

Emergency Medical Services Access Task Force Report

December 13, 2006

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Executive Summary

On May 25, 2006, Governor Janet Napolitano signed Executive Order 2006-09, forming the Emergency Medical Services Access Task Force (EMSA Task Force or the Task Force). The Executive Order recognized that Arizona faces increasing strain on its medical emergency and trauma systems, due in part to the combination of explosive population growth and national and State physician shortages. The Governor charged the EMSA Task Force with assessing the status of the emergency department and trauma center physician supply, and developing recommendations to improve the number of physicians who are providing emergency and trauma care in our State.

The Task Force obtained and reviewed data and received public input on issues related to the Task Force's objectives, and considered various recommendations presented by individual Task Force members who represent a cross section of various healthcare interests.

The Task Force found the following to be major contributing factors to the shortage of physicians serving Arizona's emergency departments and trauma centers:

- Unprecedented Demand for Health Care Services as the Result of Arizona's Population Growth and Demographics
- Limited Physician Supply
- Reluctance of Physicians to Provide On-Call Services in Emergency Departments and Trauma Centers

To address the shortage of physicians in the State and the inadequate number of physicians available to provide on-call services to hospital emergency departments and trauma centers, the Task Force has made a number of recommendations. The Task Force believes that no one recommendation will resolve the current physician shortage and access concerns but that, instead, a broad-based, comprehensive approach is critical to obtaining the desired objectives. Accordingly, the Task Force recommends the following solutions:

- Increase the Overall Supply of Physicians (Primary and Specialty) in Arizona
 - Increase Funding for Graduate Medical Education
 - Expand the Capacity of the Downtown Phoenix Campus of the University of Arizona Medical School
 - Attract and Retain Physicians from Out-of-State
 - Reduce Obstacles to Medical Practice in Arizona
 - Better Utilize Retired and Part-Time Physician Workforce
 - Implement Strategies to Improve Access to Primary Care Providers to Reduce the Need for Emergency Physician Services in the State

- Increase the Number of Physicians Available to Provide Emergency Department and Trauma Center Services
 - Enhance Reimbursement for Physicians Providing Emergency Department and Trauma Center Services
 - Redesign Relationship Among Hospitals, Managed Care Plans and On-Call Physicians
 - Improve the Medical Liability Environment for Hospitals, Health Care Providers, and Physicians That Provide Emergency Department and Trauma Center Services
 - Utilize Technology to Assist Physicians Providing Emergency and Trauma Center Services

In addition to these recommendations specifically designed to improve access to hospital emergency department and trauma center physician services, individual Task Force members made several recommendations that were outside the scope of the Task Force. The Task Force raises related recommendations for review and further discussion by the appropriate regulatory bodies. Finally, the EMSA Task Force recommends a timeframe for implementation, as well as measures of success to monitor the efforts of its recommendations.

Introduction

While the number of physicians practicing in Arizona continues to rise, Arizona's unprecedented population growth has historically outstripped the State's ability to attract and train sufficient physicians to practice in the State, particularly in rural and medically underserved areas. Without significant efforts, Arizona's critical service shortfalls will only worsen.

Likewise, Arizona hospitals are experiencing unprecedented demands for emergency and trauma services, exacerbated by a shortage of hospital beds and staff. A particularly acute dimension of this issue is the lack of physicians available and willing to serve emergency department and trauma patients. Unlike past historical practice patterns, today, most Arizona hospitals do not directly employ the majority of physicians serving on their medical staffs. Hospitals therefore, must rely on an adequate number of physicians choosing to become medical staff members and on medical staff bylaws and hospital directives that require medical staff members to serve periodically "on call" in the emergency department. A complex web of federal laws and regulations, reimbursement, liability and credentialing issues, and such matters as funding for graduate medical education, all influence physician availability and willingness to provide emergency department and trauma center services. Because of the complexity of these influences, hospitals cannot solve the physician shortage alone. However, solutions may come from meaningful discussion among key stakeholders.

It is commonly accepted that Arizona hospitals already suffer from inadequate emergency department and inpatient capacity and an overall physician shortage. Because demand for access to emergency and trauma services will increase proportionately as Arizona's population grows and ages, a comprehensive assessment and development of strategies is needed now. In order to accomplish this goal, in establishing the EMSA Task Force, Governor Napolitano brought together experienced stakeholders to address likely causes and make recommendations for meaningful improvements.

The EMSA Task Force is not alone in this effort. The Arizona Department of Health Services has formed several working groups to address related hospital overcrowding issues, including hospital throughput, diversion strategies, hospital surge capacity, education and best practices in emergency department management.

Governor Napolitano issued Executive Order 2006-09 on May 25th 2006 to establish the Emergency Medical Services Access Task Force. The Executive Order specifically charges the EMSA Task Force with assessing the status of Arizona's emergency department and trauma center physician supply, identifying factors that may have lead to the current shortage, and making recommendations, including time frames, for actions the State may take to address the situation. The Governor has requested a full report of these findings and recommendations by January 1, 2007.

The members of the Task Force are experienced individuals interested in improving access to emergency and trauma care in Arizona. Applying their own experience and expertise, as well as considering information provided by the public and the members¹, the EMSA Task Force has provided specific recommendations. Ultimately, no one recommendation will adequately increase physician resources in hospital emergency departments and trauma centers. Stakeholders, including the public, will need to work collaboratively over time to make improvements and assure public access to quality emergency and trauma services throughout Arizona.

¹ For a list of documents and references reviewed by the EMSA Task Force see Appendix A.

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Task Force Findings

The EMSA Task Force identified a set of core factors that have influenced the current shortage of physicians providing medical emergency and trauma services.

I. Unprecedented Demand for Health Care Services as the Result of Arizona's Population Growth and Demographics

Arizona is one of the fastest growing states in the nation. Arizona's population has grown from 3.7 million in 1993 to 5.9 million in 2005. This exceptional growth, over a short period of time, has produced many challenges, but one of the most serious involves the State's health care delivery system. Population growth has outpaced health care facility construction, workforce training, and physician supply.

