ON-CALL SPECIALIST COVERAGE IN U.S. EMERGENCY DEPARTMENTS

ACEP SURVEY OF EMERGENCY DEPARTMENT DIRECTORS

SEPTEMBER 2004

American College of Emergency Physicians®

Executive Summary

The American College of Emergency Physicians' (ACEP) Emergency Medicine Foundation received a grant from The Robert Wood Johnson Foundation to survey medical directors of hospital emergency departments to assess the effects of current regulations and the practice climate on the availability of medical specialists who provide care in the nation's emergency departments. The Emergency Medical Treatment and Labor Act (EMTALA) requires hospitals to medically screen every person who comes to an emergency department to determine whether an emergency medical condition exists, and if it does, to stabilize the patient. A patient may only be transferred to another hospital if — after all possible stabilizing efforts have been made — the patient's condition requires a "higher level of care" not available at the original hospital. EMTALA is essentially a non-discrimination law to ensure that every emergency patient is medically screened, regardless of ability to pay. Since its passage in 1986, EMTALA has been subject to regulatory and judicial interpretations that have expanded it into an extensive safety net program in the nation's emergency departments, which have more than 110 million visits annually. [1]

In November 2003, the Centers for Medicare & Medicaid Services (CMS) implemented revised regulations for hospitals and physicians to comply with EMTALA. The new regulations acknowledged the need to balance hospital and physician legal duties with the practical realities of today's crowded emergency departments and the concerns of on-call specialists and their practice demands. Specifically, while hospitals must continue to maintain a list of on-call physician specialists, physicians are permitted to be on call at more than one hospital at the same time and may limit the amounts of call time they are willing to take. While the EMTALA regulations took a more practical approach, recognizing physician specialists' time constraints and willingness to make additional on-call commitments, ACEP was concerned the rules would unwittingly make hospital and emergency physician services more difficult and compound an already growing problem in obtaining specialist care in a timely fashion. In addition to the recent regulatory changes, other factors — reduced payment to physicians by Medicare and other payors, the growing number of uninsured patients in America, and the increasing costs of medical liability insurance — may be affecting patients' access to timely specialty care in the nation's emergency departments.

This survey was designed to estimate, in the early months of the new regulations, the extent of problems related to on-call emergency department coverage by specialists. The survey asked emergency department medical directors whether they were experiencing problems with inadequate on-call coverage, given the needs of the patient populations at their hospitals. It asked about changes in the number of patient transfers to other hospitals and whether physicians and staff were experiencing significant increases in the time spent locating specialists willing to come to the emergency department.

The study findings, coupled with the growing demands for emergency services, show further strain on an already frayed system. Policymakers and physicians must work together to ensure that emergency care remains accessible to all. To that end, the new government-sponsored EMTALA Technical Advisory Group should include this issue in its deliberations.

Methods

Questionnaires were mailed to 4,444 emergency department medical directors between April 2004 and August 2004. This large sample comprises nearly every acute-care hospital in all 50 states and Washington, D.C. It excluded long-term hospitals (such as rehabilitation hospitals) and federal hospitals (e.g., Veterans Health Administration, Indian Health Service, military), as well as psychiatric, pediatric, and other specialty hospitals. Exclusions also were made in cases where one physician served concurrently as the medical director for two or more emergency departments. In these few cases (less than 1% of all emergency departments), ACEP mailed one questionnaire to the physician and addressed it to the larger hospital.

Survey recipients were given the option of completing the questionnaire on paper or by logging onto a Web site hosted by ACEP. Consent to participate was implied by the return or submission of a completed questionnaire. This study was approved by the Institutional Review Board at Johns Hopkins University. This survey will be repeated in spring 2005 to determine whether availability of on-call specialists has changed.

Results

There were 1,427 of 4,444 (32%) surveys returned. The large majority of respondents were from non-teaching community hospitals (93%), while the remainder were from academic teaching hospitals (7%). The teaching/ non-teaching distribution is representative of the country at large, but the responses were skewed toward a greater proportion of smaller and urban hospitals (see Figures 1 and 2). Nearly 75% of respondents were from not-for-profit hospitals, 6.5% were from public hospitals, and 19.4% were fom for-profit hospitals. This distribution over-represents not-for-profit hospitals and significantly under-represents public hospitals. These differences between respondents and the larger population of all hospitals may reflect a response bias. Emergency department medical directors experiencing greater problems with on-call coverage may be more inclined to respond to the surveys. Emergency department medical directors at hospitals with no formal trauma-center designation comprised nearly two-thirds (63%) of the respondents, and one in five (21%) practiced at an advanced trauma center (level 1 or level 2). This proportion of level 1 and 2 trauma centers is higher in the sample than in the nation.

