

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

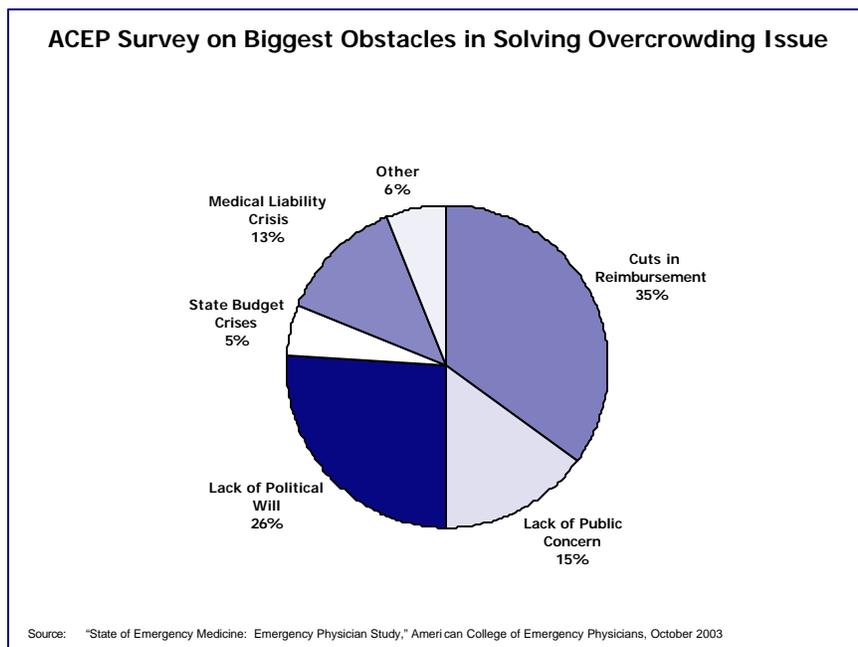
In a recent *Report to the Congress: Medicare Payment Policy*, by the Medicare Payment Advisory Commission,²² MedPac forecasts that even after several years of rapid growth in professional liability insurance costs, this will still be the fastest-growing component of the cost of physician services going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

A survey conducted in September of 2003 by the American College of Emergency Physicians²³ found that the biggest obstacles to solving ED overcrowding were cuts in reimbursement, lack of political will, and the medical liability crisis.

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

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

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

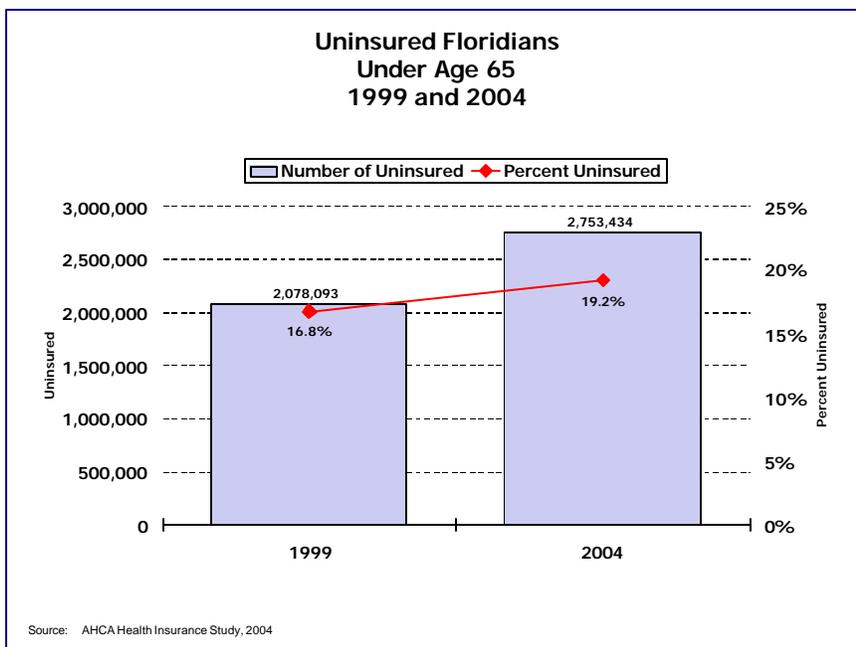


Two areas that provide better liability protection than current law are sovereign immunity and the no-fault program for Birth-Related Neurological Injury Compensation (NICA). Sovereign immunity under F.S. 768.28 is already applied in public hospitals, state medical schools, and volunteer physicians contracting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

Growing Number of Uninsured and Under-Insured Floridians

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

Approximately one of every five Floridians under the age of 65 does not have healthcare coverage. According to the latest *Florida Health Insurance Study* by AHCA, 19.2 percent of Florida’s non-elderly population was uninsured in 2004.²⁴ This represents 2.9 million residents with no healthcare coverage – approximately the same number as are covered by Medicare. Since 1999, the last time the *Florida Health Insurance Study* was conducted, an additional 800,000 Floridians joined the ranks of the uninsured.