Looking to the future, Arizona's elderly, the population with the greatest overall acute health care needs, will triple in size and represent 26% of the State's population by 2050. Based on current and projected population increases, Arizona will certainly need additional hospital beds.

With increased population inevitably comes an increased volume of patients in emergency departments and trauma centers. For most hospitals, the sheer number of patients makes it difficult and sometimes impossible to provide care for emergency department patients in a timely manner. The result is a greater need for physicians to serve those patients, both in the emergency departments themselves and during the inpatient hospital stays that follow for some patients. One component of increased patient volume believed to have an especially significant impact on emergency department crowding is the volume of patients needing urgent psychiatric care services.

II. Limited Physician Supply

While the number of physicians practicing in Arizona is increasing, the increases have not always happened fast enough to keep up with Arizona's growing population. Indeed, today, Arizona's physician workforce in Arizona continues to increase, largely by in-migration, at pace with population growth.² Still, a shortage exists. The Arizona physician workforce increased by 51% from 8,026 physicians in active practice in 1994 to 12,121 in 2004. The increase in the physician workforce outpaced the increase in the Arizona population during the same decade resulting in an increase in the physician to population ratio from 190/100,000 to 208/100,000. However, the physician to population ratio in Arizona was still far below the national average of 283/100,000 in 2004. In 2005, there were 13,215 active physicians practicing in Arizona resulting in a physician to population ratio of 219/100,000. This compared to a national estimate of 293/100,000. Arizona's physician to population ratio continued to be well below the national average. The estimated shortage of physicians in Arizona in 2005 was over 2,200.

² The Arizona Physician Workforce Study - Part 1: W. Johnson, M. Rimsza, T. Garey, M. Grossman, 2005, and The Arizona Physician Workforce Study: Part II, 1994-2005. M. Rimsza, W. Johnson, M. Speicher, M. Grossman, 2006.

All or part of every county in Arizona has been designated as a Health Professional Shortage Area (HPSA). Thirty-nine Medically Underserved Areas (MUAs) and eleven Medically Underserved Populations (MUPs) have also been designated. In total, there are fifty medically distressed areas in the State. Four counties have been designated as whole county MUAs and two counties as whole county MUPs. Although each county has improved the ratio of physicians to residents between 1992 and 2004, no county in the State has met the 2005 national average.

The EMSA Task Force attributes Arizona's physician shortage to a number of factors. One factor is the limited number of graduate medical education programs and resident training positions in the State. Arizona has only 20 residency positions for every 100,000 people, compared to 25 or more resident training positions for other western States. To reach even this basic level, Arizona must add 300 new residency positions. Since studies show that a majority of physicians who attend residency programs in Arizona later practice medicine in the State, it is important to attract new physicians with increased and enhanced graduate medical education training opportunities. Indeed, Arizona's resident retention rates are among the second best in the country.³

Arizona's medical liability environment may also be an important factor. The Arizona Medical Association and numerous specialty societies consider Arizona to be in need of medical liability reform. This lack of reform may make Arizona less attractive to physicians than other States.

There is some concern that low physician reimbursement for health care services is also a cause of Arizona's physician shortage. Despite the record increase in health insurance premiums for employers each year beginning in 2002, Arizona's managed care plan fee schedules have not kept pace with physician practice expenses within the past five years, resulting in an overall decrease in physician reimbursement. For example, nationally, primary care physicians' income, adjusted for inflation, decreased by 10.2% between 1995 and 2003.⁴

Finally, physicians also cite barriers to licensing and managed care credentialing as factors relevant to Arizona's physician shortage.

III. Reluctance of Physicians to Provide On-Call Services in Emergency Departments and Trauma Centers

The EMSA Task Force noted an increasing complaint among hospitals about the decreasing numbers of physicians available and willing to serve on-call in emergency departments and trauma centers. Task Force members identified several factors that may deter physicians from serving in an emergency department or trauma center.

3 JAMA September 7, 2005 Article volume 294 No. 9

4 Center for Studying Health System Change (HSC), 2004-2005 Community Tracking Study Physician Survey.

To begin with, physicians often find emergency service unattractive because it involves disruption to both personal life and private practice.⁵ The federal EMTALA law and regulations currently require hospitals (and their on-call physicians) to accept emergency transfers from hospitals and communities across the State and beyond, which increases the burden on on-call physicians.⁶ Once they have evaluated and treated patients in the emergency setting, physicians may be required to continue to see these patients for a period of time until their condition is stabilized or resolved, sometimes without reimbursement. In some instances, such follow-up care is made more difficult by the patient's insurance plan or failure to follow discharge instructions.

As a complicating factor, an increased patient population and use of hospital emergency departments by patients seeking primary care or non-emergent services has placed an unprecedented burden on hospital emergency departments and trauma centers.⁷ Many hospitals report that their inpatient units and emergency departments are routinely overcapacity. This increased patient volume further increases the demands on the State's on-call physicians, particularly as the demands of their own practices are also increasing.

Compounding this problem is the fact that hospitals and physicians sometimes have little historical and clinical information on emergency department patients, who frequently present with complex medical issues. Finally, uncompensated care for hospitals and on-call physicians is a significant concern.

Many physicians also contend that emergency department and trauma patients result in increased EMTALA and medical liability to the physician, which a physician is not always willing to assume. In a recent informal survey conducted by the Arizona Medical Association, 23% of physicians who do not currently take emergency department calls stated that the primary reason was increased medical liability exposure.⁸

To cope with these concerns, some physicians are increasingly obtaining selective or narrow medical staff privileges in hospitals, or dropping medical staff privileges altogether. Such a choice reduces the physician's ability to serve patients in the emergency department.⁹ Moreover, some specialists have the ability to perform their more lucrative procedures outside of the hospital setting in facilities such as specialty surgical hospitals or other ambulatory care settings, reducing the need for medical staff membership altogether.¹⁰

In an effort to maintain on-call services, as required by federal law, many hospitals now compensate physicians for their on-call services. Irrespective of this effort, hospitals are finding it increasingly difficult to provide on-call physician services in

5 See e.g., American College of Surgeons, "A Growing Crisis in Patient Access to Emergency Care" (June 2006); Arizona Medical Association, ED Specialist 2006 Survey.