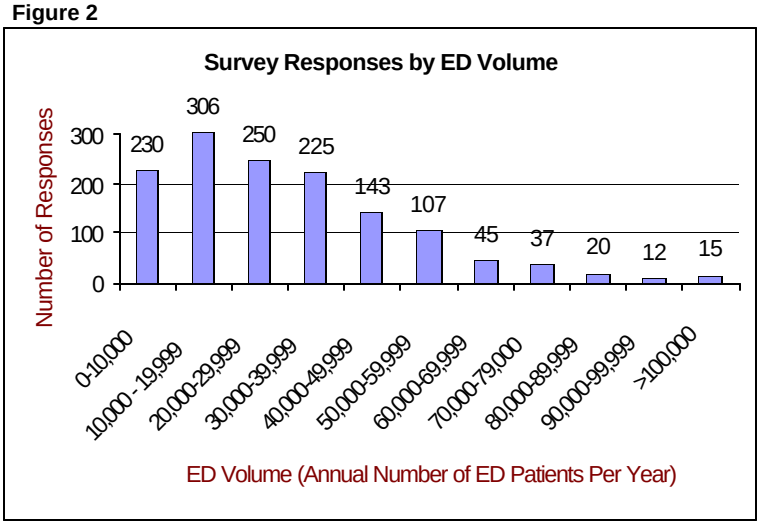
Figure 1

Hospital Characteristics Among Respondents

	Total	Respondents
	4444	1427 (32%)
Hospital Type*		
Nonteaching	92.5%	93%
Academic/teaching	7.5%	7%
Hospital Ownership**		
Not-for-profit	61%	74.1%
For-profit	16%	19.4%
Public	23%	6.5%
Hospital Trauma Level		
Level 1 or Level 2	10%	21%
Level 3	6%	16%
Not a trauma center	84%	63%
Hospital Size		
≥100 inpatient beds	53%	23%
Urban		
Located in a metropolitan statistical area (MSA)	53%	63%

Source: * AAMC 2004 **AHA Hospital Statistics 2004

Figure 2



The available national data, however, is almost two years old, and the difference most likely reflects an ongoing trend among states and hospitals to designate additional hospitals as level 2 trauma centers. [2]

Two-thirds of emergency department medical directors reported inadequate on-call specialist coverage (see Figure 3). This problem appears to affect all U.S. geographic regions, although there is a statistically significant difference between hospitals in the North Central region (59% of respondents cite a problem) as compared with those in the South and Northeast (71% and 70% respectively). Among respondents, hospital size does not appear related to the perception of a problem, but a greater percentage of Emergency Department medical directors in urban hospitals (71%) versus rural hospitals (57%) indicated that on-call coverage was inadequate at their hospitals (see Figures 4 and 5).

Respondents were asked to select the top three (of ten) consequences of the shortages. They answered: risk of harm to patients who needed specialist care, delays in patient care, and an increase in the number of transfers of patients between emergency departments (see Figure 6). Other adverse effects included decreased efficiency of emergency physicians and staff, patient frustration due to poor service, increased wait times for patients to see a physician, and more crowded referral hospitals where patients were transferred.

Figure 3

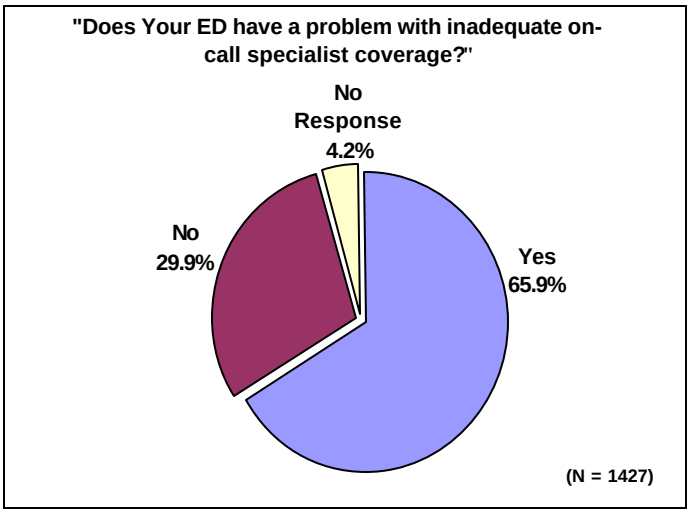


Figure 4

"Does your ED have a problem with inadequate on-call specialist coverage?"

