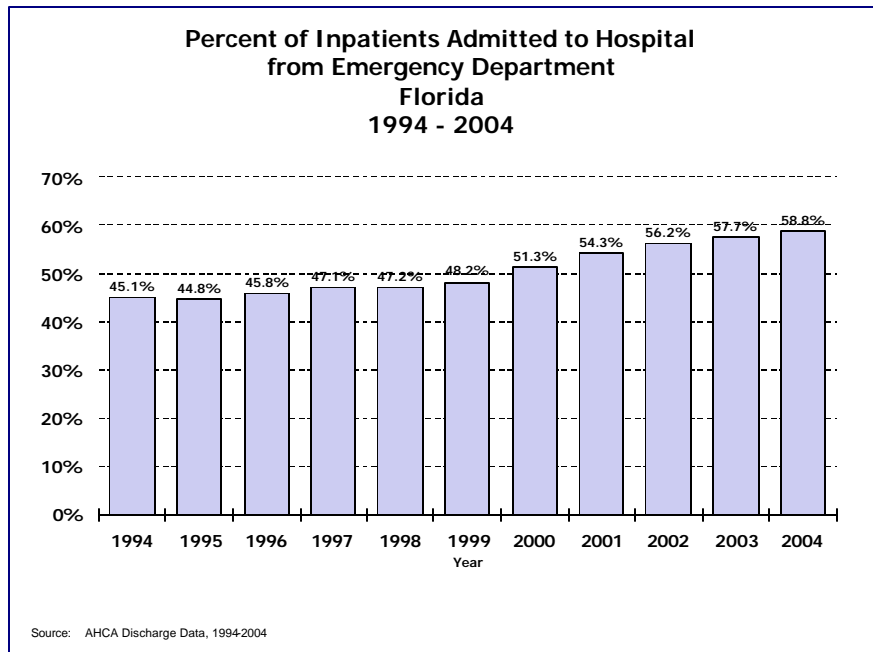
### Increased Demand for ED Services

Visits to hospital EDs grew even faster, reaching 7.2 million in 2004. The growth in ED visits is not only attributable to population growth, but increased use of the ED by individuals as well. Between 1994 and 2004, ED visits per thousand increased from 348 visits per thousand population in 1994 to 410 visits per thousand population in 2004.



The impact of this increase in ED use can be seen in the growth in the number of patients treated in Florida’s EDs on a daily basis. In 2004, almost 20,000 patients were treated in Florida’s EDs each day, up from just over 13,000 ED patients per day seen in 1994. Thus, in 2004, Florida hospitals treated 7,000 more ED patients daily than they did ten years ago, reflecting a 50 percent increase in daily ED volume. Hospital EDs treat, on average, three times as many patients as are admitted to hospitals on a daily basis.

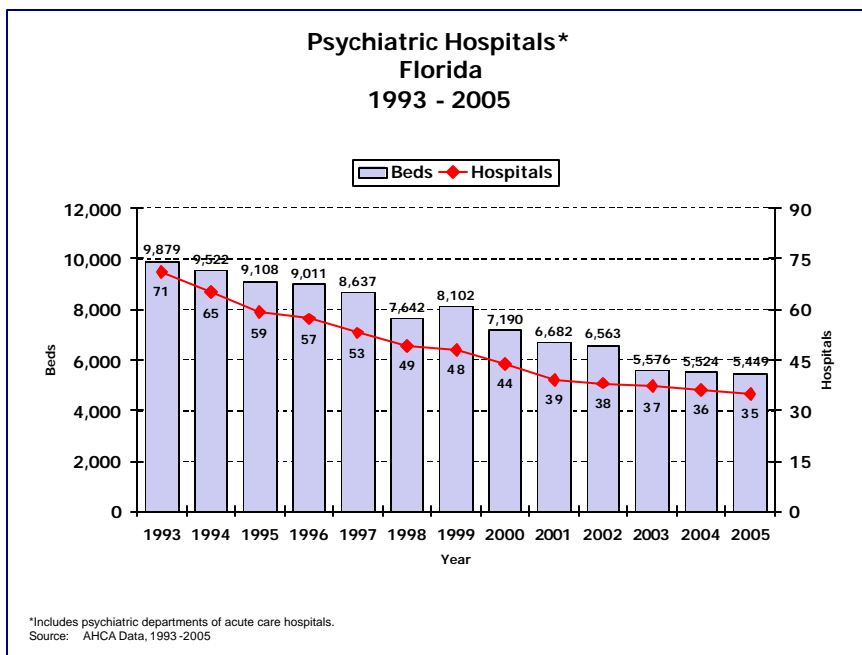
More and more patients are first seen in the ED prior to being admitted. Between 1994 and 2004, the number of inpatients admitted through the ED grew 74.4 percent. Almost 60 percent of hospital admissions, approximately 1.3 million patients, were admitted through the ED. This compares to 45 percent in 1994.



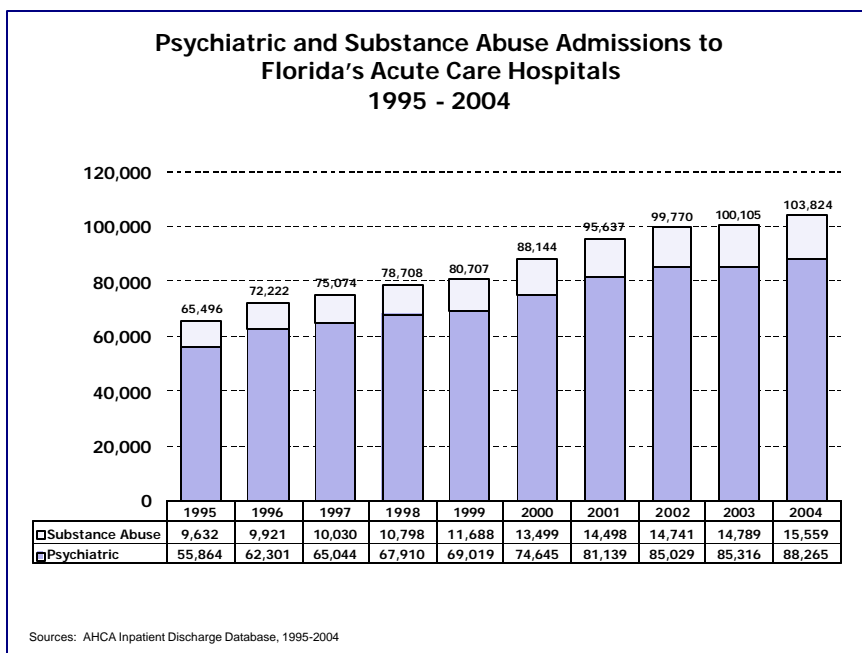
For many patients, the ED is their main access point to the hospital. An FHA study, *Care for Uninsured Non-Citizens: A Growing Burden on Florida's Hospitals*,<sup>3</sup> found that almost all of the uninsured noncitizens treated in Florida's hospitals in 2002 presented to the ED prior to hospital admission.

### Acute Care Hospitals See Increase in Psychiatric/Substance Abuse Patients

Lack of mental health services in the community is placing an additional burden on Florida's acute care hospitals and EDs. Since 1992, 36 psychiatric hospitals have closed in Florida, reflecting a loss of 4,430 psychiatric/substance abuse beds. Currently, there are 29 private psychiatric hospitals and five state mental health hospitals – less than half the number of psychiatric hospitals that were open ten years ago. There has been some increase in crisis stabilization units (CSUs), increasing from 48 CSUs in 1998 to 62 in 2004.

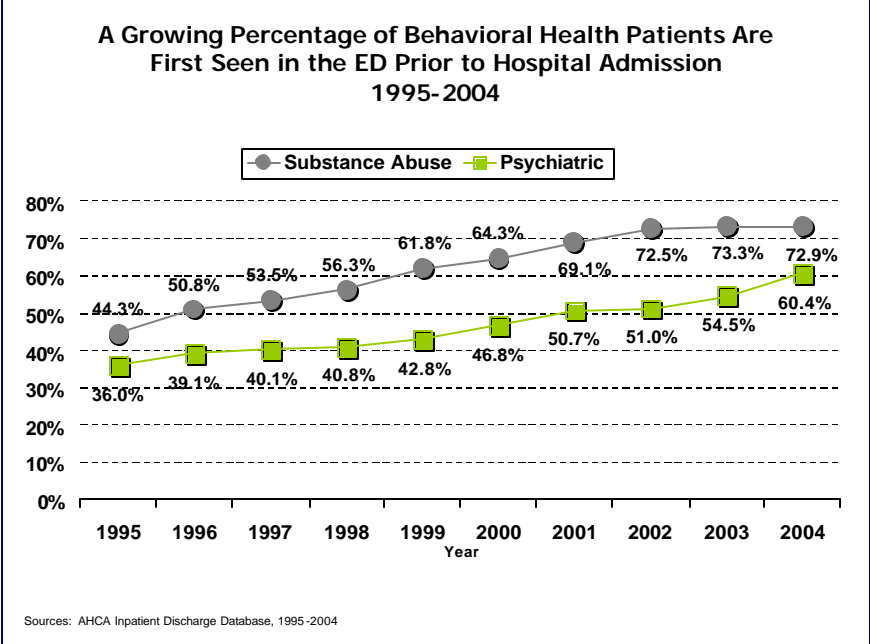


Due to the lack of psychiatric specialty hospitals, more and more psychiatric and substance abuse patients are being admitted to Florida's acute care hospitals. Between 1995 and 2004, Florida's acute care hospitals saw the number of psychiatric and substance abuse patients rise 59 percent. The volume of psychiatric admissions to acute care hospitals grew from 65,500 in 1995 to almost 104,000 patients in 2004.



In addition to the increased volume of psychiatric patients, the resource demands for these patients have grown. Shortages of mental health providers place additional time demands and burdens on the hospital ED to place psychiatric patients in specialized facilities. The use of hospital resources to care for these patients has also increased due to limited community services for psychiatric and substance abuse.

Florida’s EDs have felt this tremendous increase in psychiatric and substance abuse patients more than any area in the hospital. In 1995, less than half of the substance abuse patients and slightly more than one-third of the psychiatric patients were seen in the ED prior to admission. By 2004, almost three-fourths of the substance abuse patients and 60 percent of the psychiatric patients were first in the ED prior to admission.



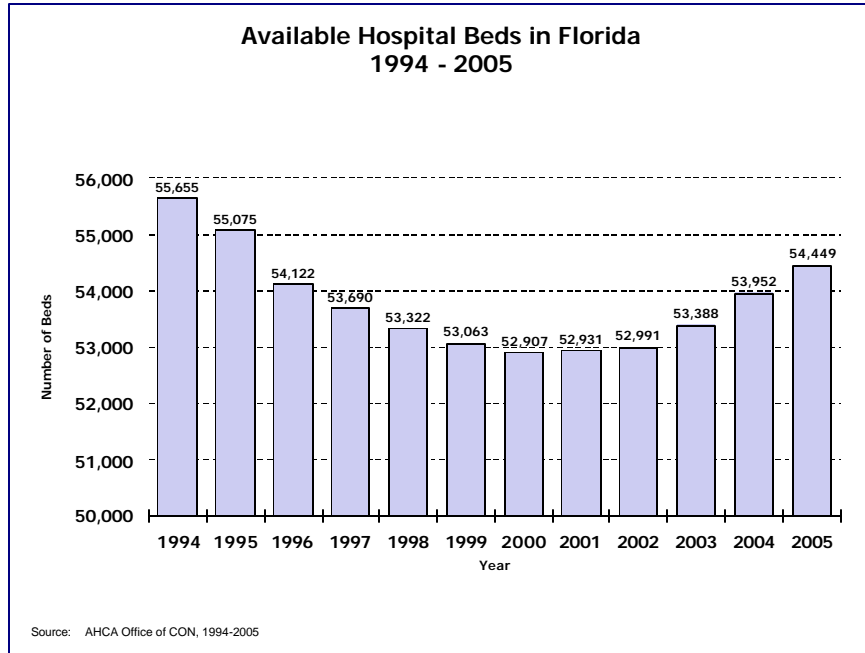
**Hospital EDs Serve as Backup to Freestanding Centers**

Hospital EDs serve as backup for freestanding healthcare centers, such as ambulatory surgery centers (ASCs) and outpatient cardiac catheterization laboratories. Thus, if a problem occurs during a procedure, the patient may be transferred immediately to the closest ED for acute care. In 2004, 1,367 ambulatory surgery patients being treated in freestanding, non-hospital affiliated ASCs were transferred to hospital EDs. During the same year, 479 patients using outpatient cardiac cath labs (four percent of the total patients receiving cardiac cath services in an outpatient facility) were transferred to hospital EDs.