In addition to the 2.9 million Floridians without coverage identified by the survey, approximately one-fourth of the non-elderly population – approximately 4.2 million – went without coverage at some point during 2004.²⁵ The two most common reasons for lacking healthcare coverage are the unavailability of coverage and the cost of insurance. Between 1999 and 2005, health insurance premium costs have risen 77 percent.²⁶

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

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

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

Source: AHCA Inpatient Discharge Database, CY2004

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

Use of the ED for Non-Emergencies

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

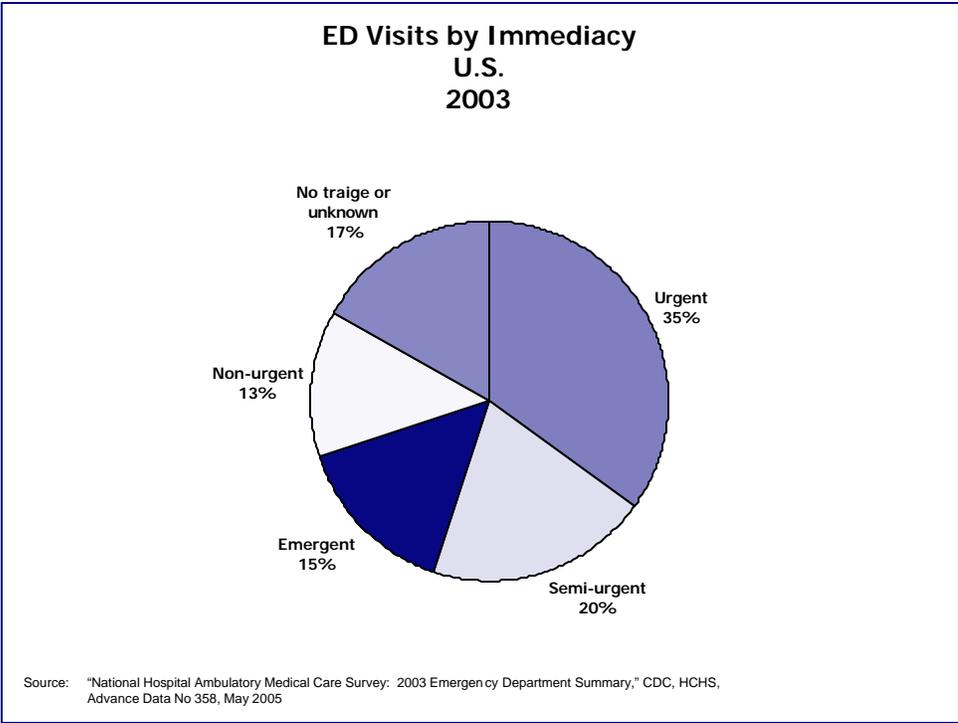
Capacity constraints experienced by office-based physicians, combined with a loosening of managed care restrictions, may be contributing to increases in non-urgent ED visits. More patients are experiencing difficulties making appointments with their doctors and the waiting times for appointments are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

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

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

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

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



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

Lack of Available Alternative Care Sites

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

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

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

Antiquated State Regulations

Hospital ED Licensure Laws

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

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

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

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

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

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

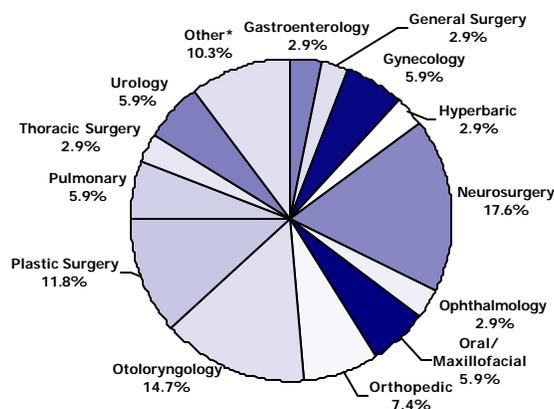
Since 1994, AHCA has received 34 applications for service exemptions for ED on-call coverage from 25 hospitals. The most common types of exemptions sought were for neurosurgery, otolaryngology, plastic surgery, and oral/maxillofacial. Hospitals typically applied for more than one service to be exempted.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

