

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.