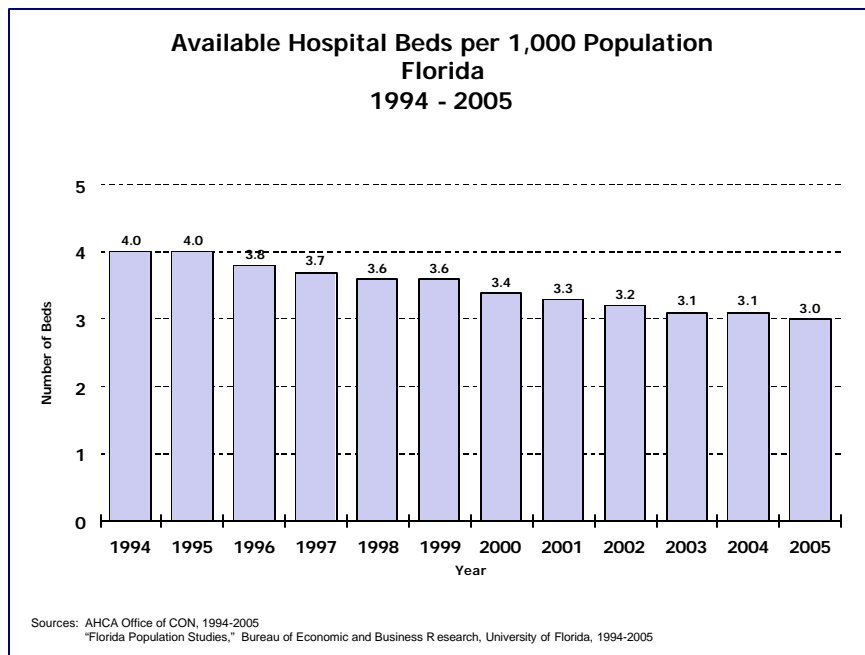
**Lack of Hospital Capacity**

**Fewer Hospital Beds**

Hospital capacity is dependent upon the number of available beds and the availability of nurses to staff those hospital beds. Despite population growth and increases in hospital use, the number of inpatient beds in Florida has diminished rather than expanded. In 2005, there were 54,449 available acute care beds, 1,206 fewer than in 1995. While Florida has added nine new acute care hospitals in the past ten years, thirteen acute care hospitals closed. The number of available beds is even further reduced due to staffing shortages.



Further evidence of the shrinking supply of hospital beds is the decline in hospital beds per thousand population. In 1994, Florida’s ratio of hospital beds to the population was 4.0 beds. By 2005, it had fallen to 3.0 beds. Florida’s significant volume of seasonal residents and out-of-state visitors spikes demand for a limited supply of beds, although these groups are not included in the bed-to-population ratio.



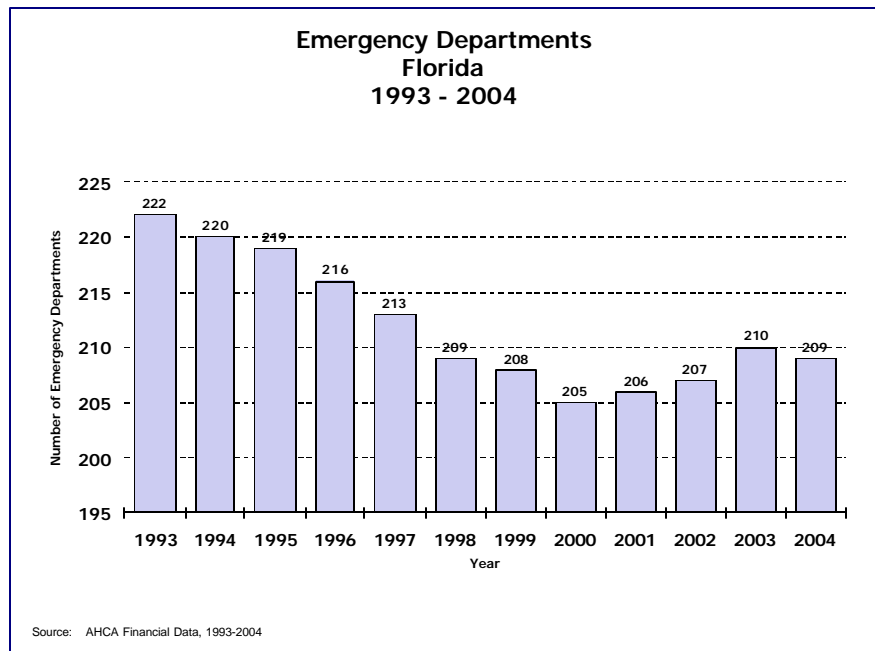
Lack of hospital capacity is due, in part, to public policy directives started over twenty years ago when the federal and state governments, along with the private sector, made healthcare cost containment a priority. The increasing cost of healthcare leads to the difficult decision to reduce hospital capacity.

### Increased Need for Monitored Beds

With hospitals treating sicker patients, the demand for monitored beds, critical care or intensive care beds, has escalated. Monitored beds are not easily created – they require telemetry equipment and trained staff to observe the telemetry equipment. While there are no available data on the supply and demand for these beds, one of the most common reasons for patients being held in the ED is that there are no monitored beds available on the inpatient units. In addition, telemetry RNs who staff monitored beds are the most difficult nursing position to fill, with vacancy rates exceeding 13 percent. Patients requiring close observation as part of their hospitalization are kept in the ED until this type of bed becomes available. Thus, the lack of available monitored beds contributes to major delays in transferring a patient out of ED into an appropriate inpatient bed.<sup>4</sup> Additionally, patients held in the ED diminish the ED’s ability to see newly presenting patients on a timely basis and maintain capacity for EMS transports.

### Changing Nature of the ED, Fewer EDs

EDs were originally intended to serve as triage centers, where patients were either quickly treated and released or admitted for further evaluations. Today, patients visiting the ED go through extensive diagnostic and often treatment protocols requiring hours of evaluation before determining the need for admission. This increases the length of time in the ED and increases demands on specialists to show up at all hours.



In addition to fewer hospital beds, Florida has seen the number of hospital EDs decline by 20 since 1993. According to data from AHCA’s Office of Plans and Construction,<sup>5</sup> approximately 31 hospitals have expanded or added to their EDs since 1994. However, there are no data to show how many additional treatment rooms or how much additional patient capacity was created due to those expansions.

Hospital	County	Reason
<b>1993</b>		
Miami Beach Community Hospital	Miami-Dade	Merged
Specialty Hospital of Jacksonville	Duval	Changed from acute to long-term
Victoria Hospital	Miami-Dade	Merged
<b>1994</b>		
Destin Medical Center	Okaloosa	Hospital closed
<b>1995</b>		
Palm Beach Regional Hospital	Palm Beach	Hospital closed
Polk General Hospital	Polk	Hospital closed
Riverside Hospital	Duval	Hospital closed
<b>1996</b>		
Pinellas Community Hospital	Pinellas	Hospital closed
Princeton Hospital	Orange	Hospital closed
Seminole Hospital & Women's Center	Pinellas	Hospital closed
<b>1997</b>		
Everglades Regional Medical Center	Palm Beach	Hospital closed
Parkway Regional Medical Center West	Miami-Dade	Hospital closed
Pompano Beach Medical Center	Broward	Hospital closed
University General Hospital	Pinellas	Hospital closed
<b>1998</b>		
Florida Medical Center South	Broward	Hospital closed
<b>1999</b>		
Atlantic Medical Center	Volusia	Merged
Clearwater Community Hospital	Pinellas	Hospital closed
Methodist Medical Center	Duval	Merged
<b>2004</b>		
Mount Sinai Med Ctr & Miami Heart Inst.	Miami-Dade	ED only
Shands Jacksonville Medical Center	Duval	Closed one of two Eds

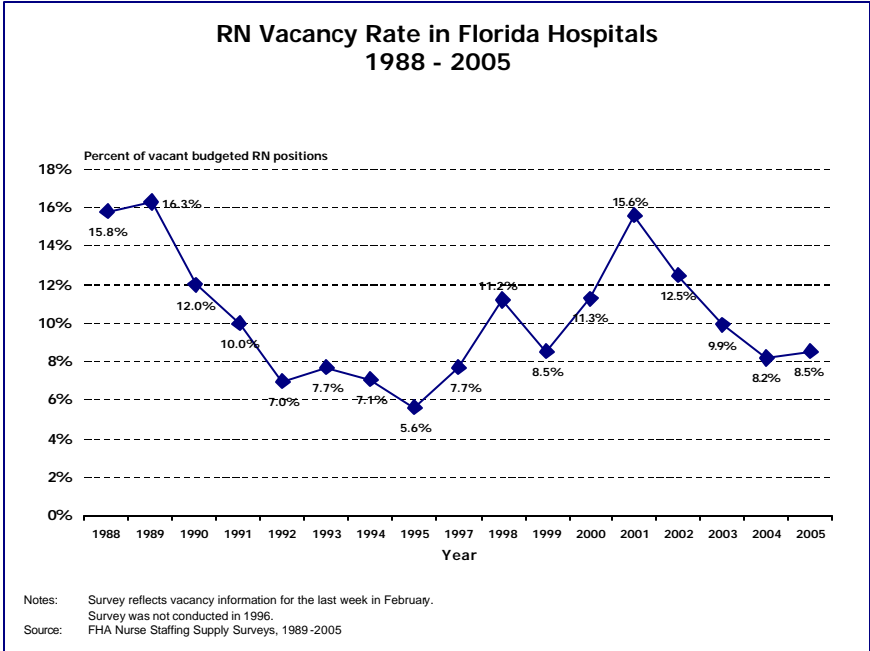
Source: AHCA Financial Database, 1993-2004

According to a survey conducted by the American Hospital Association<sup>6</sup> (AHA), 62 percent of all hospital EDs and three out of four urban EDs rate themselves as “at” or “over” capacity. ED overload is symptomatic of other capacity issues – such as lack of critical care beds and staff shortages.

**Shortages of Nurses, EMS and Other Allied Health Personnel**

The supply of non-physician health professionals in Florida has not kept up with the demand. Florida hospitals continue to struggle to find nurses, pharmacists, radiology technologists, medical technologists, and others. The EMS community is facing a significant shortage of paramedics and EMTs, as the demand for EMS services on a 24/7 basis grows. Education programs for nurses and other health professionals are constrained by shortages of faculty and funding to expand enrollment.

The nursing shortage has been well publicized. Recent data from the annual *FHA Nurse Staffing Report*<sup>7</sup> shows that while RN vacancy rates have declined since 2000, approximately 8.5 percent of the nursing positions in acute care hospitals remain vacant. A shortage of staff is typically the major reason patients cannot be moved out of the ED into a patient bed. As the demand for monitored/telemetry beds grows, so does the shortage of telemetry RNs. Telemetry RNs had the highest vacancy rate of any nursing specialty, with vacancies in 13 percent of those positions.



ED RNs are also in short supply. Almost one in five emergency RN positions are vacant, with emergency RNs seeing one of the largest increases in vacancy rates between 2004 and 2005. Shortages of critical care nurses continue as they have in the past with a vacancy rate around 10 percent.

Shortages of other health professionals such as radiology technologists, ultrasound technologists, laboratory technologists, respiratory therapists, and pharmacists also impact the ability of the hospital to handle a large increase in patient volume.

With RNs critical to the provision of patient care, any shortage of nursing staff will impact hospital operations and patient flow. The FHA study found that overcrowding in the ED was cited as the most common result of the nursing shortage. Typically, if there is a shortage of RNs on the nursing units, patients could remain in the ED until a staffed bed becomes available. Additionally, a shortage of ED nurses impacted how quickly patients were seen, admitted, or released to go home. It was reported that 63 percent of the hospitals believed that ED overcrowding was due to the shortage of nurses, up from 34 percent in 2004. Eighty-one percent believed this to occur more often in 2005 than it did in 2004.

Similarly, 24 percent of respondents indicated that a shortage of RNs caused their ED to be placed on diversion. Other negative impacts caused by the nursing shortage was a reduction of the number of staffed beds (21 percent) and increased wait times for surgery (15 percent).

