COUNTY OF **SANTA** CRUZ

April 25, 2002 AGENDA: MAY 7,2002

Board **of** Supervisors
County **of** Santa Cruz
701 Ocean Street
Santa Cruz, CA 95060

SUBJECT: REPORT ON HOSPITAL EMERGENCY DEPARTMENTS AND RELATED ACTIONS

Members of the Board:

Background:

Last year on April 24th, 2001 your Board accepted an extensive report on Hospital Emergency Room Restricted Status (Code Red/Code Yellow). That report (Appendix A) was requested by your Board to ascertain the level of access to emergency room services and concerns related to ambulance diversions due to a facility being "Code Red" and not able to accept new patients. The 2001 report reassured your Board and the community that our level of access was excellent and compared our situation to many communities with large numbers of ambulance diversions and extended Code Red status in other Counties and across the nation.

Since last year, our situation has changed significantly for the worse, and we are experiencing many of the problems that were described in other communities. The worsening conditions were described in several articles on March 17th in the *Santa Cruz Sentinel*. This report will review the reasons for this increase in "Code Red" status in the emergency rooms of Dominican and Watsonville Hospitals and recommend actions that your Board could take to improve current conditions.

Erosion of Critical Supports

Similar to police and fire, emergency room services are a critical part **of** the public safety net. Without these services, seriously ill individuals have to be transported extended distances for access to care putting their lives at risk. The pressures on the emergency rooms in Santa Cruz are similar to those throughout the nation and California with one exception, the unusually expensive housing market. California also has a very high level of managed care plans used by the public for health care insurance. Managed care plans pay lower rates to hospitals and providers. Critical supports that the emergency rooms

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need to operate smoothly and fulfill their mission are being eroded. These include access to critical care beds, nursing staff, and physician and specialist services. Impacts of these problems can be seen in a number of California Health Care Foundation reports and other articles that are included under Appendix B. There are also serious problems with the financing of health services for all community members as well as increasing mandates placed on the hospitals by federal and state government without financial supports to accomplish these mandates. As a whole the health care system is heading for a serious crisis which will require inspired leadership and a commitment of both the voters and key health stakeholders for major improvements to occur. Some of the issues that significantly impact Santa Cruz County emergency room services are as follows:

Nursing Crisis:

The national shortage of nurses is well documented and will not be repeated here. The impact in the hospitals is particularly critical and is a central issue impacting the emergency room. The emergency rooms cannot function smoothly unless the patients they stabilize can move to other areas of the hospital for continued care. The patient may need surgery related to trauma or to go to a delivery room for a birth or a general medical bed. Patients cannot be moved from the emergency room if there are not enough nurses in the receiving unit to oversee their care. Critical care beds require one on one staffing of nurses to patients. Night shifts are often the most difficult to recruit for and thus shortages often occur from the early evening into the following morning when adequate nursing staff is available then to move the patients and oversee their care.

Besides the national shortage, which all communities are struggling to address, the State has passed a law mandating specific nurse-to-patient ratios for different types of hospital units. This mandate does not come with funding to train and add more nursing staff. It will limit the hospital's ability to utilize their licensed beds thus causing increasing backlogs in the emergency rooms. Locally, the hospitals and other health care providers are working with Cabrillo College to expand their nursing program and are hiring expensive "traveling" nurses to cover critical shortages. Even with paying extremely high rates, however, there is no guarantee that nurses will be available when needed. It will take many years for there to be an adequate support of nurses even with new expanded college programs.

Of particular concern, related to the nursing crisis, is the aging of the population and particularly the "baby boomers". This major increase in the elderly population will lead to increased demands on the health system at all levels. Nursing is a critical support in so many of these services (skilled nursing, home health, hospice, outpatient clinics, public health, hospitals) that the demand is sure to increase beyond the capacity **of** new schools to produce trained graduates. Some states, such as Oregon, have tried to address part of the nursing crisis through legislation called the "Nursing Delegation Act." This law allows nurses to train and oversee other caregivers in duties previously done only by nurses. Nursing task delegation and oversight is utilized in Oregon in long term care settings and home health. California needs to consider creative options like Oregon to insure that nurses will be available in hospitals and other acute care settings where their

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skills are essential.

Critical Care Beds:

Critical care beds are needed for very sick patients who need to be admitted fiom the emergency room. These are often in short supply. Dominican has 16 beds and Watsonville has 4 with an expansion to **8** in process. Both Dominican and Watsonville are working closely to evaluate their level of need for these beds as well as other types of beds to try to help the system work smoother and provide needed relief to the emergency rooms. Licensing and construction of hospital beds is extremely time consuming and complex. The hospitals have been working with licensing to get flexibility in these crises on bed utilization. While the State Department of Health Services licenses and oversees hospitals, it has few options to assist with overcrowding and lack of staffing. The options they can provide are waivers on certain regulations while the crisis is going on. The State Department of Health needs to partner with the California Hospital Association to provide flexibility and increased supports to them in a crisis.