6 See e.g., American College of Surgeons, "A Growing Crisis in Patient Access to Emergency Care" (June 2006).

7 St. Luke's Health Initiatives, Fact and Fiction: Emergency Department Use and the Health Safety Net in Maricopa County (April 2004).

8 Arizona Medical Association ED Specialist 2006 Survey.

9 See e.g., American College of Surgeons, "A Growing Crisis in Patient Access to Emergency Care" (June 2006).

10 See e.g., Mitchell, J.M., "Effects of Physician-Owned Limited Service Spine and Orthopedic Hospitals in Oklahoma," Georgetown University Public Policy Institute (April 26, 2005).

a variety of core services, including, for example, orthopedics and neurosurgery. For fear of losing these specialists from hospital medical staffs altogether, some hospitals are forced to offer physicians less demanding on-call coverage schedules, further reducing patient access to critical on-call physician services.

Task Force Recommendations

The EMSA Task Force has generated a variety of recommendations to address the shortage of physicians available to provide services in hospital emergency departments and trauma centers. These recommendations are set forth below.

I. Recommendations to Increase the Overall Supply of Physicians (Primary and Specialty) in Arizona

The shortage of on-call physicians for emergency department and trauma services is directly tied to the overall shortage of physicians in Arizona. Task Force members believe that more rapidly increasing the number of physicians in the State would increase the pool available for emergency department and trauma services. The Task Force requests that the following recommendations be implemented, in addition to the recommendations set forth elsewhere in this report.

A. Increase Funding for Graduate Medical Education

- Increase the number of graduate medical education (GME) programs and resident slots, so that a larger number of residents and fellows will complete their training in Arizona. Studies show that physicians who train in a State are more likely to continue their practice in that State. In 2006, Governor Napolitano and the legislature approved new funding for GME programs. This is a critical investment that the State should continue to build on. A goal for the State to consider is to ensure that Arizona's GME opportunities are on par with other western States. To do this, Arizona needs at least 300 new resident positions, at an estimated total cost of \$100,000 per resident. Expansion of residency programs is an effective approach to gain ground on the current physician shortfall throughout the State, particularly in rural areas. New funding targeting programs and rotations in rural areas would significantly increase the likelihood of retaining physicians in those areas. Funding GME programs through the Medicaid program allows the State to utilize an approximate 66% match of federal dollars to help finance these programs.
- Provide graduate medical education funding to provide "refresher" courses and training programs for physicians who wish to reenter the workforce after a period of years (e.g., semi-retired physicians, physicians who have taken a leave of absence, or physicians who would like to reenter the workforce after a period of years).

B. *Expand the Capacity of the Downtown Phoenix Campus of the University of Arizona Medical School*

- It is recognized that increasing the number of medical schools in Arizona will be helpful in addressing physician shortfalls.¹¹ Leaders from the State, City of Phoenix, universities, medical sector and nonprofit sector came together and accomplished the essential task of expanding the University of Arizona's Medical School to downtown Phoenix. In the fall of 2007, the first 24 students will enter the campus. This is a critical accomplishment for Arizona. Now, however, efforts to rapidly reach the school's goal of serving a 150-student per class capacity must be a priority for the State.

C. *Attract and Retain Physicians from Out-of-State*

- Provide "one-stop shopping" service for licensure and credentialing for physicians who wish to practice in Arizona. This may be accomplished through a physician recruitment office or agency, either state or privately funded, that works with the State's two physician licensing boards, managed care plans, and hospitals to provide assistance with the physician licensure, credentialing, and hospital privileging process. The office or agency would review and approve physicians for licensure and credentialing in a manner that is compliant with State licensure requirements, National Committee for Quality Assurance (NCQA), Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and other accreditation standards for physician licensure and credentialing, which would then be accepted by the State's licensing boards and managed care plans.
- Adopt and require the use of a single application for licensure and managed care credentialing, so that physicians do not have to complete multiple applications, similar to those implemented in other states.
- Market Arizona as an attractive place for physicians to practice. Provide assistance for physicians relocating to Arizona (e.g., real estate agent referrals, physician market information, business assistance and favorable loan terms to physicians who wish to practice in Arizona).
- Establish a State physician loan payment program for physicians willing to practice in the State for at least two years and provide on-call services in the State, assuming that the physician practices in a community where a hospital is located. This program may be tailored to apply to certain types of physicians that are in demand as determined by relevant data (e.g., rural primary care physicians, designated specialists).

¹¹ The Arizona Physician Workforce Study – Part II: 1994-2005. W. Johnson, M. Rimsza, M. Speicher, M. Grossman, 2006

- Provide additional education and assistance to physicians who have just completed their residency programs to assist them in practical obstacles such as joining or opening a medical practice and obtaining managed care contracts.

D. *Reduce Obstacles to Medical Practice in Arizona*

- Provide funding to Arizona's two State physician licensing boards to expedite and streamline the physician licensure process in the event that a single licensure/credentialing process cannot be implemented as described above.
- Assist managed care companies in reducing their initial credentialing timeline by working with NCQA, JCAHO, or other national accrediting agencies to simplify their credentialing procedures, in the event that a single licensure/credentialing process cannot be implemented as described above.
- Work with managed care plans to promptly provide retroactive reimbursement for services physicians render to plan subscribers before the physician credentialing process is completed.

E. *Better Utilize Retired and Part-Time Physician Workforce*

- Provide incentives for retired and part-time physicians to continue to provide physician services within the State, consistent with those recommended for all physicians, as described elsewhere in this report.

F. *Implement Strategies to Improve Access to Primary Care Providers to Reduce the Need for Physician Services in the State*

EMSA Task Force members believe that physician workloads could be reduced if there is more effective utilization of nurse practitioners. Nurse practitioners are highly-qualified independent practitioners that can positively impact access to primary care services. In addition, recognition of nurse practitioners as independent practitioners in the field will help reduce the need for emergency department services.