### ***Shortages of Physicians Taking ED On-Call Coverage***

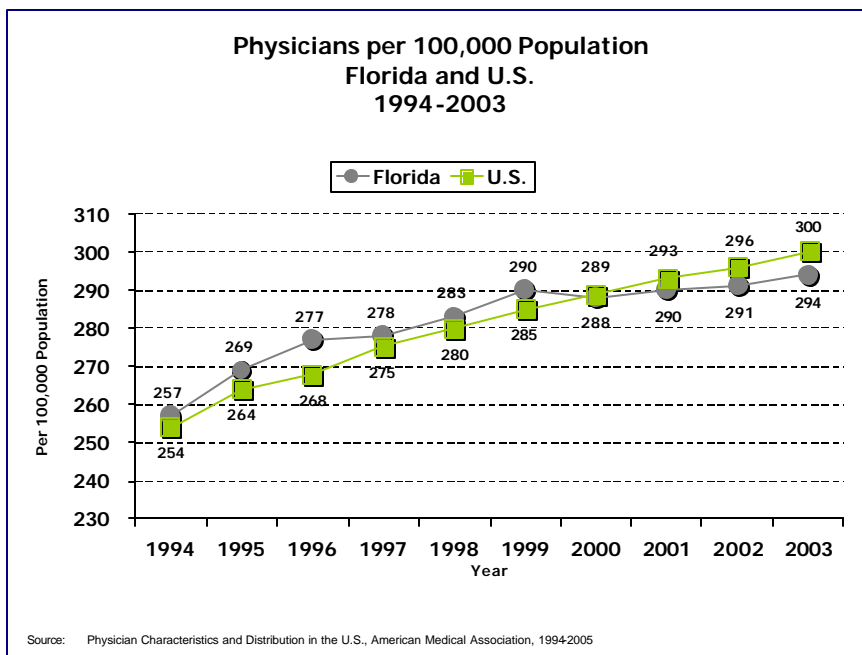
Hospitals face daily challenges with coordinating specialty coverage in the ED. This challenge stems from fewer physicians available to take, staff bylaws exempting, and lack of physicians' willingness to accept ED on-call coverage. A survey conducted by the AHA<sup>8</sup> of hospital leaders found that 41 percent of community hospitals participating in the study had experienced a lack of specialty coverage in the ED for some period of time. Reasons cited by the hospitals for losing specialty coverage include uncompensated care, liability concerns, physicians no longer looking to the ED to build their practices, retirement, loss of specialists to other facilities, and increasing productivity demands that affect physicians' ability to leave their practice to respond to ED on-call coverage.

A survey conducted by the American College of Emergency Physicians in 2003,<sup>9</sup> reported experiencing the most difficulties in finding neurosurgeons, orthopedic surgeons, and plastic surgeons for ED on-call coverage. Based on feedback from the task force and applications to AHCA for ED exemptions, Florida hospitals were also experiencing shortages of otolaryngology, gastroenterology, urology, hand surgeons and cardiology

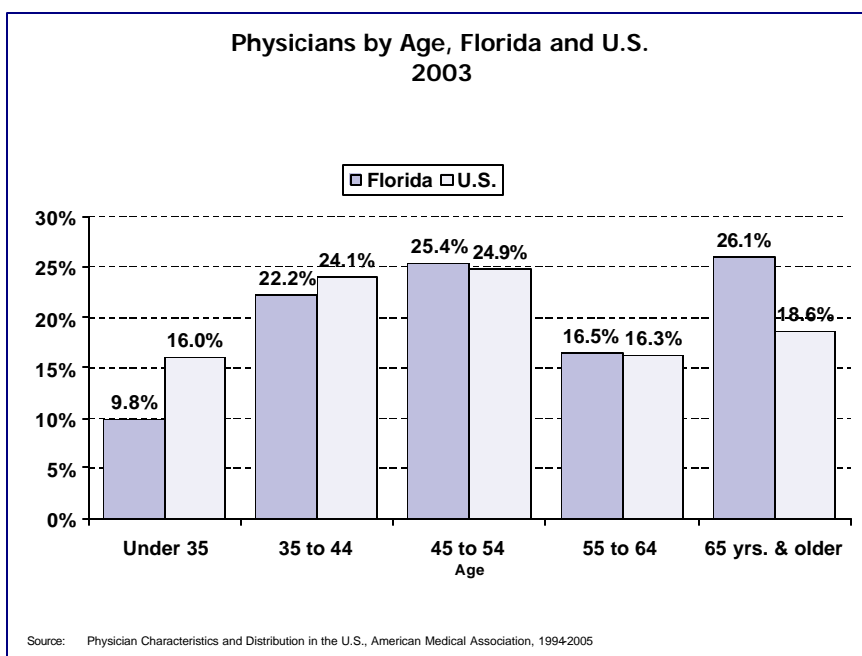
#### **Supply of Physicians Not Keeping Up with Population Growth**

According to data from the American Medical Association<sup>10</sup> (AMA), there were 50,000 licensed physicians in the State of Florida in 2003. According to the Florida Osteopathic Medical Association, there are 4,430 licensed osteopathic physicians. Neither the AMA data nor the data available from the Florida Board of Medicine identify the specialty or whether these physicians are actively practicing in a hospital within the State of Florida or practicing clinical medicine in Florida. Of the osteopathic physicians, 1,092 live outside of Florida, leaving 3,338 in Florida.

Of the 50,000 licensed physicians, three-quarters (38,121) reported they are involved in direct patient care. Ten years ago, Florida's ratio of physicians to population was above the national average. Currently, that ratio is below the national average. Florida is among the states seeing the slowest growth in physician supply, with the ratio of physicians to population growing only 3.2 percent from 1999 to 2003 compared to 13 percent growth nationally. Other large states are seeing growth in physician supply, with California experiencing a 7.0 percent increase, Michigan a 6.5 percent increase, Georgia a 5.3 percent increase, and Texas a 5.0 percent increase. Of the ten largest states, only New York saw a smaller growth rate in physician supply than Florida.



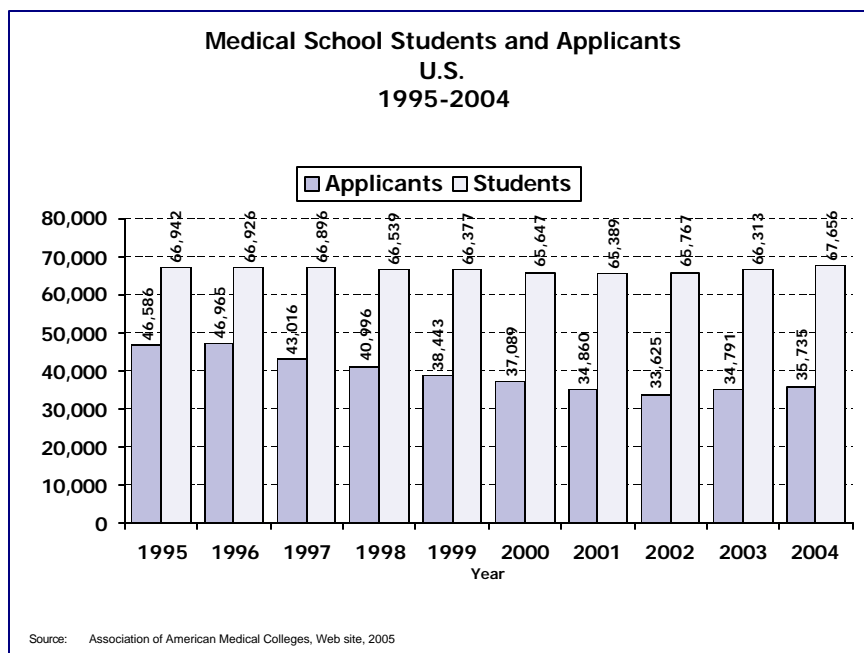
Given its demographic profile, Florida could soon see the number of physicians practicing in the state diminish. Florida's physicians are older than the national average based on the distribution of Florida's licensed physician population. One in four physicians in Florida is over the age of 65 years of age which suggests they may be retired or close to retirement. Unfortunately, there are no data to confirm the actual number of retired licensed physicians. Another 16 percent of Florida's licensed physicians are between 55 and 64 years old. These, too, likely will retire in the next decade.



Factors identified by the Council for Education Policy, Research and Improvement (CEPRI) affecting the physicians' supply and demand in Florida are significant. Among the factors impacting physician supply are "demographics, most notably age and gender; percentage of time physicians devote to active practice; specialties practiced; importation of physicians; and environmental constraints – especially geographic distribution and insurance costs." Factors impacting demand include "continued growth in Florida's population, especially the elderly, continued growth of the state's economy and its connection to health care services, and the availability of 'qualified' Florida students to attend medical school"<sup>11</sup>

Among the alternatives proposed by CEPRI to address the physician workforce shortage are expansion of residency positions, incentive programs to attract physicians, and expansion of medical school capacity.

Approximately one of three students applying to medical school is accepted. Over the last decade, the number of students at U.S. medical schools has not kept up with population growth or increased demands for healthcare services. Nationally, the number of medical school students has not increased in a decade. Recent data from the Association of American Medical Colleges reflected an upsurge in enrollment levels and applicants, with the 2005-2006 entering class being the largest on record with 17,000 new students. The data show that the number of medical school applicants for the 2005-2006 school year increased 4.6 percent over the prior year but this number is still below the volume of applicants seen in 1995.<sup>12</sup>



Medical schools in Florida have seen a 14.6 percent increase in the number of students since 2000, with most of the growth attributed to the new medical school at Florida State University. Despite the increase in the number of students, the number of medical school graduates fell 5.0 percent between 2000 and 2004. Historically, physicians are more likely to stay where they do their residency than where they go to school. According to data from CEPRI, Florida retains about 49 percent of its medical school graduates.

Medical School Enrollment and Graduations from Florida's Medical Schools 2000 - 2004						
Medical School Enrollment, 2000 - 2004						
	2000	2001	2002	2003	2004	% Change
Florida State University	32	31	68	114	173	440.6%
University of Florida	430	447	444	450	459	6.7%
University of Miami-Miller	599	586	576	576	591	-1.3%
University of South Florida	390	397	394	412	440	12.8%
<b>Total Florida - Allopathic</b>	<b>1,451</b>	<b>1,461</b>	<b>1,482</b>	<b>1,552</b>	<b>1,663</b>	<b>14.6%</b>
Nova Southeastern University	--	--	--	757	769	1.6%
<b>Total - Allopathic and Osteopathic</b>	<b>1,451</b>	<b>1,461</b>	<b>1,482</b>	<b>2,309</b>	<b>2,432</b>	<b>--</b>
<b>U.S.</b>	<b>65,647</b>	<b>65,389</b>	<b>65,767</b>	<b>66,313</b>	<b>67,656</b>	<b>3.1%</b>
Medical School Graduates 2000 - 2004						
	2000	2001	2002	2003	2004	% Change
University of Florida	117	120	107	110	116	-0.9%
University of Miami-Miller	155	147	149	134	142	-8.4%
University of South Florida	94	89	104	96	90	-4.3%
<b>Total Florida - Allopathic</b>	<b>366</b>	<b>356</b>	<b>360</b>	<b>340</b>	<b>348</b>	<b>-4.9%</b>
Nova Southeastern University	--	--	--	177	165	-6.8%
<b>Total - Allopathic and Osteopathic</b>	<b>366</b>	<b>356</b>	<b>360</b>	<b>517</b>	<b>513</b>	<b>--</b>
<b>U.S.</b>	<b>15,707</b>	<b>15,787</b>	<b>15,675</b>	<b>15,521</b>	<b>15,821</b>	<b>0.7%</b>

Sources: American Association of Colleges of Osteopathic Medicine, Annual Osteopathic Medical School Questionnaires, 2002-2004 academic years  
 Association of American Medical Colleges, FACTS - Applicants, Matriculants & Graduates, 2004

A decade ago, health policymakers felt there was a surplus of physicians. Recently, the federal Council on Graduate Medical Education (COGME), which reports physician work force trends to Congress, endorsed a study that indicates physicians could soon be in short supply in the United States. The COGME Physician Work Report provides some perspective on the future supply and demand for physicians. The supply of practicing physicians is expected to slow considerably after 2010, reflecting increased rates of physician separation due to the aging of the current physician workforce and the relatively level annual number of new physician entrants since 1980. After 2015, the rate of population growth will exceed the rate of growth in the number of physicians. At the same time, the demand for physicians is likely to grow even more rapidly over this period than the supply due to population growth and the aging of the population. According to COGME, the nation is projected to face a shortage of about 96,000 physicians in 2020. The council recommended that medical schools increase enrollment by 15 percent over the next decade to help offset potential future shortfalls.<sup>13</sup> Increasing enrollment has other challenges. For example, it takes ten years post-baccalaureate to produce a licensed physician, and the average cost of attending medical school is around \$154,000 per year. Many graduates leave medical schools with considerable debt due to the high cost of medical education.