AHCA Procedure for Decisions on Emergency Service Exemptions

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

Source: AHCA, 2005

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



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

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

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

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

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

Emergency Medical Services Laws

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

Baker Act Patients

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

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

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

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

Source: AHCA Inpatient Discharge Database, CY2004

Medical Practice Act

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

Nurse Practice Act

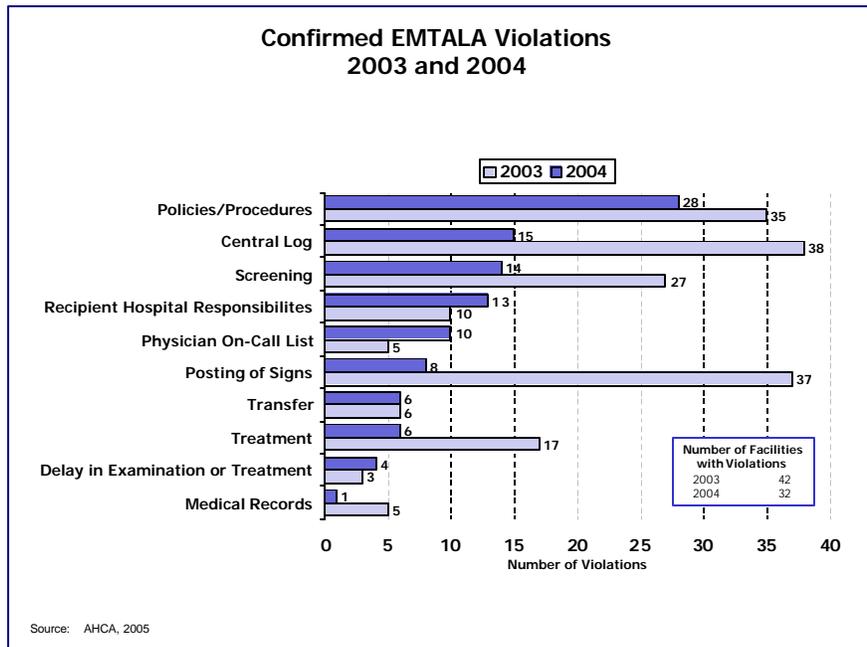
The federal EMTALA law permits physicians and other qualified medical personnel (QMP) to perform medical screenings in the ED. QMPs are defined by the hospital in its bylaws, or its rules and regulations, and approved by the hospital's board. In most states, including Florida, both physicians and allied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

Ambiguous Federal Regulations

Emergency Medical Treatment and Active Labor Act (EMTALA)

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

Originally enacted as an anti-discrimination law to protect against refusal of care to the uninsured, the federal law has become a rigid documentation law that discourages innovative ways to treat the patient. In reviewing the EMTALA complaints in Florida, it shows that there were very few complaints and only a fraction of those were deemed “violations.” Out of seven million ED visits, there were only 231 complaints in 2004. Out of those 231 complaints, only 14 percent were found to be EMTALA violations. It also shows that two-thirds of the violations were for documentation issues. Documentation presents another complicating factor in a busy ED as a recent PriceWaterhouse Coopers study²⁹ showed that every one hour of patient care in the ED generated one hour of paperwork associated with complying with regulatory and other documentation requirements.



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

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

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

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

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

RECOMMENDATIONS

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

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

To Ease Overcrowding Problems in Hospitals

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

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

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

To Ease the Shortage of Physicians Taking ED Call

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

To Modernize Regulations to Reflect the Changing Dynamics of Healthcare

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

CONCLUSION

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

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Chapter 395 – Access to Emergency Services and Care

Statutes » Title 29 » Ch. 395 » Sec. 395.1041

Access to emergency services and care.

(1)LEGISLATIVE INTENT.The Legislature finds and declares it to be of vital importance that emergency services and care be provided by hospitals and physicians to every person in need of such care. The Legislature finds that persons have been denied emergency services and care by hospitals. It is the intent of the Legislature that the agency vigorously enforce the ability of persons to receive all necessary and appropriate emergency services and care and that the agency act in a thorough and timely manner against hospitals and physicians which deny persons emergency services and care. It is further the intent of the Legislature that hospitals, emergency medical services providers, and other health care providers work together in their local communities to enter into agreements or arrangements to ensure access to emergency services and care. The Legislature further recognizes that appropriate emergency services and care often require followup consultation and treatment in order to effectively care for emergency medical conditions.