Physician Supports:

Emergency room physicians do an essential job of evaluating, stabilizing, and treating acutely ill or injured patients 24 hours per day. Physician staffing of emergency rooms has become increasingly difficult. These jobs are very demanding professionally **as** well **as** personally in terms of workload and the toll on a normal family life. Emergency medicine is one of the most stressful jobs in medicine. These doctors rely on critical supports fiom nursing as well **as** physician specialists to insure that patients get the treatment they need. The emergency room physicians can only take treatment so far. They need support fiom trained and specialized surgeons, ophthalmologists, cardiac specialists, pediatricians, psychiatrists, and many others. For example, for Dominican's emergency department to insure patients are linked to comprehensive acute care, 35 physicians are on-call at all times to serve different types of patient needs. Watsonville Hospital's emergency room is similarly dependent on specialists to provide care.

Many factors interact to create the increasing "physician gap" in our community. Housing costs for individuals coming out of medical school with $100,000-$200,000 in debt have made talented new physicians reluctant to move here after finishing their educations. Emergency medicine as well as other kinds of medical practice has very high malpractice insurance rates. Legal action by patients and families related to emergency room services is very high. Emergency physicians are seeing patients they do not know and who often cannot communicate their history or medical symptoms. Reimbursement, which shall be addressed in detail in a later section, is also a cause of significant distress for physicians in California in particular. When there are not enough specialists in a particular area of medicine, fewer and fewer individuals take hospital call. **So,** for example, a surgeon who began his career being on-call and working one out of every ten nights is now working one out of four nights. It is not unusual to have to go into the hospital once or twice a night when on-call. Getting up the next day to take care of your family and go to your regular medical practice is very difficult. As the pool of

physicians available to serve the emergency departments age, they prefer more leisure time and quality of life over reimbursement or doing on-call.

As more and more physicians retire and are not replaced by new doctors, the acute care safety net in our emergency rooms is eroding. Many critical care functions cannot be performed. While patients can fly by helicopter to hospitals up the peninsula, this time delay could put them at serious risk and frequently, they do not have staffed beds either. In addition, when weather conditions are bad, helicopters cannot fly and putting the patient who needs a particular type of specialist to provide care at serious risk.

While some hospitals have responded to physician shortages by paying for being on-call, money alone will not solve the problem. Even with generous reimbursement, many hospitals cannot find adequate specialists to provide services. Similar to nurses, hospitals sometimes hire "traveling doctors" through specific physician management companies. They are very expensive and do not know the community, if they are even available when they are needed.

The desire for voluntary on-call duties is supported by the California Medical Association which recommends that all hospital physicians be able to do call voluntarily. In addition, they recommend that hospitals reimburse for these services. Locally, our hospitals pay for limited and selected on-call services. Most on-call services are not compensated. It is estimated that it would cost conservatively 1.5 to 1.7 million dollars per hospital to have all physicians paid who do these services. This assumes however that even with pay, physicians would be willing to share call with smaller and smaller pools of participating physicians. Similar to the challenge of the nursing crisis, new models of care and financing need to be considered if the tide of emergency room closures and limited access to specialized acute care is to be stopped.

The community is facing a significant crisis in access to care if physician specialists decide they do not want to provide emergency room services and on-call availability. Dominican physicians are schedule to vote on May 7th on whether services to the Emergency Departments should be a voluntary or mandated part of having hospital privileges to practice. HSA does not have an update on Watsonville Hospital activities.

The Health Services Agency supports working with all parties to find a solution which does not compromise community care and addressing on the major system issues impacting financing of the health safety net. The Senate Office of Research (California) has just released a draft report on ED on-call coverage issues. Currently CSAC, the Health Officers, and the League of Cities are providing input on recommendations. The Health Services Agency will be preparing input and analysis of this report in conjunction with key stakeholders.

<u>Mandates on Hospitals without Financing</u>:

The last five years have seen significant and costly mandates placed on hospitals The other two significant mandates are federal: (1) the Federal Emergency Medical

Treatment and Active Labor Act (EMTALA) and (2)the Health Insurance Portability and Accountability Act (HIPAA). Two of the most significant California State mandates are: (1) earthquake retrofit requirements and **(2)** nursing staff ratios. Each of these mandates will be briefly described.