### Shortages of Specialists, Elimination of Services

According to a recent article in the Archives of Internal Medicine, a 2003 survey of Florida's licensed physicians found that 54 percent of physicians reported decreasing or eliminating services they provided in the previous year.<sup>14</sup> The researchers from Florida State University surveyed physicians to determine the effect of the professional liability insurance market on access to healthcare. The most commonly eliminated services were nursing home coverage, delivery of babies, ED coverage, and mental health services. Surgical specialists and general surgeons were the groups with the highest number of decreased or eliminated services. The researchers concluded that physicians across Florida have continued to decrease or eliminate important health services and these decreases seem to be related to the difficulty of finding or the cost of professional liability insurance.

Various studies published in the past several years point to an increased demand for specialists that outweighs the supply. Journals of medicine project shortages for most surgical specialties, include

neurosurgery, hand surgery, and orthopedic surgery. Data from the AMA<sup>15</sup> show little growth in several specialty areas including general surgery, surgical subspecialties, psychiatry, radiology, and pathology.

**Challenges Obtaining Florida Licensure and Credentialing Approval**

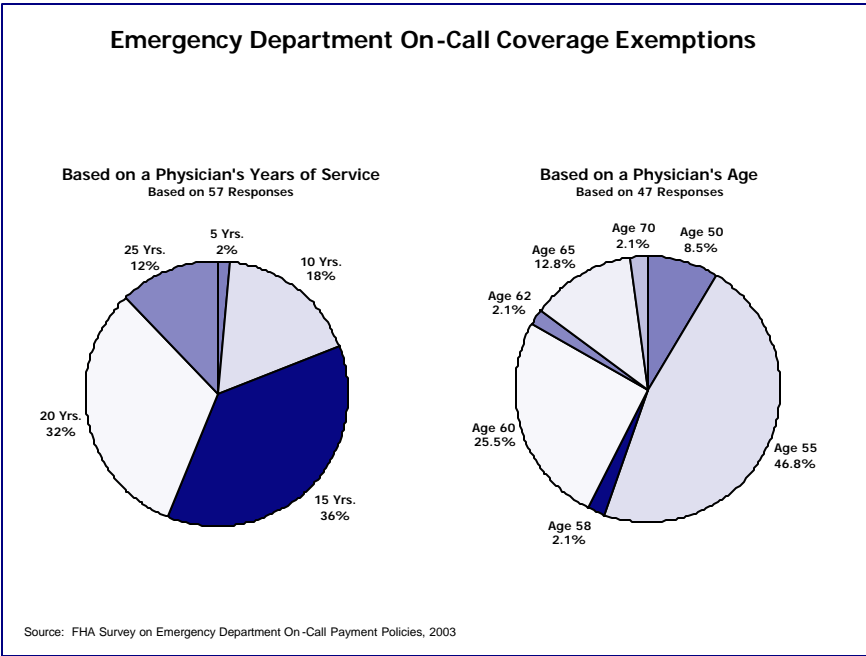
Recent medical school graduates and physicians interested in practicing in Florida must obtain a Florida license before they can treat patients. To obtain a Florida license, a physician must file an application with the Florida Board of Medicine, have graduated from a medical school, completed at least a one-year residency, passed the state licensing examination, and provided fingerprints for a background check. If there are no problems, the paperwork and necessary information for licensure can be compiled in approximately 90 days; however, the background check from the Federal Bureau of Investigation takes six to eight weeks to be conducted.

In addition to licensure, to serve on a hospital medical staff or a network panel for a health plan, an out-of-state or new physician must be credentialed by the hospital and by the health plan. This process requires verification from regulatory agencies, licensure boards and others, including the Drug Enforcement Agency certification, malpractice insurance coverage, board certification, educational training, and querying the National Practitioners Data Bank. Hospitals and health plans also require primary letters from references listed on the application, which can be delayed if the listed references do not respond in a timely manner. Hospitals submit this information to their credentialing committee for their approval prior to granting hospital privileges. After receiving hospital privileges, physicians apply for a provider number from health plans. This will require similar verifications and attestations, including evidence that they have hospital privileges. This, too, can cause delays in new physicians being able to treat patients.

The process for obtaining a license, hospital privileges and serving on a health plan provider network can be confusing, duplicative and time consuming, since there is no common data base and lack of standardization in the credentialing process. Delays in proper completion of the application, obtaining verifications, the background checks and other information, while important to ensure the quality and training of the physician, only lengthens the time for a physician moving into the state to be able to provide patient care.

**Medical Staff Bylaws Exempt Physicians from ED On-Call Coverage**

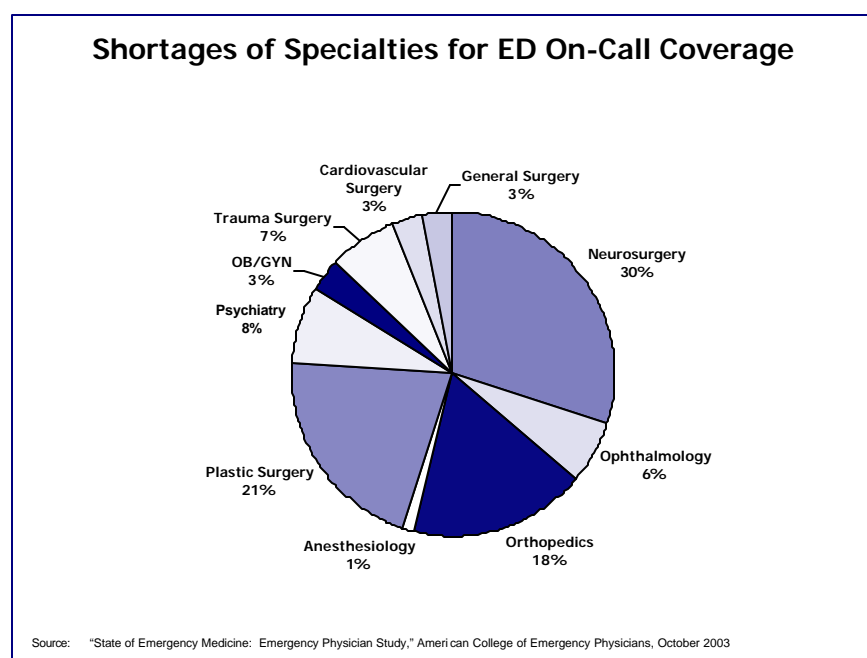
Based on a survey conducted by FHA<sup>16</sup> in 2003, the majority (94 percent) of hospitals reported their medical staff bylaws require physicians to take ED call as a condition of medical staff participation. The vast majority of these hospitals reported having some type of exemption for ED call coverage, either based on active years of service or age, number of physicians in that specialty, or some combination. Four out of five hospitals exempted physicians from ED call after 15 years on the medical staff.



Hospitals exempting medical staff members ED call based on age typically used 55 years or older as a cutoff. Slightly less than one-fourth reported exemptions for ED coverage for certain specialties. Physicians with courtesy status were also exempted from ED coverage.

Historically, young physicians used the ED to build their practices. Young physicians now rely on their group practices and contractual relationships to build their patient base. Further, the uncertainties surrounding ED call, the low reimbursement and the malpractice costs that come along with it, make ED call unattractive. The result of this is fewer specialists willing to take ED on-call coverage.

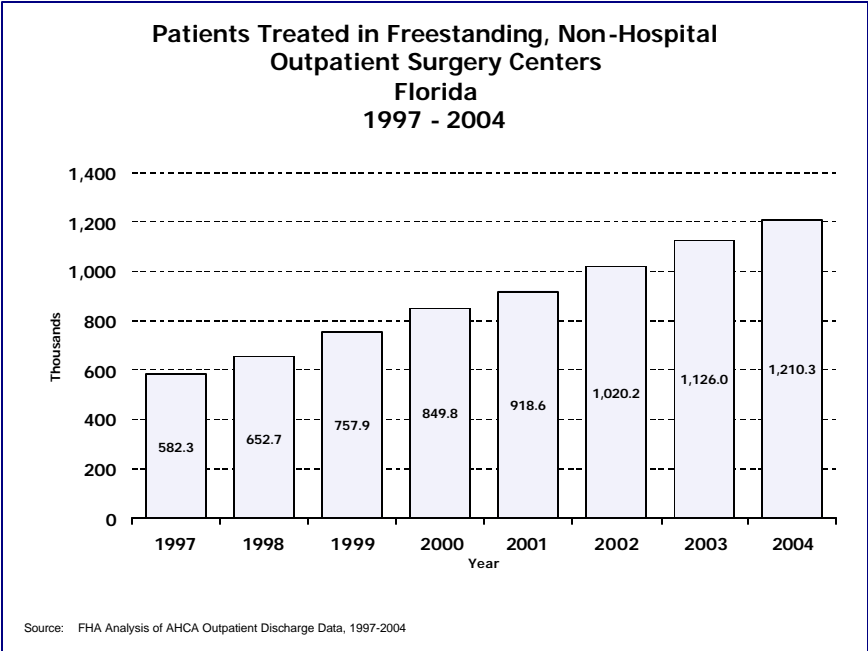
As the challenges grow in finding physicians willing to take ED on-call coverage, it is becoming more difficult to know which hospitals have certain types of specialists on call at any given time.



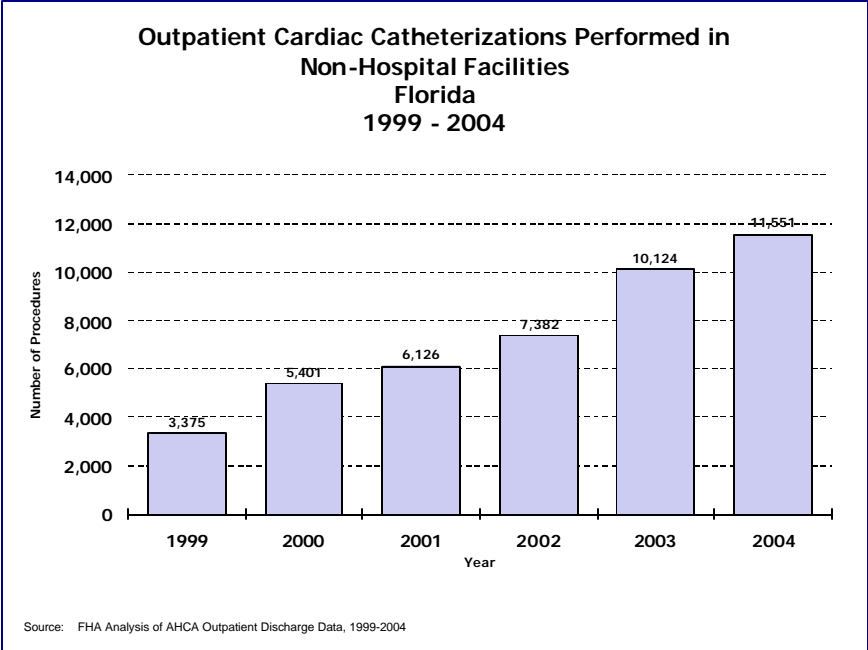
### **Physicians Leaving Hospital Setting for Freestanding Specialty Centers**

Since the 1980s, public policy and medical practice have encouraged more outpatient care. As care delivery has changed, more of these specialists are practicing in freestanding ASCs, clinics, and offices, and some specialists no longer need the hospital. The increase in the number of non-hospital affiliated ambulatory surgery centers and outpatient diagnostic imaging centers has drained hospital medical staffs of radiologists and other specialists. Many physicians who perform surgical procedures have moved their practice to outpatient facilities and no longer maintain hospital privileges. Examples include specialties such as radiologists, plastic surgery, ENT, GI, ophthalmology, psychiatry, invasive cardiologists and surgeons working in ASCs or their office. The unintended consequence of this public policy has been to move more specialists out of the hospital, decreasing the supply of specialists that were previously available for ED on-call coverage.

As more physicians are leaving the hospital, the number of outpatient surgeries and other procedures is growing. Between 1997 (the first year the data were collected) and 2004, the number of outpatient surgeries performed in a freestanding outpatient center increased from 582,300 surgeries to over 1.2 million in 2004, an increase of 108 percent. Freestanding ambulatory surgery centers represent a growing percentage of the outpatient surgery market, increasing from 36 percent of the total during the same period.