(2)INVENTORY OF HOSPITAL EMERGENCY SERVICES.The agency shall establish and maintain an inventory of hospitals with emergency services. The inventory shall list all services within the service capability of the hospital, and such services shall appear on the face of the hospital license. Each hospital having emergency services shall notify the agency of its service capability in the manner and form prescribed by the agency. The agency shall use the inventory to assist emergency medical services providers and others in locating appropriate emergency medical care. The inventory shall also be made available to the general public. On or before August 1, 1992, the agency shall request that each hospital identify the services which are within its service capability. On or before November 1, 1992, the agency shall notify each hospital of the service capability to be included in the inventory. The hospital has 15 days from the date of receipt to respond to the notice. By December 1, 1992, the agency shall publish a final inventory. Each hospital shall reaffirm its service capability when its license is renewed and shall notify the agency of the addition of a new service or the termination of a service prior to a change in its service capability.

(3)EMERGENCY SERVICES; DISCRIMINATION; LIABILITY OF FACILITY OR HEALTH CARE PERSONNEL.

(a)Every general hospital which has an emergency department shall provide emergency services and care for any emergency medical condition when: 1.Any person requests emergency services and care; or 2.Emergency services and care are requested on behalf of a person by: a.An emergency medical services provider who is rendering care to or transporting the person; or b.Another hospital, when such hospital is seeking a medically necessary transfer, except as otherwise provided in this section.

(b)Arrangements for transfers must be made between hospital emergency services personnel for each hospital, unless other arrangements between the hospitals exist.

(c)A patient, whether stabilized or not, may be transferred to another hospital which has the requisite service capability or is not at service capacity, if: 1.The patient, or a person who is legally responsible for the patient and acting on the patient's behalf, after being informed of the hospital's obligation under this section and of the risk of transfer, requests that the transfer be effected; 2.A physician has signed a certification that, based upon the reasonable risks and benefits to the patient, and based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another hospital outweigh the increased risks to the individual's medical condition from effecting the transfer; or 3.A physician is not physically present in the emergency services area at the time an individual is transferred and a qualified medical person signs a certification

that a physician, in consultation with personnel, has determined that the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual's medical condition from effecting the transfer. The consulting physician must countersign the certification; provided that this paragraph shall not be construed to require acceptance of a transfer that is not medically necessary.

(d) 1. Every hospital shall ensure the provision of services within the service capability of the hospital, at all times, either directly or indirectly through an arrangement with another hospital, through an arrangement with one or more physicians, or as otherwise made through prior arrangements. A hospital may enter into an agreement with another hospital for purposes of meeting its service capability requirement, and appropriate compensation or other reasonable conditions may be negotiated for these backup services. 2. If any arrangement requires the provision of emergency medical transportation, such arrangement must be made in consultation with the applicable provider and may not require the emergency medical service provider to provide transportation that is outside the routine service area of that provider or in a manner that impairs the ability of the emergency medical service provider to timely respond to prehospital emergency calls. 3. A hospital shall not be required to ensure service capability at all times as required in subparagraph 1. if, prior to the receiving of any patient needing such service capability, such hospital has demonstrated to the agency that it lacks the ability to ensure such capability and it has exhausted all reasonable efforts to ensure such capability through backup arrangements. In reviewing a hospital's demonstration of lack of ability to ensure service capability, the agency shall consider factors relevant to the particular case, including the following: a. Number and proximity of hospitals with the same service capability. b. Number, type, credentials, and privileges of specialists. c. Frequency of procedures. d. Size of hospital. 4. The agency shall publish proposed rules implementing a reasonable exemption procedure by November 1, 1992. Subparagraph 1. shall become effective upon the effective date of said rules or January 31, 1993, whichever is earlier. For a period not to exceed 1 year from the effective date of subparagraph 1., a hospital requesting an exemption shall be deemed to be exempt from offering the service until the agency initially acts to deny or grant the original request. The agency has 45 days from the date of receipt of the request to approve or deny the request. After the first year from the effective date of subparagraph 1., if the agency fails to initially act within the time period, the hospital is deemed to be exempt from offering the service until the agency initially acts to deny the request.

(e) Except as otherwise provided by law, all medically necessary transfers shall be made to the geographically closest hospital with the service capability, unless another prior arrangement is in place or the geographically closest hospital is at service capacity. When the condition of a medically necessary transferred patient improves so that the service capability of the receiving hospital is no longer required, the receiving hospital may transfer the patient back to the transferring hospital and the transferring hospital shall receive the patient within its service capability.