EMTALA :

This Act defines the requirements for Medicare and Medicaid participating hospitals to treat emergency cases. Congress enacted EMTALA in response to alleged discrimination against indigent patients who were denied care in EDs and "dumped" out of the hospital due to inability to pay. The intent of the EMTALA law was to insure that sick patients presenting in the emergency rooms could be evaluated, treated, and stabilized regardless of ability to pay. The original intent of this law was good, however, the manner of it's implementation and expansion by State Licensing **has** created significantly more problems for hospitals, and emergency departments in particular. The goal of the law was to insure that patients were evaluated and if needed stabilized prior to any transfers or discharge. In addition, hospital transfers now require a doctor-to-doctor conversation to discuss the case and confirm the appropriateness of the transfer.

The law has been expanded to include any patient walking into any area of the hospital requesting services or assistance even if the hospital does not have an emergency room, as well **as** any patient in the "area" of the hospital even if they do not come in and request services. ***An*** individual is considered to have come to the ED when on the hospital property. Hospital property includes anywhere on the campus including the parking lot, lawn, cafeteria, and surrounding areas. In the emergency departments, patients used to be able to be evaluated in "triage" by a nurse, and if clearly not acute, they could be sent home with some medical advice and recommendations. Now everyone has to be evaluated by doctor or a specially-trained nurse practitioner before they can be re-directed to any other service or sent home. These staff can end up telling the patient the same medical advice and sending them home, but it takes much longer and re-directs high level medical staff from more critical cases. Patients also have to wait longer to be seen. It also creates more expense for the patient and the hospital.

EMTALA also changed the way that health plans could intercede to re-direct patients to their primary care physicians from the emergency rooms. One of the advantages of some health plans was that their primary care doctor was contacted when a patient came to the emergency room so they could assist in the treatment by re-directing the patient to their office or provide direction over the phone. Now patients must be evaluated and treated even if the health plan is contacted. Some care plans abused this however by restricting outpatient access and also denying emergency room services.

HIPAA: This set of laws, originally signed by President Clinton in **1996,** is actually a whole series of significant health laws. The original intent was to improve health insurance accessibility to persons changing employers or leaving the workforce entirely. However, the bill was significantly expanded to include new electronic standards for all health providers in the areas of eligibility, billing, remittance advice, provider numbers,

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security, privacy/confidentiality, storage of records, and other items. One of the most significant changes is establishing a uniform national set of approved billing codes. There are thousands of health billing codes and modifiers in use. In the past any insurance company, state, or other entity that reimburses for care could just make up a new code with a new definition. Even with years of work, the billing code set is still "in process".

This law has so many components that the requirements are in groups with different deadlines over the next **5** years. The first group of requirements relate to electronic data transmission, unique health identifiers, security, and electronic signatures. The deadline for implementation is scheduled for October of **2003.**

The costs for computer programming, re-training staff, and re-engineering systems in hospitals will be significant. It has been stated by numerous health analysts that the changes related to HIPAA compliance will far exceed in costs the funds spent on Y2K changes. Again, there is no identified funding source for these changes.

Earthquake Retrofit Requirements: Several years ago the State passed legislation providing for mandated upgrade of all California hospitals to meet specific earthquake standards. These standards, developed after the quakes, were intented to insure the hospitals were safe from future quakes. While the intention was good, there were no funds identified to help hospitals with this costly task. Many small rural hospitals have stated that they would need to close and could not afford to rebuild. After advocacy by numerous groups, the State legislature has put off the timeline for completion of these improvements, but the fundamental problem remains. In Santa Cruz our hospitals are relatively new and have met many of the earthquake standards with the exception of Dominican's rehabilitation hospital (the old Community Hospital). This structure would need significant improvements to meet new standards and remain a licensed hospital.

Nursing Staffing Ratios: This law was approved this year and calls for specific RN staffig nursing ratios for specific types of hospital beds. In many cases, these exceed existing levels of RN to patient ratios in our hospitals. The costs, given the nursing shortage, could be significant. It is not uncommon for hospitals to have licensed beds which cannot be used due to nursing shortages. This again creates bottlenecks in the system and back up in the emergency departments.