Data collected by AHCA beginning in 1999 show a significant increase in the number of cardiac catheterization procedures performed in a non-hospital outpatient setting. Between 1999 and 2004, the number of outpatient, non-hospital cardiac catheterizations grew from 3,375 to 11,551.



### **Payment for ED Call Coverage**

To address the shrinking supply of specialists willing to take ED on-call coverage, many hospitals have been forced to pay stipends to specialists to provide emergency coverage. The amount paid for ED on-call coverage by those hospitals varies by specialty and by hospital but can add up to a substantial amount of money. While the task force recognizes that this practice is occurring, it also recognizes that this is not a long-term solution and is not economically sustainable. Not only do these payments drain limited resources from other safety net services, they create practical difficulties in determining which specialists to pay and legal difficulties in avoiding federal anti-kickback and Stark self-referral laws.

### **Use of Hospitalists, PAs and Sharing Specialists**

The *California Healthcare Foundation January 2005 Report*<sup>17</sup> said that “nearly half” the hospitals in California use hospitalists as an approach to dealing with the on-call problem. It states that “Strategies to provide on-call services range from using hospitalists, intensive care physicians, and PAs in the emergency department to coverage agreements between hospitals.” Hospitalists in the ED can provide the initial assessment of unassigned patients. They then either call in the specialist, if one is needed, or determine that specialty care can be deferred until the next day. Emergency physicians appreciate the availability of hospitalists as timesavers and facilitators to move patients into inpatient beds, while specialists value fewer calls and fewer unnecessary trips to the ED.

PAs and ARNPs also have relieved doctors for some on-call responsibilities. As first responders, PAs assess patients and then, as needed, coordinate care from admission through post-discharge planning. Physicians and the hospital jointly oversee PA credentialing and performance.

In some areas, hospitals are modifying the way they provide on-call care by sharing specialists informally; creating regional pools for high-demand, limited-supply services; or entering into formal agreements to transfer stable patients to another facility when a hospital cannot secure on-call services.

## **Effective Use of EMS**

EMS providers are a key component of the emergency care system. EMS responds to all requests for services regardless of the patient’s medical emergency or his/her ability to pay. EMS faces several challenges in getting patients to the proper care setting. Among those challenges are patients requesting assistance from EMS when they do not have an emergency condition. State laws require EMS to take patients to the hospital ED if they request it even if the patient may only require minor treatment or could be treated in an alternative care site. EMS is not allowed to take patients to urgent care centers even if the patient’s medical condition justifies that type of care. Because of hospital ED capacity issues, patients may call EMS to avoid long waits to obtain care in the ED. This inappropriate use of EMS results in crowded EDs that can disrupt patient flow and access for true emergencies.

### **EMS Transport Volume is Up**

EMS is the lifeline for many patients experiencing an emergency medical condition. The increase in patient transports provides some perspective on the increased demand on Florida’s EMS system. Data on 911 calls from 2003 and 2004 reflect an 11 percent increase in the number of calls over a one-year period. Of the 2.8 million calls in 2003, 1.7 million or 61 percent required transport to a hospital ED. In 2004, EMS received over 3.1 million calls with 1.9 million (61 percent) requiring transport to the hospital. Thus, in one year, EMS transported almost 200,000 more patients to hospital EDs.<sup>18</sup>

### **EMS Diversions Due to Hospital Capacity Issues**

Another challenge facing EMS is hospital ED and inpatient capacity. Hospital ED capacity constraints have a direct impact on EMS, leading to ambulance diversions and delaying EMS personnel the ability to return to the field to respond to other calls. When a hospital exceeds the capacity of its ED, the hospital may go on diversion, which forces EMS to find another hospital to take the patient. Florida's Bureau of Emergency Medical Services has received complaints about ambulances being diverted from their original destinations to other hospitals for the past 25 years. Unlike the past, however, ambulance diversions now occur year round. To prevent diversions from occurring, several counties prohibit hospitals from going on diversion, even if those hospitals are at critical capacity in their EDs.

Currently, EMS does not have the ability to know which hospital has what service available, the status of the ED in terms of current volume of patients, or the availability of other beds for emergency patients. This lack of communication compounds the challenges of finding the closest hospital with the types of services needed by the patient. At times, patient transport has been delayed as EMS sought to find a hospital with the types of services and/or the physician specialists needed by the patient. Currently, there is no statewide tracking system in place that provides information on a real-time basis to help facilitate getting patients to the appropriate hospital.

### **Specialty Certifications Might Require Longer EMS Transport**

Florida law and evolving standards of care require major trauma cases and certain other cases to be transported to hospitals with specialty certification. This may include air or ground transport to hospitals that are quite distant from the normal operations area of an EMS service provider. Hospital diversions often exacerbate this situation by forcing EMS units to transport to even more distant facilities than they normally would. The patient may need to be taken to a hospital that is several counties away, thus removing the EMS unit from service for many hours.

### **Delays in Handing Off Patients to ED Staff**

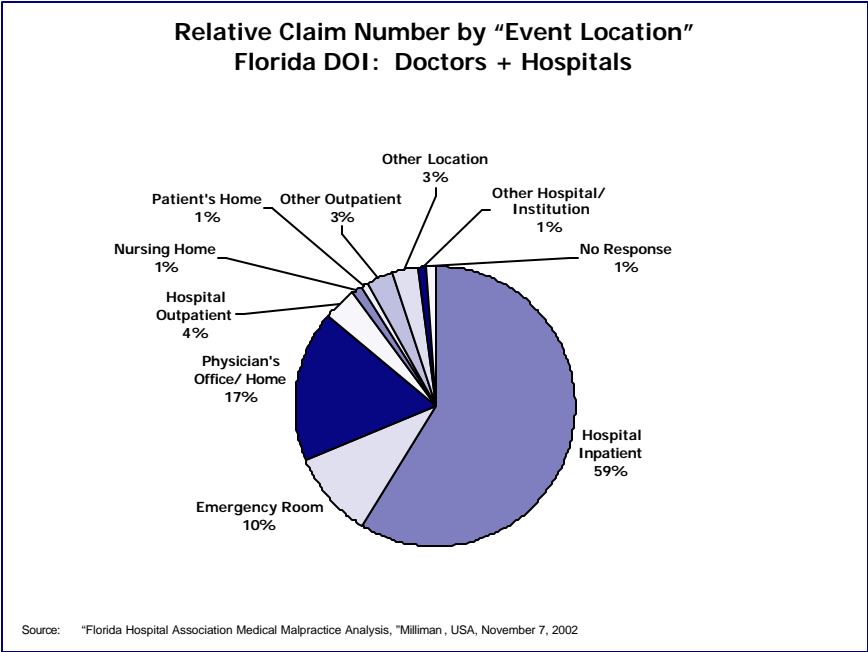
Once EMS finds a hospital with the services needed by the patient, based on ED volume and available beds, there might be delays in "handing off" the patient to hospital ED staff. EMS "hand-off" time is a term used to define the time span from when the EMS unit arrived at a hospital until the patient is delivered to an ED bed, and the EMS crew provides a patient care report to the RN and physician assuming care of the patient. The EMS hand-off times in Florida commonly are often at least thirty minutes and have exceeded four to six hours in some metropolitan areas.

A prolonged EMS hand-off time prevents the rescue or ambulance crew from returning to service. This, in turn, reduces EMS capacity to respond to other emergencies and requires the EMS agency to add more units to the EMS system. In addition, the patient is often under the care of the EMT or paramedic for an extended length of time while waiting in the ED. EMS personnel have neither the training, nor equipment to sustain care for prolonged periods..

## **Medical Liability Issues**

Physicians have expressed a reluctance to take on-call coverage because of the increased risk of liability. An on-call physician must decide life-saving diagnosis and treatment with little time and no prior knowledge of the patient or his/her history. Thus, mal-occurrences and adverse outcomes are more likely. According to an analysis of Florida medical lawsuits from 1986 to 2001 by Milliman USA,<sup>19</sup> ED liability claims and payouts accounted for a minimum of 10 percent of the total medical liability cases. Milliman indicated these data may be understated as there may be additional related claims that apply to treatment in other areas after leaving the ED. The Governor's Select Task Force on Healthcare Professional

Liability Insurance issued its report in January 2003. Among the findings was that “Florida is among the states with the highest medical malpractice insurance premiums in the nation. This increase in healthcare liability insurance rates is forcing physicians to practice medicine without professional liability insurance, to leave Florida, to not perform high-risk procedures, or to retire early from the practice of medicine.”<sup>20</sup> Concerns about liability issues also lead to increased use of ancillary services and diagnostic studies, which may contribute to prolonged ED stays and ED overcrowding.



A recent Issue Brief<sup>21</sup> published in January 2005 by the California Healthcare Foundation found that “physicians are reluctant to take call because of the real or implied threat of EMTALA, including its financial penalties; the rising cost of malpractice insurance, which is a disincentive to assume greater liability by treating unknown emergency patients; and the potential legal issues regarding patient abandonment if follow-up care does not occur. Physicians report that some emergency patients are not compliant or are difficult to contact regarding follow-up care.” This is significant because California’s malpractice reform laws, including a \$250,000 cap on non-economic damages, are often cited as a model for the rest of the nation. It appears that even California has not gone far enough to address the liability issue.

These liability concerns impact all aspects of emergency care, including emergency obstetrical care. Obstetricians providing ED on-call coverage face particular challenges in that ED physicians are reluctant to see pregnant patients that are presenting to the ED either because they are in labor or because they have a medical problem along with their pregnancy and they don’t have a personal obstetrician. These patients are sent to a labor and delivery triage area for evaluation of the patient. Specialists that participate in routine ED call are less willing to see a pregnant patient because of the perceived high risk for litigation. Obstetricians are often without support to evaluate and treat significant medical problems that occur either coincident to or in addition to the pregnancy.

Florida has a long history of medical malpractice reform legislation dating back to 1975. Unfortunately, several of the tort reforms were held unconstitutional or were weakened by the judicial system. In 1985, legislation was passed to limit ED liability by imposing a higher standard of reckless disregard that must be proved before liability is found. In 2003, legislation was enacted to provide any physician a cap on

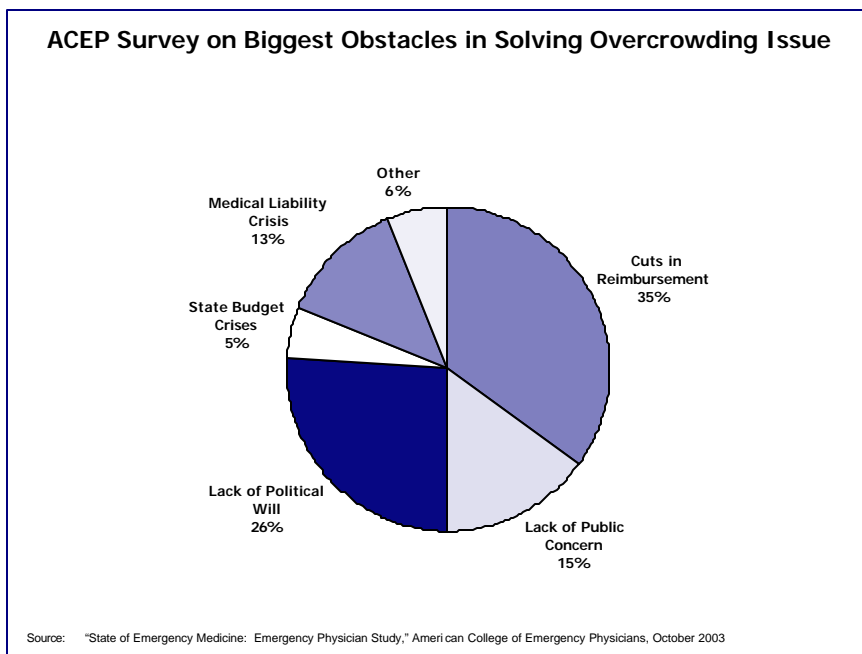
non-economic damages of \$150,000 per claimant for the emergency setting, with an aggregate cap of \$300,000. This cap can be applied toward the hospital cap of \$750,000 per claimant and \$1.5 million aggregate in an emergency setting if both doctors and the hospital are sued. The caps are applicable up to the point of stabilization, including necessary surgery within a reasonable time following stabilization. The 2004 legislation also strengthened the 1985 definition of “reckless disregard” as the standard for liability in emergency settings. The Florida Supreme Court has not ruled on the constitutionality of the 2004 legislation at this time.

