

**AMERICAN BAR ASSOCIATION**

**HEALTH LAW SECTION**

**REPORT TO THE HOUSE OF DELEGATES**

**RECOMMENDATION**

1       RESOLVED, That the American Bar Association supports the study of the regionalization of  
2       the nation’s Emergency Care System and Hospital Emergency Departments, including the  
3       need for legislation, rulemaking and policy changes that may be required in order to improve  
4       disaster preparedness and response, patient safety, quality of care, coordination of care, and  
5       increased accountability within the Emergency Care System.

## REPORT

### Emergency Care in Crisis A Case for the Regionalization of Emergency Care

#### I. BACKGROUND

This recommendation responds to increasing concerns about the functionality and viability of the nation's largest safety-net system, the Emergency Care System. Recommendations to restructure and regionalize the Emergency Department ("ED") and its emergency preparedness planning and functionality have been proposed because the emergency care system is currently in a state of crisis. The ED system is overcrowded, under-funded, and highly fragmented.<sup>1</sup> Moreover, EDs face the daunting challenges of reimbursement, ambulance diversion, lack of on-call specialists, and lack of training in disaster preparedness, and shortcomings in pediatric medicine.<sup>2</sup>

Emergency Departments hold a very strategic position in the continuum of care in our society.<sup>3</sup> The ED offers comprehensive services within the hospital (including subspecialty care). The law also requires that the ED treat all patients regardless of whether or not they can pay for the services.<sup>4</sup> Thus, the ED has become the only guaranteed access to healthcare for all Americans, particularly for the uninsured.<sup>5</sup> Although all safety net providers are interdependent, the ED bears most of the burden when other safety net providers are unable to meet the needs of the community. For all intents and purposes, the ED serves as the safety net for the safety net.<sup>6</sup>

The Institutes of Medicine ("IOM") Commission on Emergency Care provides a concise review for understanding the current crisis in emergency care<sup>7</sup>:

#### OVERCROWDING

The emergency care system in the United States is in many ways a victim of its own success. Not only has the hospital ED become the place that Americans turn to first when they have an illness or injury that demands immediate attention, but it has been given a number of other responsibilities as well. EDs today provide much of the medical

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<sup>1</sup> Institutes of Medicine, *The Future of Emergency Care in the United States Health System, Report Brief*, June 2006, at 1.

<sup>2</sup> *See Id. at 1.*

<sup>3</sup> S. Trzeciak and E.P. Rivers, *Emergency Department Overcrowding in the United States: An Emerging Threat to Patient Safety and Public Health*, *Emerg. Med. J* 2003: 20 at 402.

<sup>4</sup> *See Id. at 402.* See also The Emergency Medical Treatment and Active Labor Act ("EMTALA") requires that hospitals examine every individual who presents at the facility, regardless of insurance coverage, for serious medical conditions. 42 USCA Section 1395dd. The facility must then determine whether the condition is serious, and whether the patient is stable enough to be transferred to another facility. 42 USCA Section 1395dd(b)(1).

<sup>5</sup> *See Id.*

<sup>6</sup> *See Id.*

<sup>7</sup> For complete review, See Institutes of Medicine, *Hospital Based Emergency Care: At the Breaking Point; Emergency Medical Services at the Crossroads; and Emergency Care of Children: Growing Pains*, National Academies Press, 2006.

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care for patients without medical insurance. Insured patients increasingly turn to the ED during times when their physician is unavailable, such as evenings and weekends, and they are often sent to the ED for tests and procedures that their physician can't easily perform in the office. In some rural communities, the hospital ED may be the main source of healthcare for a large percentage of residents. EDs also play a key role in public health surveillance and in disaster preparation and response.

Between 1993 and 2003, the population grew by twelve percent and hospital admissions by thirteen percent. ED visits rose by twenty-six percent per year from 90.3 million to 113.9 million.

An aging population and an increasing number of complex medical problems have increased the severity of illness among ED patients.<sup>8</sup> Although there is an increase in the number of visits to the ED, the number of facilities available to meet these needs has decreased. The number of hospitals decreased by 703, hospital beds by 198,000, and 425 EDs.