Percentage of ED Directors by Region Who Responded "YES" (95% Confidence Interval)

Northeast	70% (64-76%)
North Central	59% (54-64%)
South	71% (67-76%)
West	66% (62-73%)

Figure 5

"Does your ED have a problem with inadequate on-call specialist coverage?"

Percentage of ED Directors Who Responded "YES" (95% Confidence Interval)

Rural Hospitals *Not* located in a metropolitan statistical area (MSA)	57% (53 – 62%)
Urban Hospitals Located in an MSA	71% (68 – 74%)
Smaller Hospitals <100 licensed inpatient beds	65% (62 – 67%)
Larger Hospitals ≥100 licensed inpatient beds	69% (64 – 74%)

Figure 6

"What is the most significant consequence of this shortage?"

Percentage of ED Directors Who Ranked Each of the Following as the Most Important

Risk or harm to patients who need specialist care	27%
Delay in patient care	21%
More transfers of patients between emergency departments	18%

Survey respondents also were asked about other changes in their emergency departments in relation to the adequacy of on-call coverage by specialists. Seventeen percent noted that some specialists had already negotiated with their hospitals for fewer on-call coverage hours. Emergency physicians also say they spent more time seeking specialists to come to the hospital (see Figures 7 and 8).

A third of the respondents cited increasing levels of patients being transferred from one hospital to another (see Figure 9). More than one-quarter of the respondents said that a growing number of patients leave crowded emergency departments before being seen by a physician (see Figure 10).

When asked whether hospitals were providing incentives to specialists to take call, 8% said their hospitals were paying stipends, 15% were guaranteeing certain levels of payment for services, and 14% were providing some measure of medical liability coverage for on-call commitments (see Figures 11, 12, and 13).