- Work with AHCCCS managed care plans and other private health insurance plans that do business in Arizona to credential, empanel, utilize and directly reimburse independent nurse practitioners, consistent with the AHCCCS and Medicare reimbursement methodology for these practitioners. Registered nurse practitioners have autonomous practice authority under Arizona law, but if they cannot be reimbursed for their services they cannot establish financially viable offices and clinics to provide primary care services to Arizona residents.

- Promote efficient use of nurse practitioner services in emergency departments.
- Implement measures similar to physician incentives set forth in this report to increase the number of nurse practitioners in the State (e.g., increased education funding, decreased obstacles to practice in the State).
- EMSA Task Force members believe that physician workloads could be reduced if the shortage of other types of health care providers within the State were adequately addressed. The Task Force recommends that the State continue its efforts to increase the nurse workforce and implement measures to attract other types of health care professionals, including physician assistants, therapists, technicians, and other providers to the State.

II. Recommendations to Increase the Number of Physicians Available to Provide Emergency Department and Trauma Center Services

A. Enhance Reimbursement for Physicians Providing Emergency Department On-Call and Trauma Center Services

EMSA Task Force members strongly believe that the number of physicians available and willing to provide emergency department, on-call, and trauma services could be increased through appropriate and targeted reimbursement. This Task Force, however, lacks the specific expertise to determine the precise changes to existing reimbursement systems necessary to accomplish this result. Accordingly, the Task Force recommends that the State, through agency staff, initiate a study to determine the best method(s) to provide additional reimbursement to hospitals or physicians for on-call emergency department and trauma center services. In undertaking the study, the relevant agency should consult with stakeholders including private and State-contracted managed care plans, physicians, and hospitals. As part of this work, the Task Force recommends that this reimbursement study specifically review and consider the following potential reimbursement mechanisms:

- Tax incentives or tax credits to licensed Arizona physicians related to the provision of on-call services. For example, such physicians could receive tax credits related to otherwise uncompensated care they provide, or related to their malpractice premiums.
- Supplemental reimbursement to licensed Arizona physicians related to the provision of on-call services to patients. For example, create a special code or modifier that will designate that on-call physician services are provided, which increases payment for the service rendered by a pre-determined percentage or amount. This reimbursement mechanism may be adopted by other payors.

- Federal and State funds to create an “indigent care fund” available to hospitals and physicians to offset the cost of uncompensated care provided to emergency and trauma patients.
- Other mechanisms designed to improve physician reimbursement and hospital reimbursement that would encourage physician participation in hospital emergency department and trauma center on-call lists.

B. Redesign Relationship Among Hospitals, Managed Care Plans and Physicians

The Task Force believes that the relationship among hospitals, managed care plans, and physicians could be improved and that these improvements would result in an increase in the number of physicians available and willing to provide services to hospital emergency departments and trauma centers. These matters are complex, however, and the Task Force does not believe that it has sufficient expertise to make specific recommendations in this regard, particularly given the time available to the Task Force. Accordingly, the Task Force recommends that a separate Task Force be established to review and make recommendations with respect to improving the relationship among hospitals, managed care plans and physicians. The Task Force recommends that this separate Task Force, which should consist of representatives from hospitals and managed care plans, as well as physicians, and other stakeholders, review and consider the following potential solutions as part of its charter:

- Streamlined managed care credentialing processes for *locum tenens* physicians who provide on-call services to managed care plan beneficiaries.
- Managed care reimbursement of non-contracted physicians for the provision of on-call services to managed care plan beneficiaries.
- Managed care plans’ authorization of non-contracted on-call physicians to provide follow-up care to patients initially seen in the emergency department or trauma center and reimbursement to non-contracted physicians for such follow-up care.
- Managed care plans agreement to assure the availability of sufficient numbers of on-call physicians at network hospitals to provide emergency and follow-up care services to insured patients. Under this approach, insured patients would never or rarely be treated as “unassigned patients” for on-call purposes.
- Establishment of a combined physician specialist call rotation for all facilities within a geographic area, utilizing a “center for excellence” approach similar to the approach taken by trauma centers and the Arizona Perinatal Trust.
- Evaluation of potential regulatory barriers that may impede the development of shared, community, or regional on-call arrangements.

- Evaluation of physician ability to obtain selective or narrowed medical staff privileges and the impact on the provision of frequently needed on-call services.
- Evaluation of whether physicians who provide services in ambulatory surgical centers or licensed outpatient treatment centers, or who provide high risk surgical procedures in private physician offices, should maintain active medical staff membership and provide on-call services at a local hospital in order to reduce physician flight from hospitals due to on-call requirements and to ensure that patients transferred from those outpatient settings with emergency conditions will have attending physicians at the receiving hospital.
- Incentives for transferring hospitals to keep and treat community residents and the provision of financial assistance, infrastructure and education as necessary to reduce the need for patient transfers outside of the community.
- Establishment of a database of on-call physicians available at various hospitals to facilitate appropriate patient transfers.
- Any other action designed to improve the relationship among hospitals, managed care plans and physicians in a manner that will increase the number of physicians available and willing to provide services to hospital emergency departments and trauma centers.