In a recent *Report to the Congress: Medicare Payment Policy*, by the Medicare Payment Advisory Commission,<sup>22</sup> MedPac forecasts that even after several years of rapid growth in professional liability insurance costs, this will still be the fastest-growing component of the cost of physician services going forward.

A survey conducted in September of 2003 by the American College of Emergency Physicians<sup>23</sup> found that the biggest obstacles to solving ED overcrowding were cuts in reimbursement, lack of political will, and the medical liability crisis.

Recently approved constitutional amendments by Florida voters have also had a negative impact on recruiting and maintaining specialists for the ED. Amendment 7 opens medical incident reports to patients and Amendment 8 prohibits licensure of physicians with three findings of malpractice.

Though the Florida Legislature passed implementing legislation to limit the negative impact of the Amendments, there is still uncertainty about how the courts will interpret both the legislation and the vague Amendments.



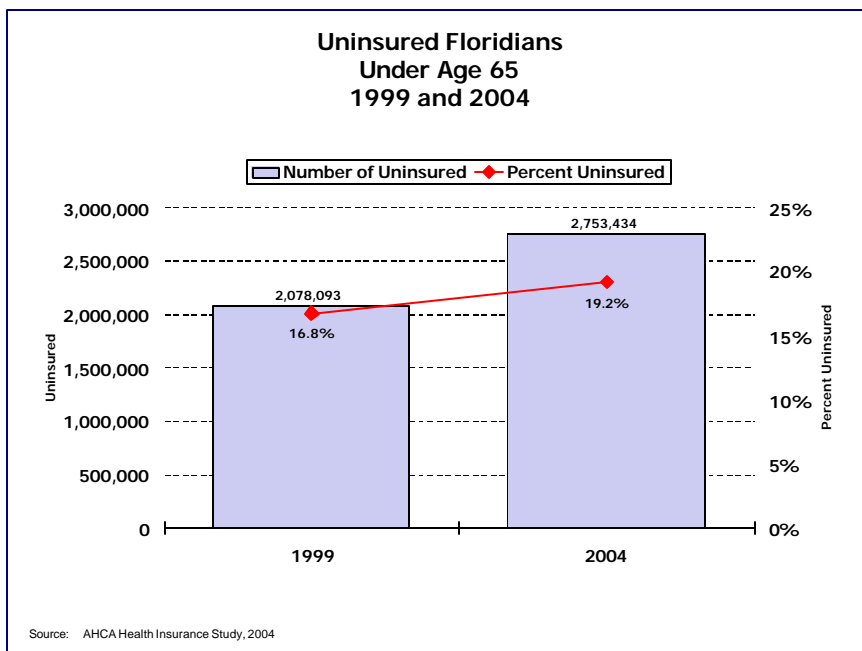
Since hospitals, physicians, and EMS are required to provide emergency care services to everyone regardless of ability to pay and assume the burdens of implementing state and federal policy under the threat of lawsuits, an immunity zone for emergency services could be created to protect EMS, EMS medical directors, hospitals, and physicians from litigation arising out of an emergency. This type of protection, i.e., an immunity zone, is needed to encourage specialists to maintain hospital privileges and make their services available for ED patients; enhance recruitment of physicians to hospitals in Florida; enable smoother operation of Florida’s EMS system; enhance the trauma system; reduce wait-times for patients needing emergency or specialist physician care; reduce the number of medically-necessary transfers; and ensure that our first responders and EDs are available for national and state disasters. While Florida’s Good Samaritan statute under F.S. 768.13 was an attempt in this direction, it has not worked. While the recent caps on non-economic damages were an attempt to ease the problem, a more complete immunity is now needed.

Two areas that provide better liability protection than current law are sovereign immunity and the no-fault program for Birth-Related Neurological Injury Compensation (NICA). Sovereign immunity under F.S. 768.28 is already applied in public hospitals, state medical schools, and volunteer physicians contracting with public entities. NICA, under F.S. 766.303, provides an exclusive remedy for certain catastrophic cases as an alternative to malpractice lawsuits against OB physicians delivering infants. The Florida Supreme Court has constitutionally upheld both of these laws.

**Growing Number of Uninsured and Under-Insured Floridians**

Health insurance coverage has a significant impact on how and when healthcare services are accessed. Those without health insurance or those that have inadequate insurance coverage are less likely to have a usual source of care, more likely to delay treatment, and are more likely to rely on the hospital ED as their “safety net,” i.e., a place that will care for them regardless of their ability to pay or serve as their primary care provider.

Approximately one of every five Floridians under the age of 65 does not have healthcare coverage. According to the latest *Florida Health Insurance Study* by AHCA, 19.2 percent of Florida’s non-elderly population was uninsured in 2004.<sup>24</sup> This represents 2.9 million residents with no healthcare coverage – approximately the same number as are covered by Medicare. Since 1999, the last time the *Florida Health Insurance Study* was conducted, an additional 800,000 Floridians joined the ranks of the uninsured.



In addition to the 2.9 million Floridians without coverage identified by the survey, approximately one-fourth of the non-elderly population – approximately 4.2 million – went without coverage at some point during 2004.<sup>25</sup> The two most common reasons for lacking healthcare coverage are the unavailability of coverage and the cost of insurance. Between 1999 and 2005, health insurance premium costs have risen 77 percent.<sup>26</sup>

Because of the high cost of health insurance coverage, individuals without employer coverage are purchasing catastrophic insurance plans or those with high, out-of-pocket costs. Likewise, employees are seeing their health insurance benefits offered by their employer reduced, with a limited plan or high out-of-pocket costs for using healthcare services. Because of the cost, many of these individuals, even though they have insurance, are less likely to seek care until it becomes an emergency.

Florida's growing uninsured population has tremendous implications for EMS and hospital EDs. Studies have shown that the uninsured are more likely to delay care, typically waiting until their condition is life- or limb-threatening, before they seek treatment.<sup>27</sup> Since state and federal laws require hospitals to treat everyone that presents at the hospital ED, without regard to his/her ability to pay, the hospital ED serves as a "safety net" for healthcare to Florida's uninsured population. In 2004, 124,529 uninsured patients presented at the ED and then were admitted to the hospital.

DRG	Description	Number Admitted	Percent of All DRGs
143	Chest Pain	7,671	6.2%
430	Psychoses	4,323	3.5%
449	Poisoning & Toxic Effects of Drugs Age >17 w CC	3,164	2.5%
204	Disorders of Pancreas Except Malignancy	2,956	2.4%
182	Esophagitis, Gastroent & Misc Digest Disorders Age >17 w CC	2,855	2.3%
127	Heart Failure & Shock	2,849	2.3%
183	Esophagitis, Gastroent & Misc Digest Disorders Age >17 w/o CC	2,693	2.2%
89	Simple Pneumonia & Pleurisy Age >17 w CC	2,294	1.8%
277	Cellulitis Age >17 w CC	2,251	1.8%
278	Cellulitis Age >17 w/o CC	2,184	1.8%
88	Chronic Obstructive Pulmonary Disease	2,146	1.7%
523	Alc/Drug Abuse or Depend w/o Rehabilitation Therapy w/o CC	2,131	1.7%
521	Alcohol/Drug Abuse or Dependence w CC	2,054	1.6%
294	Diabetes Age >35	1,960	1.6%
167	Appendectomy W/O Complications	1,808	1.5%
14	Intracranial Hemorrhage & Stroke With Infarction	1,729	1.4%
174	G.I. Hemorrhage w CC	1,717	1.4%
202	Cirrhosis & Alcoholic Hepatitis	1,518	1.2%
24	Seizure & Headache Age >17 w CC	1,324	1.1%
125	Circulatory Disorders Except AMI, w Card Cath w/o Complex Diag.	1,323	1.1%
<b>Total Top 20</b>		<b>50,950</b>	<b>40.9%</b>
<b>Total All DRGs</b>		<b>124,529</b>	

Source: AHCA Inpatient Discharge Database, CY2004

These represented 9.5 percent of all the ED patients admitted to the hospital. The diagnoses of uninsured ED patients admitted to the hospital differed somewhat from reason for admission for all patients admitted to the ED. Twenty conditions represented 41 percent of the total patients. Uninsured patients presenting in the ED are more likely to be admitted for drug overdoses, psychoses, diabetes, cellulites, and alcohol abuse than insured patients.

### **Use of the ED for Non-Emergencies**

Several issues drive the use of the ED for non-emergencies, including convenience, delays in getting appointments with physicians, and lack of alternative sites for after-hours, non-emergency care.

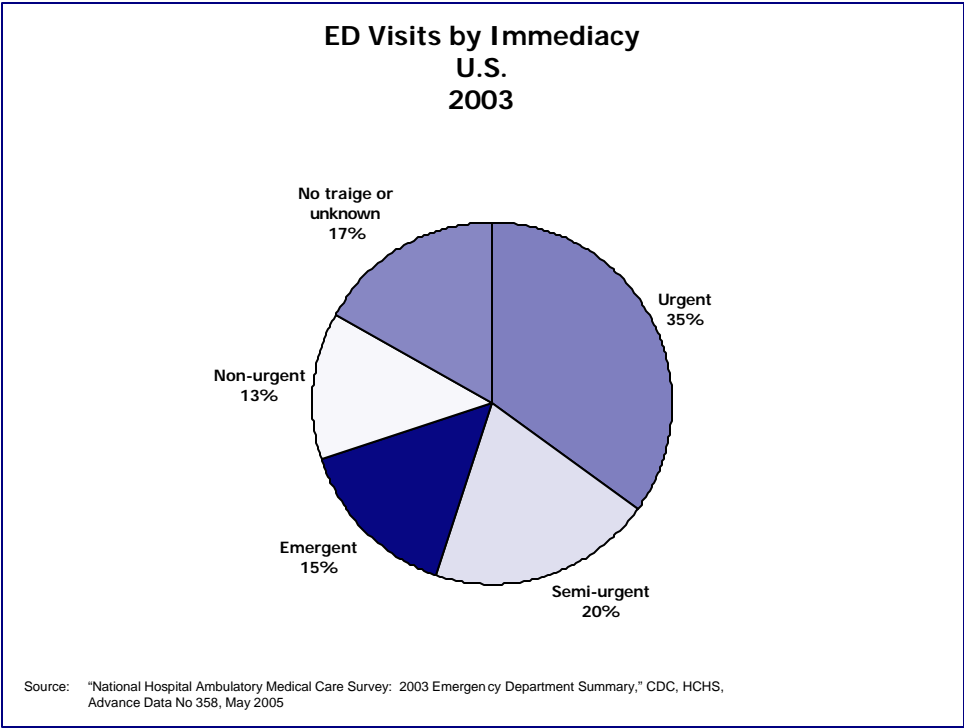
Capacity constraints experienced by office-based physicians, combined with a loosening of managed care restrictions, may be contributing to increases in non-urgent ED visits. More patients are experiencing difficulties making appointments with their doctors and the waiting times for appointments are lengthier. Physicians unable to accommodate a patient's need for an appointment will likely direct the patient to the hospital ED if the patient wants to see a physician sooner than when an appointment is available. A growing number of physicians report having inadequate time to spend with their patients and are increasingly closing their practices to some new patients. For uninsured patients, EDs are one of the few remaining primary care options.

Physicians also may be responding to increased workload by referring patients to EDs with greater frequency, and declines in risk contracting and capitation mean they no longer have financial disincentives to do so. In some cases, increased utilization may be associated with physicians practicing defensive medicine by sending potentially risky patients to EDs instead of providing care in their offices. Physicians also use the ED to get special studies performed sooner or to expedite authorization to admit the patient.

According to several studies presented to the Florida Legislature in 2004, the inappropriate use of emergency services increases the overall cost of providing healthcare, and these costs are ultimately borne by the hospitals (section 641.31097, F.S.). Legislation enacted in 2004 requires that providers and insurers share the responsibility of providing alternative treatment options to urgent care patients outside of the ED. This includes a requirement that HMOs provide information on their Web sites regarding the appropriate use of emergency care services, including a list of alternative urgent care providers, the types of services offered by these providers, and what to do in the event of a true emergency. Additionally, HMOs are required to develop community ED diversion programs, including enlisting providers to be on-call to subscribers after hours, coordinate care through local community resources, and providing incentives for case management.

As a disincentive for inappropriate use of the ED services, health plans can require higher co-payments for urgent care or primary care provided in an ED and higher co-payments for use of out-of-network EDs. These higher charges are not applicable for true emergency care.