Figure 7

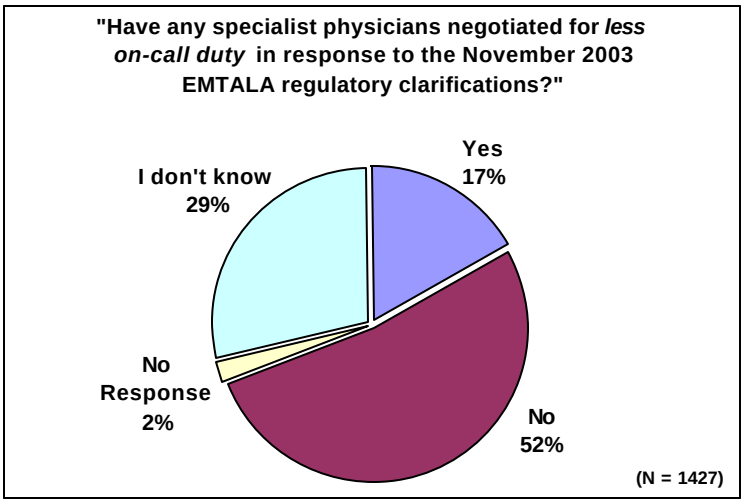


Figure 8

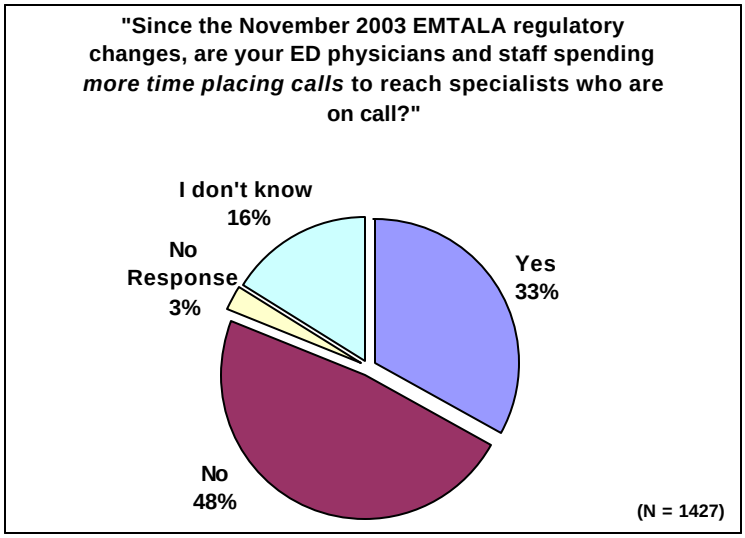


Figure 9

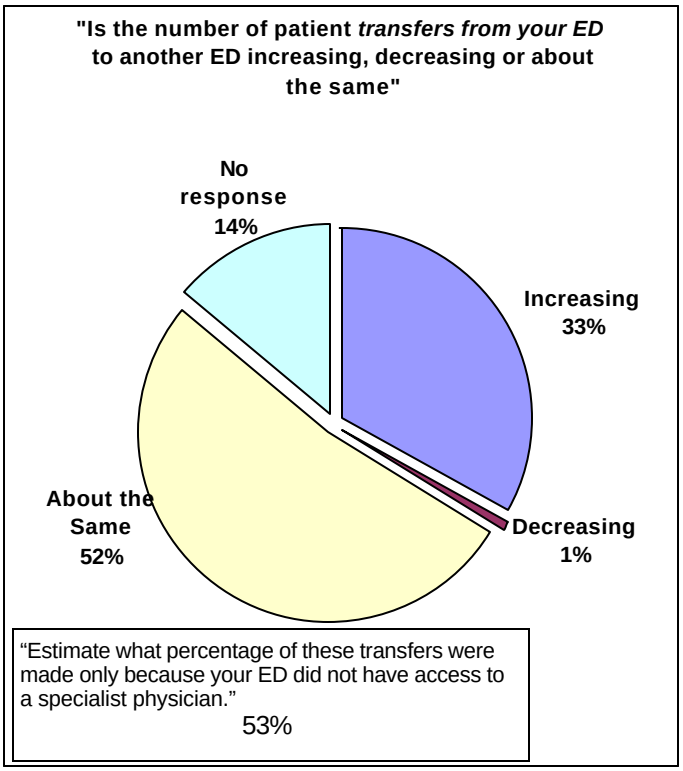
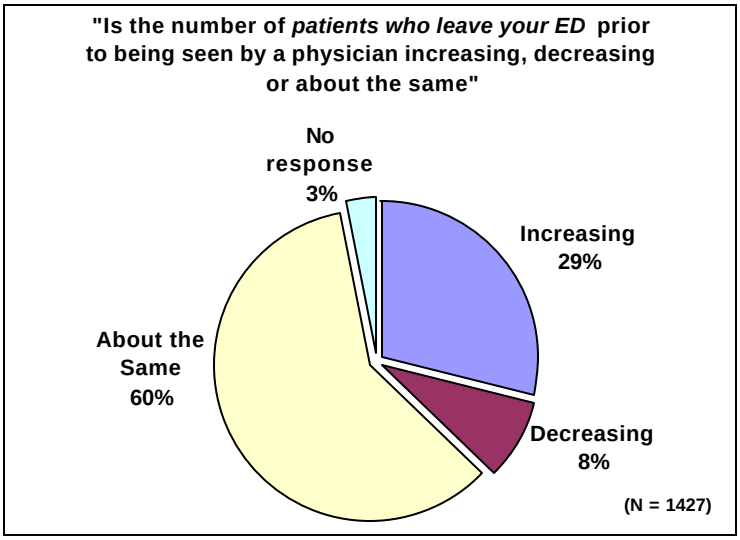


Figure 10



Conclusions

The decrease in the number of medical specialists willing to be on-call to the nation's emergency departments is a looming national health care crisis of supply and demand. While a large majority of specialists continue to take new patients and participate in the Medicare program, they are less willing to cover the nation's emergency departments. The survey findings reflect the extent of this dilemma, with two-thirds of emergency physician directors citing problems. At this time, access for patients who may need immediate emergency care is compromised, particularly in local areas such as Los Angeles and Tucson, where hospitals and trauma units are closing. This complex issue must be addressed in an equitable way that turns the tide on specialists departing from historical on-call commitments to cover emergency departments.

The results of this survey quantify one more aspect of an increasingly complex set of health system issues that affect availability of timely emergency care services all over the country. Responsibility for on-call coverage remains with the nation's hospitals, but, according to study findings, those efforts appear to be failing. The factors driving this worrisome problem — insurance coverage, funding, and liability concerns — must be addressed at the federal level.