In summary, State and Federal mandates have created serious financial and operational challenges for the hospitals with no assistance in financing these changes. After years of the State doing this to Counties, legislation was passed **(SB** 90) to mandate the State to help pay for changes it requires. Similar legislation which protects hospitals, at least to the degree that their patient mix is uninsured or underinsured patients (Medical, Medicare), should be considered. Clearly some options need to be provided for financing these numerous changes and standards created by State and Federal

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Santa Cruz Safety Net Clinic Data
OSHPD Reports

Clinic Name	Total Unduplicate Patients	Total encounters	#, % of encounters Uninsured MediCruz, HPHP, EIP	#, % of encounters Medical, CHDP, FAMPAC, Healthy Families	#, % of encounters to Hispanics	#% of encounters Income under 200% poverty
Salud Para La Gente	10,924	33,691	18,530 55%	13,813 41%	32,343 96%	33,355 99%
county Clinic North	6,947	17,011	8,335 49%	8,505 50%	5,968 35%	16,330 96%
county Clinic South	7,071	18,676	5,602 30%	12,886 69%	15,875 85%	18,115 97%
PlanParent Westside Cabrillo, SLV	9,090	25,243	5,762 23%	18,215 72%	19,184 76%	7,727 85%
Planned Parent South	4,583	12,321	2,812 23%	9,054 73%	11,212 91%	9,733 79%
Women's Health Center	3,197	8,693	3,174 37%	4,346 50% (estimate)	2,000 23%	6,867 79%
Dientes: North and South Clinic (Not Valley)	4,500	7,200	1,872 26%	4,900 68%	3,744 52%	7,200 100%
TOTALS	**46,312 Individuals**	**122,835 Encounters**	**46,087 38% 17,600 individuals**	**71,719 58% 26,860 individuals**	**90,326 74% 34,270 individual**	**99,327 81% 37,512 individuals**

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State Funds for the Uninsured and Emergency Care:

The County administers **3** different accounts of state funds for physicians for uncompensated emergency care, each with special rules and reporting requirements imposed by the State. These accounts fund the uninsured patients using emergency rooms and related services. The funds are in capped allocations so when they are used up, there is no reimbursement for the balance of the year. Even with the County providing significant additional dollars to these programs, the amount of funds are simply not adequate to fund a health care system for the uninsured. Last year, in the midst **of** the crisis **of** Los Angeles emergency rooms, the legislature provided yet another funding stream through the County to cover hospital and emergency room physician costs **(SB** 2132 Emergency Medical Services Appropriation). It brought an additional $172,094 to local hospitals and physicians providing services in these settings. It was supposed to be a one-time allocation, but appears to be continued in the proposed budget. **These funding streams need to be consolidated and allocated in a simple way to the hospitals and emergency rooms with modest reporting requirements.** Hospitals could then work with their physicians on a fair way to reimburse for services. State legislation would be required to accomplish this, but it would allow the funds to be stretched further and ease the burden on physicians and hospitals.

The detailed descriptions of the three distinct funds for physicians for uncompensated emergency services are described in Attachment C.

Medical and Medicare Rates of Reimbursement:

Medical rates of reimbursement and spending per patient have been among the lowest per capita in the nation for the past decade. While the Central Coast Alliance for Health (locally controlled Medical program) has helped keep funds here and reward providers for good care and cost efficiency, it still operates within the total financial limits of the State Medical program. **So** when the State last year approved significant rate increases for physicians and hospitals, the Alliance was going to pass these on to local providers of service, Medical has historically underpaid hospitals and providers. The Central Coast Alliance for Health has been told by the State that due to the funding crisis at the State level, rates will not be increased in the next year and some rate reductions are likely. Indeed the Governor, in his January budget, proposed a "take back" of Medical rate increases to doctors and hospitals with the exception of those serving disabled children and women.

In the Medicare program, there are also significant problems with reimbursement. Santa Cruz and Monterey Counties have been designated **as** "other urban" by the Medicare program. Since Medicare has regional rates, this means lower reimbursement for all physicians and skilled nursing providers. Local physicians are reimbursed 12-17% less than physicians doing the same services in San Jose. Meetings with Congressman Farr have shown that he is interested in Santa Cruz and Monterey getting Bay Area rates, but the OMB and administration has indicated that all changes in Medicare must be dollar neutral which means to increase our rate, a cut must be achieved somewhere else.

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Besides the low regional rate, Medicare has recommended a 5% rate reduction for physicians this year to balance the budget. The Administration is also proposing a 17% reduction in hospitals in order to find funds for their proposed pharmacy benefit. Recent meetings in Washington left no doubt was to create a pharmacy benefit at the expense of other health providers and keep the federal treasury "budget neutral." Given the potential costs of the pharmacy benefit, this idea, if implemented, would bring the health care system to its knees. Strong advocacy against this approach should be voiced at all levels. This will increase the difficulty of patients with Medicare finding a medical home and getting medical services. For physicians who serve large numbers of elderly clients, this reduction is significant. Liability insurance, HIPAA, and other requirements impact physician practices as well as hospitals creating significant pressure on incomes.