C. Improve the Medical Liability Environment for Hospitals, Health Care Providers and Physicians That Provide Emergency Department and Trauma Center Services

The majority of EMSA Task Force members believe that the number of physicians available and willing to provide emergency department and trauma services could be increased through an improved medical liability environment. The exposure to medical malpractice claims and the cost of liability insurance coverage that comes with it is cited by physicians and hospitals as a factor that makes providing emergency and trauma center services less attractive in Arizona. The majority of EMSA Task Force members, therefore, make the following recommendations to improve the State's medical liability environment:

- Increase the burden of proof to “clear and convincing evidence” in civil medical liability cases filed against physicians providing EMTALA-mandated care in emergency departments or in a disaster. This option limits medical liability reform to the emergency department and subsequent treatment of a hospital’s emergency department patients. While this recommendation lacked unanimity, the majority of the EMSA Task Force members believe that this reform is necessary because emergency department patients present unique challenges that make physicians less willing to assume their care, yet preserves the right of emergency patients to receive compensation in the event of clear and convincing evidence of a malpractice event.¹²
- Explore providing State funds to reimburse extra premiums paid by physicians providing emergency department on-call or trauma center services attributable to the provision of these services.
- Petition the Arizona Supreme Court to authorize jury instructions educating juries regarding the unique environment in which on-call physicians practice in the emergency department. The Task Force recommends that this issue be referred to the Civil Jury Instructions Committee of the State Bar of Arizona for consideration and approval.
- Instruct the Arizona Department of Insurance to evaluate disparities in medical liability insurance premiums and address any medical liability insurer disincentives to physicians providing on-call coverage. There is some evidence that some medical liability insurers discount medical liability insurance premiums for physicians who do not provide emergency department or on-call services.

D. *Utilize Technology to Assist Physicians Providing Emergency On-Call and Trauma Center Services*

EMSA Task Force members believe the work environment for physicians providing services in emergency departments and trauma centers could be improved through routine use of electronic health records and telemedicine technology. Accordingly, the Task Force recommends that the Governor continue State efforts through Arizona Health-e Connection to encourage the adoption of electronic health records and to create an e-health data exchange system throughout the State. Specifically, the Task Force recommends that the Governor:

- Support the State-wide development of a "patient health summary" or a "continuity of care record," which will communicate patient allergies, medications, significant diagnoses, and other information essential to emergency department and trauma centers caring for patients before accessing their full medical records.

¹² Five EMSA Task Force members do not agree with this recommendation. A minority report is attached as appendix B.

- Increase the use of telemedicine in emergency departments and trauma centers to help reduce the need for patient transfers.
- In the long term, implement standardized "interoperable" electronic health records, so that care providers will be able to electronically transmit the patient's record to the emergency department or trauma center for access to comprehensive records at the time and point of emergency care.

III. Related Recommendations That May Benefit the Provision of Emergency and Trauma Services, But Are Outside the Scope of This Task Force

Individual EMSA Task Force members presented a number of related recommendations designed to improve the provision of emergency and trauma services, but these recommendations were outside of the scope of the Task Force, as defined in the Executive Order. Some of these recommendations are currently under consideration by other State agency work groups, as noted below.

- Improve hospital infrastructure and resources to improve the flow of patients in the emergency department (this recommendation is currently under review by the ADHS Steering Committee on Hospital Diversion).
- Ensure that emergency departments are used only for higher-acuity patients, not primary care or non-emergent patients (this recommendation is appropriate for referral to the ADHS Steering Committee on Hospital Diversion). To do so, access to primary and non-emergency care services must be improved so that community-based outpatient care resources are readily available, on a more timely basis.
- Provide community education regarding the proper use of hospital emergency departments (this recommendation is currently under review by the ADHS Steering Committee on Hospital Diversion).
- Improve behavioral health patient resources within the State so that behavioral health patients do not have to be treated or held in the emergency department for extended periods of time waiting for appropriate transfer, referral, or State-mandated evaluations. Behavioral health patients place undue strains on Arizona's emergency departments, which are compounded by the lack of available behavioral health inpatient beds and outpatient resources.
- Support efforts to list student nurse practitioners under the same category as medical students in the federal graduate medical education program criteria.

- Monitor emergency department resources by requiring hospitals to report to ADHS certain metrics (e.g., monthly volume, throughput time, patients who leave without treatment, patient boarding hours, ambulance diversion hours, on-call services) and compare State data to available national data (e.g., ED Benchmarking Alliance). This data could be used to improve Arizona's health care delivery system performance (this recommendation is appropriate for review by ADHS' Steering Committee on Hospital Diversion).
- Improve physician supply chain for rural and medically underserved areas through the establishment of new physician offices, clinics, and graduate medical education training in these communities.
- Require and enforce adequate physician specialty and sub-specialty coverage by health plans on an outpatient basis, as opposed to relying on hospital emergency departments to supply this care.
- Extension of federal tort immunity for physicians who provide emergency department and trauma center services under EMTALA.

Timeline and Indicators of Success

EMSA Task Force members believe that time is of the essence and that the State should take prompt action to increase Arizona's physician supply and address the inadequate number of physicians available to provide on-call services to emergency departments and trauma centers. Accordingly, EMSA recommends that the State implement the recommendations outlined above within the next year.

In addition, EMSA Task Force members believe that it is necessary to review the effect that these recommendations have on physician availability. Accordingly, the Task Force recommends that the State implement and evaluate various measures of success. In order to help accomplish this goal, the EMSA Task Force recommends that the State provide funding to the Center for Health Information and Research to study specific data elements related to the provision of emergency department and trauma care and to monitor the success of the Task Force's recommendations.

Acknowledgements

The members of the EMSA Task Force would like to express our appreciation to Governor Janet Napolitano for the opportunity to collaborate and contribute these recommendations. The Task Force members share the Governor's commitment to ensuring that all Arizonans have sufficient access to care in emergency departments and trauma centers.

Appendix A

June 7th, 2006 Meeting References

The National Report Card on “The State of Emergency Medicine, Evaluating the Environment of Emergency Care Systems State by State”. The American College of Emergency Physicians. 2006.

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A fishbone diagram developed by Arthur Pelberg, MD displaying possible reasons why people may use the Emergency Department excessively.

A fishbone diagram developed by Arthur Pelberg, MD displaying possible reasons why emergency Department physicians may be frustrated with their job and leaving the State.

A fishbone diagram developed by Arthur Pelberg, MD displaying possible system problems that may cause a shortage of Emergency Department physicians.

James Carland MD, President and CEO of MICA letter of explanation of what a mutual company is and a history of MICA’s evolution in Arizona, submitted by Bruce Bethancourt, MD

“Emergency Department Visits”; the 5th in a series of Community Reports published by the Center for Health Information & Research CHIR). CHIR Emergency Department Visits Project Team members are Mary E. Rimsza, MD, FAAP, Co-Director, CHIR; Amy Bartels, MPH, Senior Research Analyst; Wade Bannister, MS, Data Analytics Manager; Michelle Segal, MA, Management Research Analyst; Kathleen Russell, BS, Program Manager; Anika Chartrand, Graphic Designer.