The increased number of visits has led to overcrowding in the ED.<sup>9</sup> Patients back up in the ED because they cannot get admitted to the inpatient beds. As a result, patients are often boarded-held in the ED until an inpatient bed becomes available – sometimes up to forty-eight hours. These patients have limited privacy, receive less timely services, and do not have the benefit of expertise and equipment specific to their condition that they could get within the inpatient department. “Boarders”, as these patients are called, shrink the capacity of the ED and compromise its ability to provide timely care for incoming ambulance cases. Acute patients who are still waiting to be seen have their ability to receive timely care compromised, and often results in poor outcomes.<sup>10</sup>

An additional practice that negatively impacts patient care is “patient parking.” This occurs when there is adequate emergency staff to see a patient but the staff cannot accommodate the patient at that particular moment, and the ambulance is asked to wait in the parking lot until the patient can be brought into the facility.<sup>11</sup>

Finally, overcrowding of the ED has led to ambulance diversion. Once considered a safety valve to be used only in the most extreme circumstances, such diversions are now commonplace. Half a million times each year—an average of once every minute—an ambulance carrying an emergency patient is diverted from an ED that is full and sent to one that is farther away. In 2004, according to the American Hospital Association (“AHA”), nearly half of all hospitals – and close to seventy percent of urban hospitals –

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<sup>8</sup> Treciak and Rivers, *at 404*.

<sup>9</sup> *See Id.* at 403. (note, overcrowding is defined as an extreme excess of patients in the treatment areas, exceeding ED capacity and frequently necessitating medical care to be provided in the ED hallways and other makeshift examination areas).

<sup>10</sup> Pediatrics, *Overcrowding Crisis in Our Nation's Emergency Departments: Is Our Safety Net Unraveling*, Vol. 114, No. 3, September 2004 at 882-883.

<sup>11</sup> Statement of William A. Sanger, Emergency Medical Services Corporation, Health Subcommittee of the House Ways & Means Committee, July 27, 2006.

diverted patients at some point during the year. Each diversion adds precious minutes to the time before a patient can be wheeled into an ED and be seen by a doctor. These delays may in fact mean the difference between life and death for some patients. Moreover, the delays increase the time that ambulances are unavailable for other patients.

## **FRAGMENTATION**

The emergency care system is also a fragmented one. Once known as the “emergency room”, the ED is now frequently staffed with specialists trained in emergency medicine. Many ambulances employ specialized equipment and EMS personnel trained to stabilize patients and keep them alive until they reach the hospital. But the organization and delivery of these services has lagged behind their technical capabilities, limiting communication and cohesion among the various components of the system. As a result, today’s emergency care system is highly fragmented and variable.

A single population may have many different EMS agencies – some volunteer, some paid, some based in fire departments, others operated by hospitals or private companies – and these agencies do not always interact with one another effectively. EMS workers often cannot even communicate with police and fire departments because they lack compatible communications equipment or operate on different frequencies. Furthermore, EMS agencies in one jurisdiction are often unable to communicate with those in adjoining areas.

There is similar lack of coordination between EDs and the EMS services that deliver their patients. Few systems around the country coordinate the regional flow of emergency patients to hospitals and trauma centers effectively. Most fail to take into account such things as the levels of crowding and the differing sets of medical expertise available at each hospital. Indeed, in most cases, the only time an ED passes along information concerning its status to EMS agencies is when it formally goes on diversion status and refuses to take further deliveries of patients. As a result, the regional flow of patients is managed poorly and individual patients may have to be taken to facilities that are not optimal given their medical needs.

Adding to the fragmentation is the fact that there is tremendous variability around the country in how emergency care is handled. There are actually more than six thousand 9-1-1 call centers around the country and depending on their location, may be operated by the police department, the fire department, the city or county government, or some other entity. There are no nationwide standards for the training and certification of EMS personnel. Also, there is no national accreditation of the institutions that train them. Additionally, there is no single agency in the federal government that oversees the emergency and trauma care system. Instead, responsibility for EMS services and for hospital based emergency and trauma cases scattered among many different agencies and federal departments, including Health and Human Services, Transportation, and Homeland Security. Because responsibility for the system is fractured, it has very little accountability. In fact, it can be difficult to determine where system breakdowns occur or why.