Emergency departments are very expensive to operate and because they cannot control access, they can take significant losses putting the hospital itself at risk. For that reason, many communities have seen their emergency rooms close. While there are notice requirements for this type of change, there is no mandate for hospitals to have emergency departments. Unlike fire stations, where the community expects to see services in each major region of the County, there is limited government control over private hospital services in terms of scope in the current system. It is the commitment of the hospitals to the community that keeps them providing these services.

Increased Use Patterns of Emergency Departments:

Emergency departments are challenged to find creative ways to meet the needs of the community and provide a vital and important safety net service which we all count on in time of need. The increased utilization and decreasing support have made this job very difficult. Leaders at Dominican and Watsonville Hospitals have been working both internally and externally to try to find solutions to these difficult problems. Both hospitals are represented at the Emergency Medical Care Commission and try to use this important forum to solve problems and made sound recommendations to policy makers.

Many communities have been trying to understand the increased use patterns we see statewide in emergency departments. High users are not just the uninsured patient who wants treatment without payment. The EMCC, Netcom, the Hospitals, and Ambulance providers have begun looking at data to identify high users, seasonal patterns of use, acuity level of patients, and other factors. Sacramento County just finished an extensive analysis of their hospital diversions and will be providing the report to Santa Cruz so we can consider some of the recommendations. In addition, Sonoma has just begun a detailed analysis of its emergency department overcrowding problems and this report will also be available to us for review.

Patients come to the emergency room from several sources: ambulance, walk-in, brought in by police, and transferred from other health settings (skilled nursing, jail, other hospitals). Trends in the Use and Capacity of California's emergency departments 1990-1999, a report in the Annals of Emergency Medicine, show a steady trend of increasing

volume with peaks in the winter flu season. This study showed that California's Emergency Departments had similar utilization trends to others in the nation. The data showed that 14% of the ED patient visits were critical, 50% were urgent, and 36% were not urgent.

Patients from many sources: ambulance, walk-in, and police arrivals all included non-urgent patients. Transfers fiom other hospitals and skilled nursing were rarely non-urgent. The community has been well trained to use 911 if they are in a crisis or concerned with someone's health. While the review of Netcom data did not reveal a particularly high level of non-urgent cases, many communities are instituting other "warm lines" for social service and health information to access service or just get advice. To the extent these lines are successful at meeting people's needs and re-directing care, there should be a positive outcome on emergency department use by non-urgent patients.

Other communities are trying to organize health providers to have better, easier to use after-hours consultation with physicians or nurse practitioners who can assist them until the outpatient clinic is open. Nurse advice lines are also helpful to assist individuals who are concerned about an issue, but uncertain about calling 911. Homebound seniors often use 911 to get to care because of the significant challenges they have in routine access. In Home Support Services **(IHSS)** can provide assistance to many seniors in getting to and fiom appointments, picking up medications, etc.

Individuals who walk in have a mix of insurance coverage and levels of acuity. Some patients with insurance including Medical have developed a pattern of using the emergency department when it is difficult to get an appointment at their doctor's office. Health Plans like Medical and PacifiCare should work with the hospital emergency departments to identify ways to engage the patient in primary care in a way that reduced non-urgent use. Case management has been used by San Francisco General Hospital and Santa Clara Valley Medical Center to reduce inappropriate use of the emergency room. These programs focus on chronic patients, often with drug, alcohol, or mental health issues, as well as health problems.

In relation to law enforcement, there are a variety of patients brought to the emergency departments. Some are non-urgent and might be able to be redirected. Police use the hospitals for blood draws for *drunk* driving and for individuals who are too intoxicated to stand and need to time to become more sober before going to jail. Also individuals who are injured in fights or altercations are brought to the emergency room before going to jail. Communication has begun between the Sheriffs Department, the Chiefs' Association, and the emergency rooms to discuss how to manage and supervise individuals who are intoxicated. Since many jurisdictions are paying for police time, there may be some options for better supervision and management if they do need to come to the emergency department. In addition, there may be some options other than the emergency departments for blood draws. The option of establishing a sobering facility has been explored without success in the past, however, this would be a helpful community resource which could reduce emergency room utilization.