Medical Liability Update; Dr. James Carland; Medical Insurance Carriers of Arizona; President and CEO; Presentation Materials relevant to the Task Force understanding the impact of medical professional liability on physician services.

December 2006 References

Letter from Dr. Mark Mecikalski discussing the number of civil actions resulting from care provided in emergency rooms.

Email Letter from Dr. Christine Harter expressing support of legislation to change the evidentiary standard.

Email Letter from Harry Broome MD, FAAP expressing support of medical professional liability reform.

Appendix B

Minority Report Referenced on Page 16

The EMSA Task Force was charged with providing recommendations that will increase the number of physicians servicing patients in emergency departments in Arizona. While there are solutions in the report based on solid data and research, the recommendation to limit a patient's right to seek reimbursement for an injury is not one of them.

To begin with, the effects of this proposal should be made clear. Changing Arizona's burden of proof in medical negligence cases to "clear and convincing" evidence will clearly eliminate legitimate cases of medical negligence from being heard in our courts – even when gross negligence is committed. Without a doubt, this can allow negligent hospitals, HMOs, and medical professionals completely off the hook even when they caused a patient's injury or death. This proposal would eliminate the standard of negligence, and would require proof that a doctor was injuring a patient with wanton and willful disregard - for example, cutting off the wrong limb may be deemed "mere" negligence and the injured patient may be totally barred from bringing suit.

In short, hospitals and doctors would be shielded from claims of negligence from anyone entering the hospital via the emergency room – and anything short of physical assault and abuse may be shielded by this measure. Not once has it been stated that a patient negligently injured in an emergency department is somehow less worthy of having the right to seek amends for an injury, yet this is what this proposal would accomplish.

Another particularly troubling consequence of this proposal should concern any policymaker, as well as anyone who seeks care in an emergency department or who has a loved one who must seek such care. The recommendation in this report would ultimately grant favored status to every physician or medical professional that subsequently touches the patient when treatment is outside of the emergency department. So long as the hospital initially "evaluates or treats" the patient in the emergency room any further professional would be given the benefit of the emergency room treating physician even if the patient were to be sent to another unit within the hospital or were to receive follow-up care weeks later.

Putting aside the serious concern that this proposal raises, it should be noted that the physician workforce in Arizona has significantly grown. In fact Arizona's physician workforce is now increasing at pace with population growth. This is an important point because it demonstrates that physicians are attracted to practicing in Arizona today and the current civil justice system is not a barrier.

Finally, despite the lack of evidence, even if one believes that more physicians would be willing to work in emergency departments if they faced less legal claims, this doesn't make it the right thing to do. The reimbursement and administrative burdens that are most frequently cited as problematic for physicians should be addressed now. It is clear that progress on those fronts is difficult because it requires compromise on the part of industries that must each protect their own interests. However, policymakers should do more to compel such collaboration because that is where the real solutions lie to reducing burdens faced by physicians. Attempting to solve these problems on the backs of Arizonans by limiting a patient's right to seek recovery for an injury is an easy, but truly misplaced target.

From: Christine Harter
Sent: Saturday, November 25, 2006 8:12 AM
To: Chris Skelly
Subject: EMSA recommendations

Dear Mr. Skelly and the EMSA Task Force,

I am a practicing physician and member of MICA. I would like to express my strong support of legislation to change the evidentiary standard for emergency care to "clear and convincing", from the present "preponderance of evidence." Mr. Thomas Ryan's statement in his August 17th letter to the task force, that "only 5.8% of medical malpractice filings go to trial" is hardly reassuring to physicians, as you can well imagine. This should certainly not be used as evidence against the above reasonable change in the evidentiary standard. Mr Roy Ryals' arguments in his letter presented for the 9/25 meeting are well-put, and again support this change.

I would also like to mention that, as is the case with many small businesses, keeping the tax code simple and tax rates low will be an overarching reason for physician practices for locate to Arizona. So recommendations such as "creating a state-sponsored fund to pay additional premiums for 'unassigned patients'," as suggested in Mr Ryan's 8/17 letter, would NOT be the way to go. Please examine each of your recommendations in light of the state budget.

The above-mentioned change to the evidentiary standard for emergency care is both reasonable and cost-effective; it does not reasonably restrict the plaintiff's rights, particularly given the fact that (as was mentioned in Mr. Roy Ryals' letter) in pre-hospital care, the standard is set at "gross negligence", recognizing the inherent difficulty of emergency care. Please include this reasonable change in your final report to the governor.

Sincerely
Christine Harter, MD

From: Harry Broome
Sent: Monday, November 20, 2006 8:33 PM
To: Chris Skelly
Cc: Christie Frakes; Joe Wells; Fred Shulski; Pat/Marty Berger;

Subject: medical professional liability - support for reform

Hello,

I am Dr. Harry Broome, a pediatrician in the West Valley. I read recently that you were heading up an Arizona task force regarding remedies to ER overcrowding and other health care woes. I can assure you that the need for medical liability reform weighs heavily on the overwhelming majority of physicians that I know. It remains a major issue in health care and needs to be addressed. The Governor's vetoing of the House Bill that moved to change the language of evidentiary standards to "clear and convincing" sent ripples through the medical community. It was afterwards discussed with much disapproval online and in our AZ AAP "eblast" email as a significant legislative defeat, and as a misjudgment by the Governor.

I know I speak for the other members of my group (Drs. Berger, Wells, Shulski, Broughton, Frakes) as well as other West Valley pediatric doctor (e.g., Dr. Spiekerman) when I say that more Governor support of tort reform efforts are urgently needed if Arizona's health care system's prognosis is to improve.