(f) In no event shall the provision of emergency services and care, the acceptance of a medically necessary transfer, or the return of a patient pursuant to paragraph (e) be based upon, or affected by, the person's race, ethnicity, religion, national origin, citizenship, age, sex, preexisting medical condition, physical or mental handicap, insurance status, economic status, or ability to pay for medical services, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental handicap is medically significant to the provision of appropriate medical care to the patient.

(g) Neither the hospital nor its employees, nor any physician, dentist, or podiatric physician shall be liable in any action arising out of a refusal to render emergency services or care if the refusal is made after screening, examining, and evaluating the patient, and is based on the determination, exercising reasonable care, that the person is not suffering from an emergency medical condition or a determination, exercising reasonable care, that the hospital does not have the service capability or is at service capacity to render those services.

(h) A hospital may request and collect insurance information and other financial information from a patient, in accordance with federal law, if emergency services and care are not delayed. No hospital to which another hospital is transferring a person in need of emergency services and care may require the

transferring hospital or any person or entity to guarantee payment for the person as a condition of receiving the transfer. In addition, a hospital may not require any contractual agreement, any type of preplanned transfer agreement, or any other arrangement to be made prior to or at the time of transfer as a condition of receiving an individual patient being transferred. However, the patient or the patient's legally responsible relative or guardian shall execute an agreement to pay for emergency services or care or otherwise supply insurance or credit information promptly after the services and care are rendered.

(i) Each hospital offering emergency services shall post, in a conspicuous place in the emergency service area, a sign clearly stating a patient's right to emergency services and care and the service capability of the hospital.

(j) If a hospital subject to the provisions of this chapter does not maintain an emergency department, its employees shall nevertheless exercise reasonable care to determine whether an emergency medical condition exists and shall direct the persons seeking emergency care to a nearby facility which can render the needed services and shall assist the persons seeking emergency care in obtaining the services, including transportation services, in every way reasonable under the circumstances.

(k) 1. Emergency medical services providers may not condition the prehospital transport of any person in need of emergency services and care on the person's ability to pay. Nor may emergency medical services providers condition a transfer on the person's ability to pay when the transfer is made necessary because the patient is in immediate need of treatment for an emergency medical condition for which the hospital lacks service capability or when the hospital is at service capacity. However, the patient or the patient's legally responsible relative or guardian shall execute an agreement to pay for the transport or otherwise supply insurance or credit information promptly after the transport is rendered. 2. A hospital may enter into an agreement with an emergency medical services provider for purposes of meeting its service capability requirements, and appropriate compensation and other reasonable conditions may be negotiated for these services.

(l) Hospital personnel may withhold or withdraw cardiopulmonary resuscitation if presented with an order not to resuscitate executed pursuant to s. 401.45. Facility staff and facilities shall not be subject to criminal prosecution or civil liability, nor be considered to have engaged in negligent or unprofessional conduct, for withholding or withdrawing cardiopulmonary resuscitation pursuant to such an order. The absence of an order not to resuscitate executed pursuant to s. 401.45 does not preclude a physician from withholding or withdrawing cardiopulmonary resuscitation as otherwise permitted by law.

(4) RECORDS OF TRANSFERS; REPORT OF VIOLATIONS.

(a) 1. Each hospital shall maintain records of each transfer made or received for a period of 5 years. These records of transfers shall be included in a transfer log, as well as in the permanent medical record of any patient being transferred or received. 2. Each hospital shall maintain records of all patients who request emergency care and services, or persons on whose behalf emergency care and services are requested, for a period of 5 years. These records shall be included in a log, as well as in the permanent medical record of any patient or person for whom emergency services and care is requested.

(b) Any hospital employee, physician, other licensed emergency room health care personnel, or certified prehospital emergency personnel who knows of an apparent violation of this section or the rules adopted under this section shall report the apparent violation to the agency within 30 days following its occurrence.

(c) A hospital, government agency, or person shall not retaliate against, penalize, institute a civil action against, or recover monetary relief from, or otherwise cause any injury to: 1. A physician or other person for reporting in good faith an apparent violation of this section or the rules adopted under this section to the agency, hospital, medical staff, or any other interested party or government agency; 2. A physician who refuses to transfer a patient if the physician determines, within reasonable medical probability, that the transfer or delay caused by the transfer will create a medical hazard to the patient; or 3. A physician who effectuates the transfer of a patient if the physician determines, within a reasonable medical probability, that failing to transfer the patient will create a medical hazard to the patient.

(5)PENALTIES.

(a)The agency may deny, revoke, or suspend a license or impose an administrative fine, not to exceed \$10,000 per violation, for the violation of any provision of this section or rules adopted under this section.