According to data collected by the National Center for Health Statistics,<sup>28</sup> only 15 percent of visits to hospital EDs are for “emergent” conditions. Emergent is defined as those patients that should be seen in less than 15 minutes. Another 35 percent of the visits were classified as “urgent,” where the patients should be seen within 15-60 minutes. Twenty percent were classified as “semi-urgent,” requiring treatment in one to two hours, and 13 percent were nonurgent, requiring treatment in 2- 24 hours.



Responding to requests from Marion County hospitals, AHCA approved a proposal to reduce the number of patients seeking primary care for non-emergent conditions in the hospital EDs. The system created allows the hospitals to refer the patient to community resources if a medical screening examination finds that a non-emergent condition exists. If the patient does not want to be referred to community resources, he/she will be required to pay for the ED visit. (See Appendix)

## ***Lack of Available Alternative Care Sites***

All patients – uninsured and insured – requiring after-hours, non-emergency care have few options available. While some communities have “urgent care” centers and community health clinics, these are not necessarily available 24/7 like the hospital ED. Since these facilities are not separately licensed as “urgent care centers,” there are no data on the exact number available in the state. However, data from one of the health plans on the task force showed that there are approximately 122 urgent care centers in Florida. Of these, about half are open until 8:00 p.m. but less than one-fourth are open past 8:00 p.m. These types of providers could help ease the burden on the hospital ED if they were an option for non-emergent care.

The Florida Legislature in 2004 also encouraged federally-qualified health centers (FQHCs) to provide extended hours of operation to treat urgent care patients and provide case management for ED follow-up care. This same legislation requires hospitals to develop diversion programs such as an “emergency hotline” to help patients determine if their condition is an emergency and to develop “fast track” programs allowing non-emergency patients to be treated at an alternative site, such as a FQHC, county health department, or other non-hospital provider.

Health plans are required to provide a list of alternative urgent care contracted providers and develop community ED diversion programs, which include enlisting providers to be on-call to subscribers after hours, coordinating care through local community resources, and providing incentives to providers for case management. Under consumer-driven healthcare, patients are more sensitive to differences in out-of-pocket costs associated with various settings. Thus, use of higher co-payments and deductibles might result in patients finding alternative, less costly sources for emergency care.

## ***Antiquated State Regulations***

### **Hospital ED Licensure Laws**

The Florida laws dealing with emergency care are primarily located under the hospital licensure statutes in chapter 395 and the Emergency Medical Services statutes in chapter 401.

The Florida Access to Emergency and Care law is in section 395.1041 of the hospital licensure statutes. This law was created in 1988 and, similar to the federal EMTALA law, is focused on ensuring that all patients can obtain access to emergency care regardless of ability to pay.

Additionally, the Florida law requires hospitals to make available on an emergency basis those services that are available on an elective basis. The law identifies a hospital’s emergency capability as any service that appears in a patient’s medical record or itemized bill. The Florida law requires that a hospital must provide such emergency services:

1. 24/7 using it’s own medical staff; or
2. through a prior arrangement with another hospital or other physician; or
3. obtain an exemption from the state.

Hospitals interested in obtaining an exemption from certain types of emergency services must file an application with AHCA. The application for Hospital Emergency Exemption is included in the Appendix. Among the data requested for the exemption application is the number of physicians credentialed to provide that service in which an exemption is sought; a copy of the medical staff bylaws concerning medical staff privileges; number of patients presenting to the ED requiring that service requested in the exemption; number of patients

transferred or diverted requiring that service; number of patients receiving that service on an inpatient basis; a projection of the number of emergency procedures relating to the exemption; a list of hospitals within 50 miles capable of providing that services; and documentation of attempts made by the hospital to enter into agreements with other hospitals or physicians to provide that service.

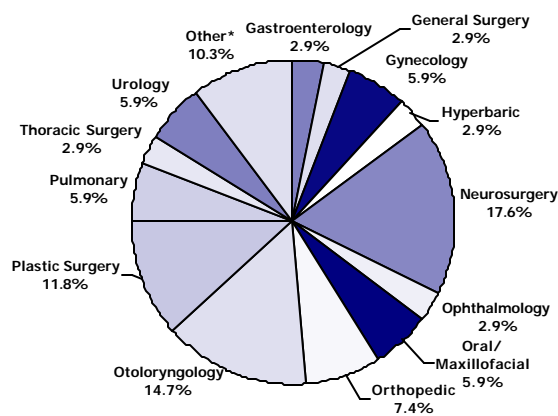
Since 1994, AHCA has received 34 applications for service exemptions for ED on-call coverage from 25 hospitals. The most common types of exemptions sought were for neurosurgery, otolaryngology, plastic surgery, and oral/maxillofacial. Hospitals typically applied for more than one service to be exempted. Once an application is received by AHCA, it can either deny or approve the exemption or grant a partial exemption. Hospitals also could withdraw their application.

### AHCA Procedure for Decisions on Emergency Service Exemptions

- ❖ Emergency Service Exemption Requests are filed by hospitals on specific forms provided by the Agency.
- ❖ The application is reviewed by staff from AHCA's Hospital & Outpatient Services Unit and DOH's Office of Emergency Management.
- ❖ Applicants must demonstrate that the hospital lacks the ability to ensure such capability and it has exhausted all reasonable efforts to ensure service capability through backup arrangements.
- ❖ Information that is reviewed during the process related to the specific service:
  - The total number of specialty physicians on staff.
  - The ability of those physicians to provide ED coverage (age and longevity is considered.)
  - Efforts by the hospital to recruit additional physicians.
  - The number of procedures provided on an inpatient basis for the previous twelve-month period.
  - The number of cases requiring the specialty service in the ED for the previous twelve-month period.
- ❖ When granted, full and partial Emergency Service Exemptions are valid through the hospital's current licensure period. Reapplication must be made at the time of licensure.

Source: AHCA, 2005

**Types of Service Exemption Sought  
Hospitals  
1994 - 2005**



Note: Other includes the following services with only one request: cardiology, hand surgery, infectious disease, intensive care, OB, pediatric, and podiatry.  
Source: AHCA Office of Licensure, 2005

Of the applications filed between 1994 and 2005, AHCA denied a service exemption to 25 hospitals, approved exemptions for 34 hospitals, granted a partial exemption for 23 hospitals, and 12 hospitals withdrew their application.

	Number of Hospitals Filing an Application	Agency Action			
		Denied	Partial	Approved	Withdrawn
1994	2	3	0	8	0
1995	0	0	0	0	0
1996	1	1	0	0	0
1997	0	0	0	0	0
1998	2	0	0	6	0
1999	1	0	0	1	0
2000	0	0	0	0	0
2001	1	1	0	0	0
2002	1	0	0	9	0
2003	7	2	9	5	8
2004	8	6	5	1	2
2005	11	12	9	4	2
<b>Total</b>	<b>34</b>	<b>25</b>	<b>23</b>	<b>34</b>	<b>12</b>

Note: Applications typically included request for exemption for more than one service. Agency action on the same application could have differed by service.  
Source: AHCA Office of Licensure, 2005

Since the passage of this law, the capabilities of hospitals and the volume of emergency care have changed. Because of the complexities of both the federal and state laws in this area, there is concern that many hospitals are unclear as to what the requirements are for both service capability and a state exemption. With fewer specialists, it is more difficult for hospitals to provide on-call services by themselves. There are no standards for what would constitute an exemption from the state.

### **Emergency Medical Services Laws**

Current Florida law under Chapter 401 requires EMS to transport patients to a hospital ED from emergency scenes, regardless of whether the patient actually requires emergency care. Chapter 401 limits the type of care paramedics may provide emergency patients in the field even though they are under the supervision of a medical director. Current definitions of life support techniques and the management of the patient inaccurately describe and limit the scope of practice for a paramedic. There are no provisions in the current law to allow EMTs and paramedics to perform preventative treatments in conjunction with community health programs. With the shortages of specialists and overcrowding in the ED, better use of existing personnel is a priority.

### **Baker Act Patients**

Psychoses is the third most common diagnosis for patients admitted to the hospital from the ED and ranks second for uninsured patients that were admitted to the hospital from the ED. In total, 65,933 patients with psychiatric or substance abuse conditions were admitted to the hospital from the ED in 2004. This represents 5.0 percent of the total admissions from the ED. Of these psychiatric/substance abuse patients, 17 percent were uninsured.

These types of patients typically require a lot of ED resources, including time required to place these patients in an appropriate setting. Delays in finding placement for these patients also contributes to the overcrowding of the ED. Private hospitals, whether for-profit or non-profit, that are designated as Baker Act receiving facilities are not eligible for reimbursement from the DCF.

**Psychiatric/Substance Abuse Admissions  
Where Patient Presented in Emergency Department  
2004**

DRG	Description	All	Uninsured
425	Acute Adjust React & Psychological Dysfunction	2,190	312
426	Depressive Neuroses	4,144	938
427	Neuroses Except Depressive	1,898	366
428	Disorders of Personality & Impulse Control	297	41
429	Organic Disturbances & Mental Retardation	2,746	91
430	Psychoses	42,333	4,323
431	Childhood Mental Disorders	831	58
432	Other Mental Disorder Diagnoses	70	8
	<b>Total Psychiatry</b>	<b>54,509</b>	<b>6,137</b>
433	Alcohol/Drug Abuse or Dependence, Left AMA	957	610
521	Alcohol/Drug Abuse or Dependence w CC	5,647	2,054
522	Alc/Drug Abuse or Depend W Rehabilitation Therapy w/o CC	114	42
523	Alc/Drug Abuse or Depend W/O Rehabilitation Therapy w/o CC	4,706	2,131
	<b>Total Substance Abuse</b>	<b>11,424</b>	<b>4,837</b>
	<b>Total</b>	<b>65,933</b>	<b>10,974</b>

Source: AHCA Inpatient Discharge Database, CY2004

### Medical Practice Act

The Medical Practice Act under chapters 458 and 459 provide for a limited license for physicians who work in medically underserved areas, work for public or nonprofit agencies, or for no compensation. Some retired physicians or part-time residents of the state are interested in working in volunteer clinics for the uninsured but must file for a limited license in order to practice medicine in the State of Florida. While recent legislative changes have made it easier for active license physicians to convert to a limited license and the Board of Medicine gives first priority to applications for limited licenses, there can still be delays in licensing physicians who want to volunteer.

### Nurse Practice Act

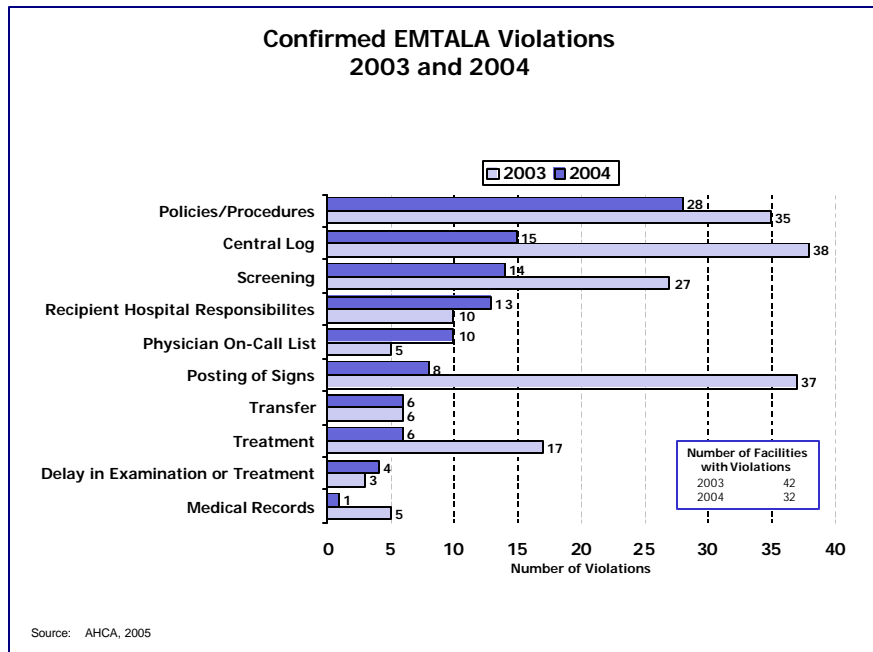
The federal EMTALA law permits physicians and other qualified medical personnel (QMP) to perform medical screenings in the ED. QMPs are defined by the hospital in its bylaws, or its rules and regulations, and approved by the hospital's board. In most states, including Florida, both physicians and allied health practitioners may perform medical screenings for purposes of EMTALA. The Florida Board of Nursing has indicated that the scope of practice for registered nurses in section 464.003(3)(a), F.S., permits the RN to perform observation, assessment, intervention, and evaluation of care. Under the Nurse Practice Act, registered nurses are able to perform the medical screening exams if the nurses demonstrate competency in performing the exam. The registered nurse performs the administration of medications and treatments as prescribed by a duly licensed physician or nurse practitioner. Therefore, the facility would need to have written protocols approved by the medical staff for the ordering of treatments or tests based upon defined symptoms. The protocol should also include procedures for escalation to a physician or nurse practitioner for those situations beyond the scope of the registered nurse's education, experience, and competency. Typically, a quality review process is also instituted to assure proper procedures and outcomes.