Thank you,
Harry Broome MD, FAAP



Arizona Community Physicians

John G. Corcoran, M.D., F.A.C.P.
Internal Medicine - Infectious Disease

Robert R. Johnson, M.D.
Practice Limited to Internal Medicine

Mark Mecikalski, M.D.
Internal Medicine

Roy Loewenstein, M.D.
Internal Medicine

November 24, 2006

Christopher Skelly
c/o Scott and Skelly, LLC
1313 East Osborn Road, Suite #120
Phoenix, Arizona 85017

✓ copy Ron Anderson
for distribution to
the task force.
CMS

Dear Mr. Skelly:

I am dictating this letter because a recent article in the MICA report that named you as the chairman of the Governor's Task Force regarding emergency medical services. The MICA newsletter stated that the number of lawsuits resulting from care provided in the emergency room has risen dramatically, up 130%, against MICA members in just the last two years. I think we should all be extremely concerned about this.

I was speaking with one of my colleagues very recently about a couple of physicians working in the emergency room at Tucson Medical Center who were leaving or had already left. The consensus seemed to be that they were truly overworked and overburdened and finally had it after serving reliably in the emergency room for over twenty years.

I, myself, have been practicing medicine in Tucson since 1983, first as a pulmonary physician, doing a lot of ICU care, later as a hospitalist, and finally as a general internist doing office medicine. Part of the reason I do not go the hospital anymore is because I am getting older, and it is difficult to take care of critically ill patients in the middle of the night, but one other important reason, quite frankly, is the liability situation. I was sued a long time ago, about 1986, and was actually dragged into the suit by a hospital attorney, since the hospital was sued first. Since that time, I have forced myself to be fairly cautious about what I do. I have been involved as a witness or had to testify in some other suits, and every single one of these has resulted from actions taken in the emergency room and/or the critical care unit or both. I believe this is part of the reason I do not go to the hospital anymore. My colleagues in pulmonary medicine have seen their malpractice rates rise dramatically.

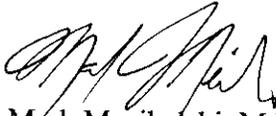
I think that the hassle of malpractice actions, combined with increasing costs of liability insurance in the face of decreasing or stable reimbursement, actually going down with inflation, is going to discourage people from going into certain fields. It does not matter how much money you have to pay for a service if you just cannot get the service, and I think that the situation in the emergency rooms in this state is really becoming critical after many, many years of stress.

November 24, 2006
Christopher Skelly
Page 2 of 2

One of the first jobs I had, after an internship in Los Angeles, was working in an emergency room, because I wanted to make some money. This was in 1976, and was pre DRGs. At that time, if somebody needed a workup in the emergency room, I simply admitted them to the hospital and got on with my work, seeing patients as rapidly and expeditiously as possible. That is not possible now, for if the patient is admitted to the hospital without a definite diagnosis, Medicare will not pay the DRG, and the hospital loses money. This, for the last twenty years, has forced emergency physicians to do tremendously complicated workups while the patient is still in the emergency room, putting great stress on those facilities, so in a way, Medicare has been responsible for part of the emergency room mess.

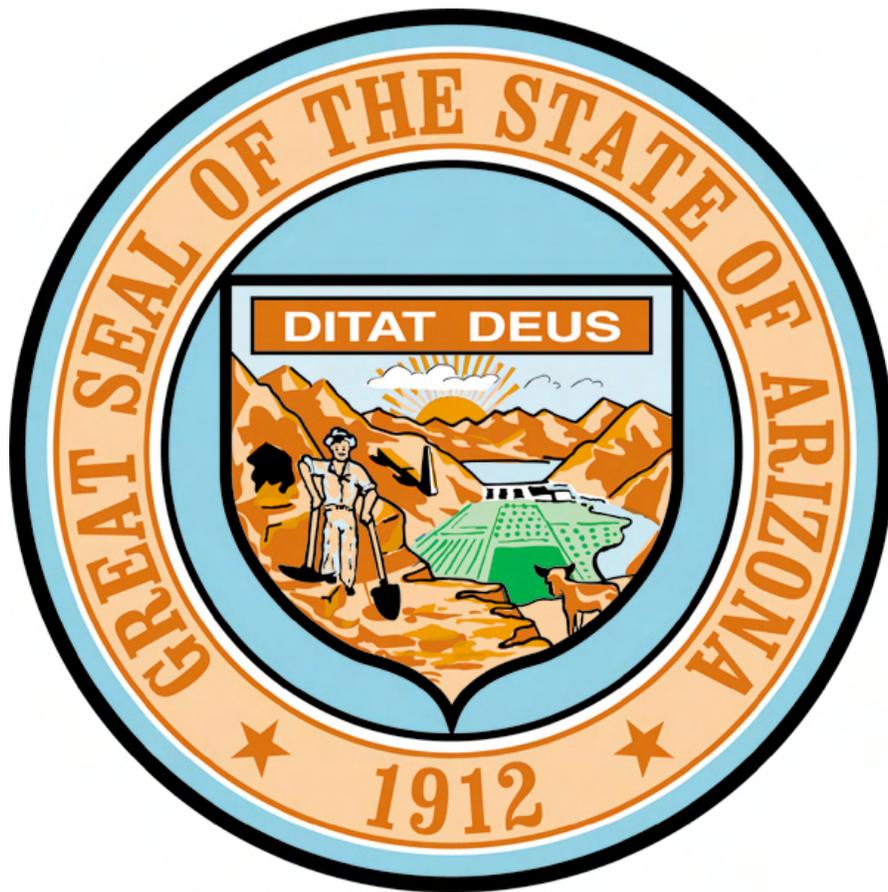
I am not an expert in how to solve this situation, but I am frankly concerned, because I feel that someday I am going to use the emergency room, as will you, as will Governor Napolitano most likely. It behooves you and all of us to try to improve this situation for the sake of all of the citizens of Arizona.