(b)Any person who suffers personal harm as a result of a violation of this section or the rules adopted hereunder may recover, in a civil action against the responsible hospital administrative or medical staff or personnel, damages, reasonable attorney's fees, and other appropriate relief. However, this paragraph shall not be construed to create a cause of action beyond that recognized by this section and rules adopted under this section as they existed on April 1, 1992.

(c)Any hospital administrative or medical staff or personnel who knowingly or intentionally violates any provision of this section commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

(d) 1.Any hospital, or any physician licensed under chapter 458 or chapter 459, who suffers a financial loss as a direct result of a violation by a physician or a hospital of a requirement of this section may, in a civil action against the physician or the hospital, obtain damages for financial loss of charges and such equitable relief as is appropriate, including reasonable attorney's fees and costs. 2.If the defendant prevails in an action brought by the hospital or physician pursuant to this paragraph, the court may award reasonable attorney's fees and costs to the defendant.

(e)A physician licensed under chapter 458 or chapter 459 who negligently or knowingly violates any requirement of this section relating to the provision of emergency services and care shall be deemed in violation of the provisions of such chapters for any of the following violations: 1.Failure or refusal to respond within a reasonable time after notification when on call. 2.Failure or refusal to sign a certificate of transfer as required by this section. 3.Signing a certificate of transfer stating that the medical benefits to be reasonably expected from a transfer to another facility outweigh the risks associated with the transfer, when the physician knew or should have known that the benefits did not outweigh the risks as required by this section. 4.Misrepresentation of an individual's condition or other information when requesting a transfer. Any fine collected for a violation of this section, including any fine collected from a physician licensed under chapter 458 or chapter 459, shall be deposited into the Public Medical Assistance Trust Fund.

(f)In determining whether a licensee is deemed in violation of this section and in assessing any penalties for violation, the agency shall consider, and the licensee may offer as an affirmative defense or in mitigation, whether the licensee has established that the alleged violation arose from the unanticipated changes in service capability or other factors beyond the licensee's control.

(6)RIGHTS OF PERSONS BEING TREATED.A hospital providing emergency services and care to a person who is being involuntarily examined under the provisions of s. 394.463 shall adhere to the rights of patients specified in part I of chapter 394 and the involuntary examination procedures provided in s. 394.463, regardless of whether the hospital, or any part thereof, is designated as a receiving or treatment facility under part I of chapter 394 and regardless of whether the person is admitted to the hospital.

(7)EMERGENCY ROOM DIVERSION PROGRAMS.Hospitals may develop emergency room diversion programs, including, but not limited to, an ""Emergency Hotline" which allows patients to help determine if emergency department services are appropriate or if other health care settings may be more appropriate for care, and a ""Fast Track" program allowing nonemergency patients to be treated at an alternative site. Alternative sites may include health care programs funded with local tax revenue and federally funded community health centers, county health departments, or other nonhospital providers of health care services. The program may include provisions for followup care and case management.

History

s. 6, ch. 88-186; s. 1, ch. 89-296; s. 68, ch. 91-224; s. 4, ch. 91-249; ss. 24, 25, 98, ch. 92-289; s. 30, ch. 96-169; s. 2, ch. 96-199; s. 10, ch. 96-223; s. 182, ch. 98-166; s. 2, ch. 99-331; s. 1, ch. 2000-295; s. 5, ch. 2004-297. Note.Former s. 395.0142.

Statutes » Title 29 » Ch. 395 » Sec. 395.1031

Emergency medical services; communication.

Each licensed hospital with an emergency department must be capable of communicating by two-way radio with all ground-based basic life support service vehicles and advanced life support service vehicles that operate within the hospital's service area under a state permit and with all rotorcraft air ambulances that operate under a state permit. The hospital's radio system must be capable of interfacing with municipal mutual aid channels designated by the Department of Management Services and the Federal Communications Commission.

History

ss. 23, 99, ch. 92-289; s. 72, ch. 95-143; s. 99, ch. 98-279.

Chapter 401 – Emergency Medical Services

Statutes » Title 29 » Ch. 401 » Sec. 401.211

Legislative intent.

The Legislature recognizes that the systematic provision of emergency medical services saves lives and reduces disability associated with illness and injury. In addition, that system of care must be equally capable of assessing, treating, and transporting children, adults, and frail elderly persons. Further, it is the intent of the Legislature to encourage the development and maintenance of emergency medical services because such services are essential to the health and well-being of all citizens of the state. The Legislature also recognizes that the establishment of a comprehensive statewide injury-prevention program supports state and community health systems by further enhancing the total delivery system of emergency medical services and reduces injuries for all persons. The purpose of this part is to protect and enhance the public health, welfare, and safety through the establishment of an emergency medical services state plan, an advisory council, a comprehensive statewide injury-prevention program, minimum standards for emergency medical services personnel, vehicles, services and medical direction, and the establishment of a statewide inspection program created to monitor the quality of patient care delivered by each licensed service and appropriately certified personnel.