For ambulance transports, if the patient refuses to get transported to the hospital, the ambulance is not reimbursed at all. Patients can refuse to go to the hospital and be released against medical advice (AMA) but it does not happen often. If ambulance staff encouraged a patient to not go to the hospital, and indeed, there was something wrong with them, there would be significant liability. Third party insurance payors will not pay emergency ambulance bills for patients who are transported to an urgent care center or alternate disposition. For all of these reasons, most calls result in transports even though the patient might be able to be treated and assessed at an urgent care center or alternate disposition. Many counties have been discussing the possibility of having more alternate dispositions available to the ambulance and patient without penalty. This would require changes by the federal agency over Medicare and Medicaid (CMS), but has some merit in identifying individuals who might be able to get treatment in a lower level of care.

Local Activities To Address Emergency Departments Challenge:

The Health Services Agency, local fire agencies and AMR staff, the hospitals, Netcom, Medical Society, and the community coalition working on the Disaster Plan have all been trying to improve conditions in the emergency departments. With the passing of the flu season and no major holidays to bring large numbers of tourists to the area, the number of hours on diversion has dropped down again. The system however is very fragile in terms of staffing and options when the flu season arrives in November. For this condition to change, significant structure changes need to be made in the operation and financing of these services. For that reason activities with short and long term goals have been identified and are being worked on by an adhoc committee of stakeholders.

Public Education Activities:

1. Educate the public and other health providers on appropriate use of hospital emergency departments. For the general public, the message is to not come to the emergency room unless you truly believe it is an emergency. Use urgent care and your primary care office whenever possible or the community clinic safety net providers if you are not insured. The Health Department did a press release on appropriate use of the emergency department as did the Medical Society. Stories have been in the ***Santa Cruz Sentinel,*** and the President of the Medical Society also did a special article under "Dear Doctor." Additional articles are being written to provide information to the public on this issue and access to care for local newspapers. These articles will focus on preventive care, the importance of a medical home, insurance options, and appropriate use of 911 and emergency rooms.

2. Develop a quality alternative to 911 for health and social service information (311) including a nurse advice line, getting referrals to community clinics and urgent care centers, health insurance options, in home support services, etc.

3. Educate and develop analysis of problems to share with State, Federal, and local

officials. Collect data to refine problem definition and options for improvement. Keep all levels of government informed of the crisis.

4. Advocate for a stable funding source for the hospitals to secure services of needed doctors and nurses for the emergency departments including availability of specialists through on-call or another structure **to** insure vital capacity for handling trauma.

Communication/Information Improvements:

1. Pursue purchasing software to track area hospital bed status including emergency departments. This is in use in Monterey and Santa Clara and has proved helpful to them when managing in a crisis.

2. Netcom will provide more detailed reasons for Code Red status to paramedics in the field who are transporting clients. This will allow for more appropriate disposition. Also page **HSA** when both hospitals are Code Red to respond and provide assistance.

3. For health care providers such as private doctors and skilled nursing facilities, the media activities were to encourage them to delay sending individuals if possible until the facility is no longer on Code Red. A fax communication system was being developed to make it easy to send out alerts. Broadcast pages were also being discussed, but this is more challenging to accomplish.

4. For physicians who have patients in hospital beds, the hospital was going to set up ways to communicate to them on bed capacity and discharge issues. If patients can be discharged earlier in the day it could provide access for patients in the emergency rooms.

5. Consider adding software in Emergency Departments linked to local providers to track and access medical information in an emergency (Axolotl/Elysium). The result would be better patient dispositions and access to primary care providers.

6. Begin communication with criminal justice community on alternatives to emergency departments for blood draws and also management and supervision of inebriates.

7. Begin discussions on alternative ambulance dispositions and process for having more flexibility.

8. Strengthen discharge planning to avoid re-admissions by collaboration with local health and social service agencies.

9. Begin discussions on priority access to skilled nursing beds under Code Red

status to create bed capacity.

Legislative Advocacy:

Meet with elected officials at all levels to educate them on the emergency department crisis and work actively on legislation to address issues.

Advocate for funding **for** emergency department safety net services including purchase of specialist services for 24-hour emergency response and availability.

Strongly recommend and advocate for restoring rate increases to Medical and Medicare **for** hospitals and physicians.

Recommend financial assistance for hospitals for new mandates imposed fiom the State and Federal governments.

Recommend expansion **of** nursing programs and additional hnding of physicians through the public health service corp.

Recommend state funding consolidation and increases **for** emergency departments and physicians in to be managed by the hospitals.

Support legislation to simplify Medical, Healthy Families, and other insurance access to reduce uninsured individuals.

8. Work with key stakeholders on getting Medicare regional designation changed.

Emergency Transportation:

1. Develop expanded systems for EMS mutual aid in the case of hospital diversions.

2. Continue to explore alternative dispositions with the State and others to encourage clinically appropriate treatment at the least restrictive health destination without sacrificing reimbursement.