## SHORTAGE OF ON-CALL SPECIALISTS

The shortage of on-call specialists and shortcomings in pediatric emergency care contribute to the crisis. Key specialists are in short supply. For example, the number of neurosurgeons declined between 1990 and 2002, while the number of trauma visits increased. Hospitals are required to provide the same services to its inpatients as well as those treated in the ED. The problem is finding specialists who are willing to be on-call in the ED.

There are a variety of reasons for the shortage of on-call specialists. First, many specialists find that they have difficulty getting paid for their ED service because many emergency and trauma patients are uninsured. Specialists are also deterred by the additional liability risks of working in the ED. Many of the procedures performed in the ED are inherently risky and physicians rarely have an existing relationship with emergency patients. The result is that insurance premiums for doctors who serve as on-call specialist are too expensive. Specialists who attempt to find work-life balance discover that the demands of providing on-call services are too disruptive to their private practices and their family life. Additionally, specialists tend to interpret EMTALA as a mandate to provide uncompensated care. Research also shows that the law is widely believed to be a primary factor behind behavior changes that are taking surgeons away from hospitals and the ED.<sup>12</sup> Moreover, hospital by-laws require surgeons to participate in on-call panels, although older individuals are often allowed to “opt out”, and more are choosing this option, thus further straining the system.<sup>13</sup>

Secondly, in November 2003, the Centers for Medicare & Medicaid Services published new rules for interpretation of EMTALA.<sup>14</sup> Accordingly each hospital must maintain an on-call list of physicians on its medical staff in a manner that best meets the needs of its patients, in accordance with available resources.<sup>15</sup> As such, there is no minimum requirement for frequency of on-call coverage according to the number of specialists a hospital has on its medical staff and that it would be up to each hospital to adopt its own reasonable coverage standards.<sup>16</sup>

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<sup>12</sup> American College of Surgeons, *A Growing Crisis in Patient Access to Emergency Surgical Care*, 2006 at 8. See also S. 1003 and H.R. 882, *Access to Emergency Medical Services Act of 2007* which seeks to amend title XVIII of the Social Security Act to improve access to emergency medical services and the quality and efficiency of care furnished in emergency departments of hospitals and critical access hospitals by establishing a bipartisan commission to examine factors that affect the effective delivery of such services, by providing for additional payments for certain physician services in such emergency departments, and by establishing a Centers for Medicare & Medicaid Services Working Group, and for other purposes.

<sup>13</sup> *Id.*

<sup>14</sup> *Annals of Emergency Medicine, The On-Call Crisis: A Statewide Assessment of the Costs of Providing On-Call Specialist Coverage*, Vol. 49, No. 6: June 2007 at 727-728.

<sup>15</sup> *Id.*

<sup>16</sup> *Id.*

In response, many hospitals have resorted to offering payment of nightly or monthly stipends to specialists to take a call, guaranteeing pay for care provided to uninsured patients, or by abandoning any pretense of call coverage for many specialties.<sup>17</sup>

In order to address this growing problem, the Oklahoma state legislature recently enacted a “pay or play” statute aimed at spreading the responsibility of call coverage among several hospitals, requiring hospitals that do not maintain specialist on-call panels to contribute financially to the program.<sup>18</sup>

### **SHORTCOMINGS IN PEDIATRIC EMERGENCY MEDICINE**

Hospitals are ill equipped to treat the most vulnerable patients: children. Injured children have different medical needs than adults with the same problem, and their bodies will respond differently than adults in similar medical crisis.<sup>19</sup> They also have different emotional needs, often reacting differently to an injury or illness than adults do.

Only six percent of US EDs have all supplies necessary for handling a pediatric patient although children make up twenty seven percent of all visits to the ED. Moreover, only about half of the departments had even eighty five percent of the essential supplies. Training is also an issue. Many EDs, particularly those in rural communities, rely on doctors and nurses without specialized pediatric training to handle pediatric patients. Many EMS agencies require little pediatric training of their personnel.

A number of large cities do have children’s hospitals or hospitals with pediatric EDs that offer state of the art treatment for children. Unfortunately, the vast majority of ED visits by children are made instead to general hospitals, which usually do not have either the specially trained staff or the special equipment necessary to provide the best care to these younger patients.