History

ss. 3, 25, ch. 82-402; ss. 1, 13, ch. 83-196; s. 3, ch. 84-317; s. 53, ch. 86-220; s. 12, ch. 89-275; s. 10, ch. 89-283; ss. 2, 36, ch. 92-78; s. 35, ch. 2004-350.

Statutes » Title 29 » Ch. 401 » Sec. 401.23

Definitions.

As used in this part, the term:

- (1) "Advanced life support" means treatment of life-threatening medical emergencies through the use of techniques such as endotracheal intubation, the administration of drugs or intravenous fluids, telemetry, cardiac monitoring, and cardiac defibrillation by a qualified person, pursuant to rules of the department.
- (2) "Advanced life support service" means any emergency medical transport or nontransport service which uses advanced life support techniques.
- (3) "Air ambulance" means any fixed-wing or rotary-wing aircraft used for, or intended to be used for, air transportation of sick or injured persons requiring or likely to require medical attention during transport.
- (4) "Air ambulance service" means any publicly or privately owned service, licensed in accordance with the provisions of this part, which operates air ambulances to transport persons requiring or likely to require medical attention during transport.
- (5) "Ambulance" or "emergency medical services vehicle" means any privately or publicly owned land or water vehicle that is designed, constructed, reconstructed, maintained, equipped, or operated for, and is used for, or intended to be used for, land or water transportation of sick or injured persons requiring or likely to require medical attention during transport.
- (6) "Ambulance driver" means any person who meets the requirements of s. 401.281.
- (7) "Basic life support" means treatment of medical emergencies by a qualified person through the use of techniques such as patient assessment, cardiopulmonary resuscitation (CPR), splinting, obstetrical assistance, bandaging, administration of oxygen, application of medical antishock trousers, administration of a subcutaneous injection using a premeasured autoinjector of epinephrine to a person suffering an anaphylactic reaction, and other techniques described in the Emergency Medical Technician Basic Training Course Curriculum of the United States Department of Transportation. The term "basic life support" also includes other techniques which have been approved and are performed under conditions specified by rules of the department.

- (8) "Basic life support service" means any emergency medical service which uses only basic life support techniques.
- (9) "Certification" means any authorization issued pursuant to this part to a person to act as an emergency medical technician or a paramedic.
- (10) "Department" means the Department of Health.
- (11) "Emergency medical technician" means a person who is certified by the department to perform basic life support pursuant to this part.
- (12) "Interfacility transfer" means the transportation by ambulance of a patient between two facilities licensed under chapter 393, chapter 395, or chapter 400, pursuant to this part.
- (13) "Licensee" means any basic life support service, advanced life support service, or air ambulance service licensed pursuant to this part.
- (14) "Medical direction" means direct supervision by a physician through two-way voice communication or, when such voice communication is unavailable, through established standing orders, pursuant to rules of the department.
- (15) "Medical director" means a physician who is employed or contracted by a licensee and who provides medical supervision, including appropriate quality assurance but not including administrative and managerial functions, for daily operations and training pursuant to this part.
- (16) "Mutual aid agreement" means a written agreement between two or more entities whereby the signing parties agree to lend aid to one another under conditions specified in the agreement and as sanctioned by the governing body of each affected county.
- (17) "Paramedic" means a person who is certified by the department to perform basic and advanced life support pursuant to this part.
- (18) "Permit" means any authorization issued pursuant to this part for a vehicle to be operated as a basic life support or advanced life support transport vehicle or an advanced life support nontransport vehicle providing basic or advanced life support.
- (19) "Physician" means a practitioner who is licensed under the provisions of chapter 458 or chapter 459. For the purpose of providing "medical direction" as defined in subsection (14) for the treatment of patients immediately prior to or during transportation to a United States Department of Veterans Affairs medical facility, "physician" also means a practitioner employed by the United States Department of Veterans Affairs.
- (20) "Registered nurse" means a practitioner who is licensed to practice professional nursing pursuant to part I of chapter 464.
- (21) "Secretary" means the Secretary of Health.
- (22) "Service location" means any permanent location in or from which a licensee solicits, accepts, or conducts business under this part.