Figure 11

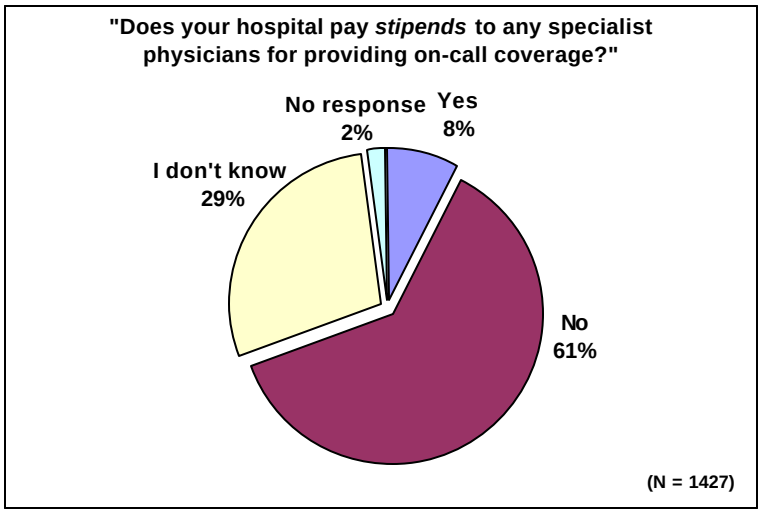


Figure 12

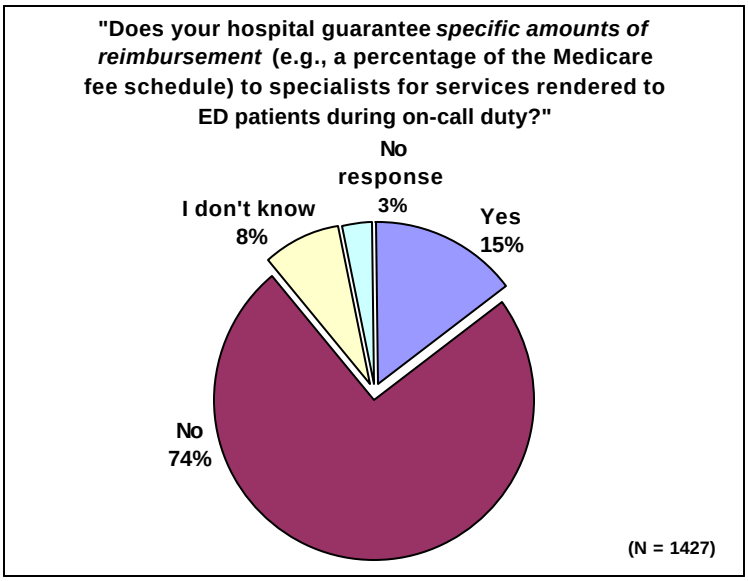
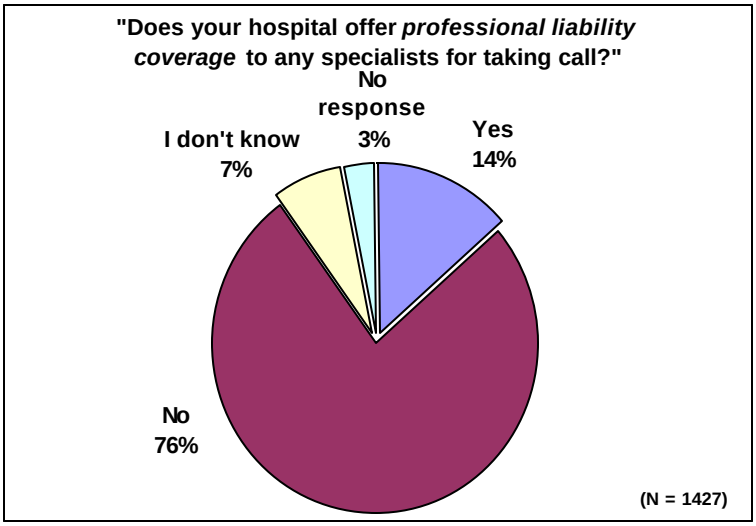


Figure 13



References

1. McCraig, LF, Burt, KW. National Hospital Ambulatory Medical Care Survey: 2002 Emergency Department Summary. NCHS/ CDC. March, 2004.
2. MacKenzie EJ, Hoyt DB, Sacra JC, et al. National Inventory of Hospital Trauma Centers. JAMA. 2003 Mar 26;289(12):1515-22.

For more information regarding this report, please contact:

Ben Vanlandingham MD
Principal Investigator
Robert Wood Johnson Clinical Scholar at
The Johns Hopkins University
bvanlandingham@jhmi.edu

Barbara Marone
Project Director
American College of Emergency Physicians
bmarone@acep.org