Sincerely,



Mark Mecikalski, M.D.
MM/js 11/24/2006

cc: MICA



Emergency Medical Services Access Task Force Meeting

December 13, 2006



Emergency Medical Services Access Task Force Draft Agenda

DATE: December 13, 2006 **TIME:** 1:15 PM

LOCATION: Arizona State Capitol Executive Tower 2nd Floor Conference Room
1700 W. Washington, Phoenix, Arizona

1. CALL TO ORDER

2. TASK FORCE MEMBER ROLL CALL

A. Determination of quorum

3. WELCOME FROM THE CHAIR

A. Task Force member acknowledgement of service

4. MEETING MINUTES

A. Review and acceptance of the November 15, 2006 minutes

5. ITEMS

A. Welcome and presentation of the final report with the Governor

6. CALL TO THE PUBLIC

A public body may make an open call to the public during a public meeting, subject to reasonable time, place and manner restrictions, to allow individuals to address the public body on any issue within the jurisdiction of the public body. At the conclusion of an open call to the public, individual members of the public body may respond to criticism made by those who have addressed the public body, may ask staff to review a matter, or may ask that a matter be put on a future agenda. Members of the public body shall not discuss or take legal action on matters raised during an open call to the public unless the matters are properly noticed for discussion and legal action. A.R.S. § 38-431.01(G).

7. ADJOURNMENT

Persons with a disability may request a reasonable accommodation, such as a sign language interpreter, by contacting Amanda Valenzuela, Program and Project Specialist, 602-364-3150; State TDD Number 1-800-367-8939; or Voice Relay Number 711. Requests should be made as early as possible to allow time to arrange accommodations.

Emergency Medical Services Access Task Force
Meeting Minutes
November 15, 2006
150 N. 18th Avenue, Suite 540-A
Phoenix, AZ

I. Call to Order

The Emergency Medical Services Access Task Force was called to order by Chairman Chris Skelly at 1:00 p.m.

II. Task Force Member Roll Call

Present:

Chris Skelly	Dr. Bruce Bethancourt	Judith Berman
Pat Rehn	Richard Polheber	Jim Ledbetter
January Contreras	Art Pulberg	Roy Ryals
Julie Nelson	Dr. Charles Finch	Anne Winter
Tom Ryan	Linda Hunt	
Debi Wells for Tony Rodgers		
Ron Anderson for Susan Gerard		

Absent:

Mark Enriquez	Donald Warne	Msgr. O'Keeffe
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III. Welcome from the Chair

A. Welcome and opening statement from the Chairman

Chris Skelly welcomed the task force to the meeting and announced to the task force that they will continue to read through the rough draft beginning on page 11.

It was reported that the task force will vote on certain items in the rough draft report and that the task force members' vote will be recorded in the minutes.

IV. Meeting Minutes

A motion was made to accept the minutes of October 25, 2006 as presented in the agenda packet.

Motion carried

V. Items

A. Review of rough draft report

A motion was made to replace pages 9 and 10 from rough draft report and insert the two page handout presented by January. This adds a recommendation to support acceleration of the expansion of the UA Downtown Medical School.

Motion carried

On page 11 Section II.A. it was suggested that the task force include in their report to recommend further study of reimbursement for physicians providing emergency department on-call and trauma center services.

It was recommended to remove AHCCCS from the second bullet point under section II.A.

Discussion ensued regarding “clear and convincing evidence” under section II.C. first bullet point.

The question was raised as to whether this proposal would have an actual impact on physician supply or premium rates. It was reported that no data has been found to support that a correlation exists between increasing the burden of proof to clear and convincing evidence and increasing the number of physicians practicing in Arizona. It was noted this proposal would limit the rights of the patients/consumers.

It was reported that the most asked question by physicians is “What is the malpractice climate?”

A vote was held to determine if this sentence should be removed from the report under section II.C. bullet point one: “Increase the burden of proof to “clear and convincing evidence” in civil medical liability cases filed against physicians providing EMTALA-mandated care in emergency departments or in a disaster.” The results of the vote were 10-4-1abstained; and the sentence remains in the draft report.

A vote was held to determine if this sentence should be removed from the report: “This option limits medical liability reform to the emergency department and subsequent treatment of a hospital’s emergency department patients.” Some members stated that the reference to subsequent treatment goes beyond the scope of the legislation that was run in the 2006 session. The results of the vote were 10-4-2 abstained; and the sentence remains in the draft report.

A vote was held to determine if this sentence should be removed from the report: “Increase the required qualifications for expert witnesses testifying in medical

liability lawsuits.” The results of the vote were 2-3-4 abstained; and the sentence was deleted from the draft report.

A vote was held to determine if this sentence should be included in the report: “Petition the Arizona Supreme Court to authorize jury instructions educating juries regarding the unique environment in which on-call physicians practice in the emergency department.” The results of the vote were 9-1-1 abstained; and the sentence remains in the report.

It was suggested that “hospitals” Be added to the first sentence of the first bullet point under section II. C.

It was suggested to add explore to the beginning of the sentence in bullet point two under section II. C.

It was suggested to combine the last bullet point on page 12 and with the second bullet point under section II. C.

It was suggested to remove the first bullet point on page 13.

It was suggested to remove the first and fourth bullet points under E on page 13.

Discussion ensued regarding the first bullet point on top of page 14. It was reported that the topic of the bullet point should be transformed as a positive measure regarding hospital incentives and transfer patients. In addition, it was suggested to add to the final report that this particular issue is a national issue and not only affecting Arizona.

It was suggested to remove Section II. F.

B. Timeline and indicators of success

It was agreed that a general timeline would be included rather than specific dates.

Mr. Skelly thanked the task force for their assistance with the report and posed the question to the task force if they would like to be present at the next meeting. The task force agreed that everyone should be present for the December 13th meeting.

It was reported that the task force will have a one page minority report drafted to accompany the final report.

VI. Call to the Public

No report given.

VI. Summary of Current Events

No report given.

VII. Announcement of Next Meeting

Next meeting is scheduled for December 13, 2006 at 1:00 p.m. The meeting will take place at the Governor's Office. It was reported that the report will be summarized by Mr. Skelly and the task force will have about half an hour with the Governor to present the report.

VIII. Adjournment

Meeting adjourned at 4:20 p.m.