## Ambiguous Federal Regulations

### Emergency Medical Treatment and Active Labor Act (EMTALA)

The U.S. Government enacted EMTALA in 1986 and over the years has developed a complex set of regulations and interpretative guidelines requiring a medical screening examination to anyone coming to the hospital, regardless of ability to pay, and if an emergency exists, to either treat the patient or provide for an appropriate transfer. Though the interpretative guidelines have been slightly modified in the past several years, there is still a lack of clarity in several areas.

Originally enacted as an anti-discrimination law to protect against refusal of care to the uninsured, the federal law has become a rigid documentation law that discourages innovative ways to treat the patient. In reviewing the EMTALA complaints in Florida, it shows that there were very few complaints and only a fraction of those were deemed “violations.” Out of seven million ED visits, there were only 231 complaints in 2004. Out of those 231 complaints, only 14 percent were found to be EMTALA violations. It also shows that two-thirds of the violations were for documentation issues. Documentation presents another complicating factor in a busy ED as a recent PriceWaterhouse Coopers study<sup>29</sup> showed that every one hour of patient care in the ED generated one hour of paperwork associated with complying with regulatory and other documentation requirements.



EMTALA places a broad framework of regulations directly on hospitals and indirectly on physicians to ensure emergency healthcare coverage. Unfortunately, these regulatory mandates, created over the past 20 years, are an unfunded mandate and do not address the growing shortages of hospital specialists nor recognize that more care is being handled outside the hospital setting.

EMTALA was also drafted in isolation of managed care and individual state plans for specialized care such as mental health. This lack of coordination has caused great confusion over what is permissible or best for the patient. Added to this confusion is an enforcement mechanism that severely punishes alleged violations with publicity and revocation of Medicare funding with only limited due process.

Though some of these consequences are unintended, this collection of problems creates confusion and ambiguity. That result prevents innovation at a time when the federal government needs to assist hospitals in their efforts to provide needed emergency care to our communities.

More care and treatment is being provided outside the hospital today than it was when the EMTALA law was created in the 1980s. EMTALA needs to recognize a greater use of prior arrangements between hospitals and other treatment sites, greater flexibility on areas where both screening and treatment is performed, greater understanding of the need to direct patients with non-emergent and non-urgent problems to other facilities, and more encouragement of “fast track” programs for low-acuity patients.

For instance, if hospitals and their medical staffs in a particular community agree that community-wide, on-call coverage best meets the needs of their patients, EMTALA should provide clear guidance on how hospitals can collaboratively accomplish that goal. Just as EMTALA recognizes community response plans in national emergencies, the shortage of specialists has reached a point where EMTALA must permit special considerations for on-call coverage ideas. The State of Florida’s statute permits a hospital to meet its emergency care capability requirements either through its own medical staff or through prior arrangements with another hospital or with other physicians. The concept of cooperative agreements that would be encouraged by the federal government could provide some legal comfort. Legislative Intent language from the Florida Access to Emergency Services and Care statute, section 395.1041(1), states: “It is further the intent of the Legislature that hospitals, emergency medical services providers, and other health care providers work together in their local communities to enter into agreements or arrangements to ensure access to emergency services and care.”

## RECOMMENDATIONS

The FHA Task Force on *Addressing the Crisis in Emergency Care Services* explored the problems facing Florida’s emergency medical system. Included among these are ED overcrowding that causes delays in treating and off-loading patients from EMS, inappropriate use of the hospital ED for non-emergency conditions, shortages of physicians willing to take ED call coverage, and outdated federal and state regulations that cause confusion in today’s environment.

After several meetings and conference calls, the FHA Task Force agreed upon the following recommendations as potential strategies for easing the problems in Florida’s emergency care system.

### To Ease Overcrowding Problems in Hospitals

1. Maximize effective use of the hospital ED.
  - a. Expand chapter 401, F.S., the EMS Scope of Practice, to permit EMTs and paramedics to treat patients not requiring hospital emergency care in the field under the direct supervision of the EMS medical director.
  - b. Modify chapter 401, F.S., to allow EMS to transport patients, under the supervision of the EMS medical director, to the most appropriate licensed setting for the patient’s need. These facilities must agree to treat all patients regardless of their ability to pay. Hospital-based ambulances would continue to comply with EMTALA regulations.
  - c. Consider using PAs or ARNPs in conjunction with EMS to treat patients not requiring emergency care in their homes rather than transport them to hospital EDs.
  - d. Encourage physicians, county health departments, and FQHCs to offer extended office hours to their patients to allow more convenient times for patients.
  - e. Increase the availability of alternative sites for non-emergency care, such as FQHCs, volunteer clinics, urgent care centers, and county health departments to provide another option of care for the uninsured.
  - f. Offer “bridge” antibiotic programs that provide a source of medications without requiring the patient to visit the ED.

- g. Educate the public and provide information regarding alternatives to the ED and the potential out-of-pocket cost differences.
  - h. Educate physicians as to the availability of other care sites and incentivize them not to inappropriately use the ED. Provide incentives to physicians for better management of patients with chronic conditions to avoid requiring emergency care services.
  - i. Work with health plans to educate their members on alternative sites of care for non-emergency conditions.
  - j. Explore community case management programs through county health departments, hospitals, and EMS to better manage those patients frequently using the hospital ED for nonemergent care needs.
  - k. Identify a master list of urgent care centers.
2. Reduce backlogs in the ED.
- a. Ensure that EMS patients are off-loaded to the hospital ED as quickly as possible.
    - Encourage prompt off-load of EMS patients by designating a person in the ED to be responsible for ambulance receiving.
    - Change the scope of practice to allow EMS to help with off-loading the patients to the hospital ED subject to each hospital's protocol.
    - Develop regional dispatch programs to better coordinate patient transportation to the hospital that is best able to treat the patient.
    - Implement a real-time system that allows EMS, hospitals, and emergency physicians to know the availability of services, current capacity, and on-call specialties at each hospital and to ensure that each unit is in direct contact with the hospital that is to receive the patient. This would include direct transmission of data to ED computer system.
  - b. Explore ways of improving the medical screening process.
    - Educate hospitals on how registered nurses and other personnel could be used to a greater extent in providing medical screening exams in the ED under the supervision and protocols approved by the hospital. Expanded use of qualified personnel will help ease overcrowding and assist with physician shortages.
  - c. Promote innovative strategies to increase patient throughput in the ED.
    - Implement programs such as a hospital "bed czar" to oversee the demand and resource needs for the entire hospital.
    - Identify processes to minimize the time a patient waits in the ED until admitted to an inpatient or critical care bed.
    - Identify best practices for defining which patients require critical care plans; this would include developing protocols to ensure that patients are placed in the appropriate type of bed.
    - Encourage each hospital to develop an "ED overcapacity crisis plan."
    - Use hospitalists, internists, and PAs to better manage the inpatient stay.
    - Work with medical staff to ensure patients are discharged or transferred to a step-down or a medical bed as soon as possible.
    - Explore creating alternative sites in which to discharge patients that no longer need acute care.
    - Evaluate standing orders for consults to determine if they are appropriate.
  - d. Ensure there is an adequate supply of nurses, paramedics, and allied health professionals to take care of Florida's growing and aging population.
    - Develop and implement equivalency measures to allow Florida to streamline the licensure process between states for nurses, paramedics, and other allied health professionals.

- Expand funding of nursing school programs, nurse faculty positions in Florida, paramedics, EMTs and allied health training programs, such as radiology and ultrasound technologists.

### **To Ease the Shortage of Physicians Taking ED Call**

1. Increase the supply of physicians
  - a. Require the Board of Medicine and the Board of Osteopathic Medicine to expand and enhance licensure data to assess whether a shortage of physicians exists and which specialty areas are most affected. This would include identification of additional data elements addressing physician characteristics, medical specialty, and practice settings that should be collected through the licensure process.
  - b. The state should monitor gaps in the availability of specialties.
  - c. Increase state funding for residency programs. Develop strategies, such as incentives and grants, to encourage Florida medical school graduates to stay in Florida.
  - d. Consider using physicians with medical degrees without a Florida license as a “house” physician. The Board of Medicine permits these unlicensed “house” physicians to be employed by a hospital and used for duties such as histories and physicals, laboratory work, and other functions approved by the medical staff. The “house” physician must work under the direct supervision of a Florida-licensed physician.
  - e. Modify requirements for limited licenses to permit a more expedited application and licensure process before the Board of Medicine and Board of Osteopathic Medicine under chapter 458 and chapter 459, F.S., for physicians wanting to volunteer their time to help the uninsured. A current out-of-state license should be permitted as a substitute for some of the required documentation such as educational background. Also, background checks by the Florida Department of Law Enforcement and the Federal Bureau of Investigation should be expedited.
  - f. Streamline hospital and health plan credentialing processes to expedite granting of privileges to newly licensed and out-of-state physicians interested in practicing in Florida.
2. Encourage licensed physicians to take ED call.
  - a. Explore the option of community-based ED call coverage to determine the feasibility and whether antitrust exemptions are necessary to implement. The creation of a community-based ED call coverage approach is currently being developed in Palm Beach County. This effort should be monitored to determine the appropriateness for other areas.
  - b. Explore potential revenue sources to provide funding to those hospitals and physicians treating uninsured patients in the ED.
3. Grant additional liability protections for emergency services.
  - a. Develop data to create a litigation immunity zone for emergency services to protect EMS, EMS medical directors, hospitals, and physicians.

## **To Modernize Regulations to Reflect the Changing Dynamics of Healthcare**

1. Generally, state laws regulating access to hospital emergency services should be maintained and hospitals and their medical staffs should provide emergency care if they have that capability. However, a few modifications should be implemented that would reduce some of the confusion with the Florida Access to Care laws.
  - a. Educate hospitals on the current capability, exemption, and complaint requirements under state law. Emphasize that if hospitals provide inpatient services as evidenced by their billing records, then the hospital is responsible for providing that service on an emergency basis either through its medical staff or through prior arrangements with other hospitals. Only if those two criteria are not met should a hospital seek an exemption from the state.
  - b. Modify the AHCA form for exemptions to change the requirement to seek local community transfer agreements from hospitals within a 50-mile radius to either the five closest hospitals or all hospitals within a 10-mile range.
  - c. Analyze the state's inpatient database to determine the extent of hospitals' problems with providing services on an emergency basis.
  - d. Evaluate the impact of the current public policy that encourages more specialties to function outside the hospital and not be available for ED coverage. Further study is needed to determine the type of physicians that practice in these settings and whether they have hospital on-call responsibilities or ED transfer agreements.
  - e. Expand the Baker Act to allow private hospitals to be eligible for reimbursement from DCF.
  - f. Develop guidelines for CSUs to provide a minimum mental and medical health screening exam prior to leaving the CSU and to call ahead to the ED and make arrangements for transfer similar to the EMTALA transfer requirement.
  - g. Increase funding of community mental health services to minimize the reliance on acute care hospitals to treat these patients.
2. The EMTALA Interpretative Guidelines should be modified to reflect the current healthcare environment.
  - a. Modify the EMTALA Interpretative Guidelines to either encourage, or at least not discourage, hospitals that want to create innovative community-wide, on-call coverage. Further federal or state action may be needed to provide legal comfort for any antitrust concerns that arise.
  - b. Reevaluate the original intent of the law and allow more flexibility in where patients are screened and treated, including facilities outside the hospital.
  - c. Change the 23/90-day termination process to permit more due process before threatening to publicize the alleged violation or withdrawing Medicare certification based on the alleged violation.

## **CONCLUSION**

Floridians depend upon the emergency care system on a daily basis. Given the increased volume of patients transported by EMS and treated in hospital EDs, the demand on the system is growing to a point that the current system cannot sustain. This crisis facing Florida's emergency care system will have a negative impact on patients, emergency physicians, EMS, and hospitals. No one solution or recommendation will solve these problems. It will require a multi-faceted approach of legislative, regulatory, and operational changes to ease some of the problems facing emergency services in the State of Florida. The issues and recommendations outlined in this paper represent the consensus of the task force members.

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