History

s. 3, ch. 73-126; s. 3, ch. 76-168; s. 248, ch. 77-147; s. 1, ch. 77-347; s. 1, ch. 77-457; ss. 1, 4, 10, ch. 79-280; s. 257, ch. 81-259; ss. 2, 3, ch. 81-318; ss. 4, 24, 25, ch. 82-402; ss. 2, 12, 13, ch. 83-196; s. 4, ch. 84-317; s. 54, ch. 86-220; s. 1, ch. 89-283; ss. 3, 36, ch. 92-78; s. 42, ch. 97-237; s. 107, ch. 2000-318.

Statutes » Title 29 » Ch. 401 » Sec. 401.265

Medical directors.

(1) Each basic life support transportation service or advanced life support service must employ or contract with a medical director. The medical director must be a licensed physician; a corporation, association, or partnership composed of physicians; or physicians employed by any hospital that delivers in-hospital emergency medical services and employs or contracts with physicians specifically for that purpose. Such a hospital, physician, corporation, association, or partnership must designate one physician from that organization to be medical director at any given time. The medical director must supervise and assume direct responsibility for the medical performance of the emergency medical technicians and paramedics operating for that emergency medical services system. The medical director must perform duties

including advising, consulting, training, counseling, and overseeing of services, including appropriate quality assurance but not including administrative and managerial functions.

(2) Each medical director shall establish a quality assurance committee to provide for quality assurance review of all emergency medical technicians and paramedics operating under his or her supervision. If the medical director has reasonable belief that conduct by an emergency medical technician or paramedic may constitute one or more grounds for discipline as provided by this part, he or she shall document facts and other information related to the alleged violation. The medical director shall report to the department any emergency medical technician or paramedic whom the medical director reasonably believes to have acted in a manner which might constitute grounds for disciplinary action. Such a report of disciplinary concern must include a statement and documentation of the specific acts of the disciplinary concern. Within 7 days after receipt of such a report, the department shall provide the emergency medical technician or paramedic a copy of the report of the disciplinary concern and documentation of the specific acts related to the disciplinary concern. If the department determines that the report is insufficient for disciplinary action against the emergency medical technician or paramedic pursuant to s. 401.411, the report shall be expunged from the record of the emergency medical technician or paramedic.

(3) Any medical director who in good faith gives oral or written instructions to certified emergency medical services personnel for the provision of emergency care shall be deemed to be providing emergency medical care or treatment for the purposes of s. 768.13(2).

(4) Each medical director who uses a paramedic or emergency medical technician to perform blood pressure screening, health promotion, and wellness activities, or to administer immunization on any patient under a protocol as specified in s. 401.272, which is not in the provision of emergency care, is liable for any act or omission of any paramedic or emergency medical technician acting under his or her supervision and control when performing such services.

(5) The department shall adopt and enforce all rules necessary to administer this section.

History

ss. 6, 25, ch. 82-402; ss. 12, 13, ch. 83-196; s. 8, ch. 88-186; s. 15, ch. 89-275; s. 13, ch. 89-283; s. 70, ch. 89-374; ss. 8, 36, ch. 92-78; s. 34, ch. 93-211; s. 793, ch. 95-148; s. 45, ch. 97-237; s. 3, ch. 98-87; s. 20, ch. 98-151.

Statutes » Title 29 » Ch. 401 » Sec. 401.45

Denial of emergency treatment; civil liability.

(1)

(a) Except as provided in subsection (3), a person may not be denied needed prehospital treatment or transport from any licensee for an emergency medical condition.

(b) A person may not be denied treatment for any emergency medical condition that will deteriorate from a failure to provide such treatment at any general hospital licensed under chapter 395 or at any specialty hospital that has an emergency room.

(2) A hospital or its employees or any physician or dentist responding to an apparent need for emergency treatment under this section is not liable in any action arising out of a refusal to render emergency treatment or care if reasonable care is exercised in determining the condition of the person and in determining the appropriateness of the facilities and the qualifications and availability of personnel to render such treatment.

(3)

(a) Resuscitation may be withheld or withdrawn from a patient by an emergency medical technician or paramedic if evidence of an order not to resuscitate by the patient's physician is presented to the emergency medical technician or paramedic. An order not to resuscitate, to be valid, must be on the form adopted by rule of the department. The form must be signed by the patient's physician and by the patient or, if the patient is incapacitated, the patient's health care surrogate or proxy as provided in chapter 765, court-appointed guardian as provided in chapter 744, or attorney in fact under a durable power of attorney as provided in chapter 709. The court-appointed guardian or attorney in fact must have been delegated