3. **Do** contingency planning **for** Code Red status in both hospitals.

Hospitals

1. The hospitals are jointly developing internal and regional plans **for** dealing with overloads in their emergency departments. They are working on this in consultation with the State and other stakeholders.

2. Work with County and others on strategies for attracting more physicians to the area.

3. Work with Cabrillo College and County on enhancing nursing development resources.

4. Educate and advocate with others for funding for on-call coverage of critical specialists for emergency care.

5. Continue excellent partnerships with community members and physicians working on solutions and strengthening the safety net.

In summary, local activities have focused on stabilizing the immediate emergency conditions, but much needs to be done to stem the tide of serious ongoing emergency department problems. Human resource issues and financial supports for hospitals and providers are significant environmental issues which will take significant collaboration regionally to impact.

Emergency Medical Services & Public Health:

1. Work with the hospitals to advocate for funding and support to address critical coverage issues in the emergency room including on-call specialists, nurses, and enough physicians to share the duties of an emergency department.

2. Coordinate and support activities to improve conditions in emergency departments.

3. Finish Disaster/Influenza Pandemic Plan and provide to Board of Supervisors for approval.

3. Work with health stakeholders on public education campaign, funding advocacy, and human resources development.

4. Support a Health Summit on June 29th to discuss the issues of the uninsured and to seek solutions.

The Community Foundation of Santa Cruz County and others focused on challenges of the uninsured last year through a health advisory committee. The deteriorating situation makes it imperative to convene a community-wide ***Summit on the Uninsured*** to search for solutions. The Community Foundation has accepted the challenge, and together with other co-sponsors will convene a ***Summit on the Uninsured*** in late June. Arrangements are still being made. The Summit will likely foster several working groups to address different aspects of the problems, and their work will consume several months of dedicated effort. The outcomes will be improvements in the utilization of current resources in the system, modest expansion of capacity to care for the uninsured, possibly new financing models to broaden participation of more providers and patients in the care process, and ultimately improved health status for the entire community.

6. Work on legislative advocacy to improve reimbursement for hospitals and providers as well as community clinics to strengthen outpatient access.

There are numerous options for working on these issues where the Board of Supervisors can play a constructive role. These options are outlined in the following recommendations.

It is RECOMMENDED that your Board take the following actions:

1. Direct staff to educate State and Federal elected officials on impacts of Medical and Medicare rate reductions and recommend legislation which would assist in this restoration; and

2. Direct staff to work with the Hospitals and Medical Society on changing the Medicare regional designation and report back on options; and

3. Direct Health Services'Agency staff to continue community education efforts and investigate further these efforts in other communities; and

4. Direct Health Services Agency to continue grant development efforts to expand and strengthen the community clinics, and enhance emergency room communication and computer ties to safety net providers; and

5. Direct Health Services Agency staff to work on expanded health insurance options including but not limited to assisting with the Health Summit in June 2002; and

6. Discuss options for alternate ambulance dispositions including development of possible federal legislative proposals in collaboration with other counties; and

7. Direct Health Services Agency staff to bring legislation to the Board of Supervisors for consideration as part of the Counties legislative platform in the following areas: Medical simplification and other health insurance expansion bills, improved reimbursement of costs for state and federal mandates to hospitals, expanded nursing programs, flexibility in nursing scope of practice laws, access to specialist supports in emergency departments; and development of alternate disposition options for emergency transportation; and

8. Report back to the Board on these issues on August 27th, 2002.

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Sincerely,

Rama Khalsa, Ph.D.
Health Services Agency Administrator

RECOMMENDED

Susan A Mauriello
County Administrative Officer

Attachments: Reference documents, prior board letter on emergency department code reds issues.

cc: EMCC
Vol Ranger, EMS Administrator
Public Health Commission
Santa Cruz County Medical Society
AMR
Dominican Hospital
Watsonville Hospital
Sutter Hospital
EMSIA

ATTACHMENT A

VARIOUS INFORMATION ITEMS ON EMERGENCY ROOM USE

Trends in the Use and Capacity of California's Emergency Departments, 1990-1999

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Study objective: Concerns over the ability of the nation's emergency departments to meet current demands are growing among the public and health care professionals. Data supporting perceptions of inadequate capacity are sparse and conflicting. We describe changes in the use and capacity of California's EDs between 1990 and 1999, as well as trends in severity of patient illness or injury.