### **LACK OF DISASTER PREPAREDNESS**

A necessary component of the emergency response to terrorism, bioterrorism, and disaster is the readiness of the US ED.<sup>20</sup> The most relevant question is whether or not our emergency care system can handle a disaster on a large scale. The terrorist attacks of September 11, 2001 have brought greater focus on US disaster preparedness. Moreover, US News and World Report stated in its September 10, 2001 issue that the nation’s emergency care system was in critical condition as a result of demand far in excess of its

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<sup>17</sup> *Id.* At 728.

<sup>18</sup> *Id.*

<sup>19</sup> Testimony of Steven Krug, MD, FAAP, On Behalf of the American Academy of Pediatrics, Homeland Security Subcommittee on Emergency Preparedness, Science and Technology, July 26, 2006.

<sup>20</sup> Institutes of Medicine, *Hospital-Based Emergency Care: At the Breaking Point*, The National Academies Press, at 202. (noting The International Federation of Red Cross and Red Crescent Societies defines a disaster as an event that causes more than ten deaths, affects more than 100 people, or leads to an appeal by those affected for assistance. The IOM report expands the definition in the context of hospital-based emergency and trauma care to include any event that creates a significant, short-term spike in the demand for emergency care services which requires extraordinary measures to adequately address.)

capacity. This revelation remains true today. Many hospitals currently operate at capacity or near capacity. A majority, however, of EDs reported that they were at or overcapacity for at least fifty percent of the time in 2003. Forty-five percent of emergency departments diverted ambulances during 2003. Although overcrowding is an issue, for the most part, hospitals can maintain their normal standard of care through temporary surges. Yet, in a disaster situation, surge capacity becomes a problem, as hospitals may need to shift to a sufficiency-of-care mode.

In order to respond effectively, incident control must be clear, communications good, and providers at the local level involved in the process. In the event of a disaster, local emergency providers must respond as additional resources are mobilized at state or federal levels. Furthermore, only regional and local planning can adequately anticipate and address local utilization patterns that will impact execution of plans. All hospitals must be prepared to receive patients suffering from any type of illness, injury or exposure in order to respond effectively.

The ability of a hospital to respond and execute its disaster preparedness plan is exacerbated by a lack of funding. Hospital grants for the Health Resources and Services Administration's ("HRSA") Bio-terrorism Hospital Preparedness Program in 2002 were generally between \$5,000-\$10,000. The amount is not enough to equip even one critical care room. Hospitals must be able to protect its patients and its staff in the event of a disaster.

Joint Commission for Accreditation of Healthcare Organizations requires hospitals to have an emergency preparedness plan, with training as a key component. Training varies among the hospital staff with ninety two percent of nurses receiving training in at least one type of emergency. The percentage decreased among residents and interns. Approximately forty nine percent of residents and interns received training. In addition, training provided to physicians in medical school and continuing education program does not uniformly incorporate training on the threat of disasters, types of Weapons of Mass Destruction (WMD) agents, and procedures for handling mass casualty incidents and events. Disaster training is not a core component for nursing curriculum. WMD topics and agents have been added to the Emergency Nurses Association's (ENA) Emergency Nurse's Core Curriculum. Only a small percentage of nurses, however, undertake this training.<sup>21</sup>

## II. ABA POLICY AND RECOMMENDATIONS

The nation's emergency care system and ED are at a critical juncture in our society. In order to improve the nation's emergency care system, The IOM, the American Academy of Pediatrics, and the Emergency Nurses Association, recommend the regionalization of emergency care, specifically as it relates to disaster preparedness. This recommendation is in response to the fragmented nature in which our emergency care is distributed. The emergency care system should be coordinated, regionalized, and accountable. The American Bar Association ("ABA")

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<sup>21</sup> See Institutes of Medicine, *Hospital Based Emergency Care: At the Breaking Point*, at 212.

encourages further study of their recommendations that emergency care should be coordinated and one of accountability. With regard to regionalization of emergency care, particularly disaster preparedness, the ABA concurs that this approach in addressing the crisis in emergency care ad should be explored.

Despite the potential benefits of regionalization, the ABA recognizes that there are challenges to its implementation. First, the issue of whether regionalization satisfies EMTALA regulations need to be addressed.<sup>22</sup> The Centers for Medicare & Medicaid Services (“CMS”) have not clarified whether regionalization satisfies EMTALA regulations.<sup>23</sup> Regionalization requires the cooperation and collaboration of health care providers who otherwise are competitors or potential competitors. There needs to be substantial clarification or waivers of the federal antitrust, antikickback, and Stark referral laws in order for regionalization to work.<sup>24</sup>

It is not the ABA’s policy to dictate to the federal, state and territorial governments how much they should spend. The fact is simple and plain. This multi-disciplinary approach will not work without additional government funding for disaster preparedness. Hospitals will require funding to strengthen and sustain the trauma care systems, effectively train staff on explosives and biological terrorism, and appropriate personal protective equipment. It should be able to have the enhanced availability of decontamination showers, standby ICU capacity and negative pressure rooms.

### III. CONCLUSION

The American Bar Association (ABA) recognizes and understands that the significance of the crisis in the nation’s emergency care system and the lack of disaster preparedness. Health care and public health preparedness are front and center on all levels of government-local, state and federal.

The ABA is uniquely qualified to engage its colleagues and stakeholders in dialogue about this important issue. First, the members of the ABA have a vast knowledge of healthcare and the legal and policy aspects surrounding it. Secondly, the ABA members are willing to share their knowledge and offer advice and counsel about healthcare and public health law. They are intertwined and cannot be discussed in silos. By sharing and discussing these matters with stakeholders across the board, both sides will develop a deeper knowledge base regarding this important issue. Third, and most importantly, the ABA recognizes that improvements in the Emergency Care System may require changes to current laws, rules and policies to realize its full potential.

Respectfully submitted,

Paul R. DeMuro

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<sup>22</sup> Annals of Emergency Medicine, at 732.

<sup>23</sup> *Id.*

<sup>24</sup> *Id.*

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Chair, Health Law Section

August 2007

## GENERAL INFORMATION FORM

To Be Appended to Reports with Recommendations  
(Please refer to instructions for completing this form.)

Submitting Entity: Health Law Section

Submitted By: Paul R. DeMuro, Chair

1. Summary of Recommendation(s).

The report and recommendation encourages the ABA to support study of the regionalization of the nation's Emergency Care System and Emergency Departments specifically as it relates to disaster preparedness.

2. Approval by Submitting Entity.

Approved by Section Council May 7, 2007.

3. Has this or a similar recommendation been submitted to the House or Board previously?

No.

4. What existing Association policies are relevant to this recommendation and how would they be affected by its adoption?

The following policies are relevant to, and would be enhanced by, this recommendation:

- Policy 06M305 which addressed the issues identified by Hurricanes Katrina and Rita by specifically including issues related to the provision of health care in emergencies.
- Policy developed in February 1990 and affirmed in February 1994 which would "provide for every American to have access to quality health care..." This report and recommendation would ensure that such access would be available in times of emergency.
- Policy 06A305, the Uniform Emergency Volunteer Healthcare Practitioners Act, which allows necessary regionalization should emergencies arise.

5. What urgency exists which requires action at this meeting of the House?

The nation's Emergency Care System is currently in crisis and action is needed as soon as possible.

6. Status of Legislation. (If applicable.)

Congress has before it legislation to form a committee to provide recommendations on physician fee payment in Emergency Departments. S1003 - Access to Emergency Medical Services Act of 2007 was introduced in the Senate on March 28, 2007 by Senator Stabenow and Senator Specter. HR 882, the House version, was introduced by Representative Gordon of Tennessee on February 7, 2007.

7. Cost to the Association. (Both direct and indirect costs.)

None.

8. Disclosure of Interest. (If applicable.)

None.

9. Referrals.

This report and recommendation will be referred to the Section of State and Local Government, the Young Lawyers Division, the Section of Individual Rights and Responsibility, , the Section of Family Law, and the General Practice Division.

10. Contact Person. (Prior to the meeting.)

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11. Contact Person. (Who will present the report to the House.)

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