Methods: Data from California's Office of Statewide Health Planning and Development (OSHPD), which describe all hospital and health service use in the state, were analyzed and later verified using a telephone survey of all 320 open EDs in California. Six variables were analyzed: hospital's ownership type (public or private), total number of annual ED visits, severity of patient illness or injury (percentage of visits categorized as critical, urgent, or nonurgent), number of ED beds, proximity to a closed ED, and teaching status. We tested 2 main hypotheses: (1) Have statewide ED visits, ED beds, visits per ED, and visits per bed increased or decreased between 1990 and 1999? and (2) Has severity of patient illness or injury, as reported to OSHPD, changed over the past decade? State level data were analyzed using ordinary least-squares regression. Hospital level data were analyzed using repeated measures analyses.

Results: The number of EDs in California decreased by 12% ($P<.0001$). The number of ED treatment stations (ie, physical spaces for the treatment of patients) increased by 687 (16%) statewide ($P=.0001$), or an average of 79 beds per year. The average annual change in ED visits was not statistically significant ($P=.5$), whereas visits per ED increased by 27% for all EDs ($P<.0001$), although with differing trends noted at public and private hospitals. At private hospitals, the average increase was 512 visits/ED each year, whereas at public hospitals, visits decreased by an average of 1,085 visits/ED each year ($P<.0001$).

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ED data from OSHPD's Annual Utilization Report of Hospitals were examined for logical inconsistencies, and these were investigated and resolved. Between August 15 and August 20, 2000 we also conducted a telephone survey of all 320 facilities that had reported basic or comprehensive emergency services to OSHPD on December 31, 1998. The purpose of the survey was twofold: (1) to validate any openings, closures, or downgrades OSHPD had reported and (2) to identify and resolve any logical inconsistencies in the OSHPD data. ED personnel who answered the telephone were asked whether their hospital had a functioning ED with a physician on duty 24 hours a day and whether they received severely ill patients via ambulance. If they responded "yes" to both questions, they were classified as a basic or comprehensive ED. Of the 490 variables collected by OSHPD, we limited our validation efforts to these variables because they are the variables that are most critical to the classification of EDs for our analysis.

Using this same methodology, we also verified OSHPD–reported ED closures and downgrades by surveying the 24 facilities whose EMS level had changed from basic or comprehensive to standby or no EMS between January 1, 1996, and August 2000. If we were unable to reach hospital personnel (eg, when a hospital was no longer in operation), we contacted nearby hospitals and community organizations (eg, the local chamber of commerce) to verify the status of the closed ED. When we found inconsistencies between the OSHPD data and the telephone survey results, we used the information obtained from the telephone survey. For example, the OSHPD dataset reported 2 hospitals as providing basic emergency services, although they were licensed as psychiatric acute care facilities. Interviews with hospital personnel revealed that neither facility had reported ED visits or beds, and we subsequently excluded these 2 sites from the analysis.

To better characterize data collection procedures for OSHPD's ED measures, we conducted telephone interviews with hospital administrators and ED managers at 6 EDs. All 6 sites had 3 reporting procedures in common. First, the hospital administrator responsible for reporting to OSHPD obtained ED data from the ED nurse manager or director. Second, annual ED visits were determined from administrative or triage data and not from claims or financial data. Third, severity of illness or injury was determined on the basis of the patients' level of severity as designated at ED triage.

However, severity levels were not defined in a uniform manner at all 6 sites. For example, at 1 private Southern California trauma center, patients are triaged into 3 categories when they arrive, and the administrative nurse reports to OSHPD that patients with the highest severity rating are critical, those in the middle category are urgent, and those with the lowest rating are nonurgent. In contrast, at a rural community hospital, there are more than 3 original triage categories, and a physician determines which patients should be categorized as critical, urgent, and nonurgent from their original triage classification and/or medical charts.

Using the OSHPD data, we determined the EMS level (ie, the level at which the facility is licensed by the California Department of Health Services' Division of Licensing and Certification) for each hospital. Title 22 of the California Code of Regulations defines 3 licensing levels for EDs: standby, basic, or comprehensive.[20] Standby EDs provide emergency medical care in a specifically designated area of the hospital that is equipped and maintained at all times to receive patients with urgent medical problems and are capable of providing physician services within a reasonable period of time. A physician need not be present in the hospital at all times but must be readily available when summoned. Basic EDs, by contrast, must have a physician on the premises and available 24 hours a day (eg, a community hospital ED). Comprehensive EDs provide a more extensive scope of services than basic EDs, with inhouse capability for managing all medical situations on a definitive and continuing basis (eg, a tertiary care center ED).

We defined (1) an "opening" as any hospital whose OSHPD reporting status changed from no EMS or standby EMS to basic or comprehensive services between January 1, 1990, and December 31, 1999, and (2) a "closure" or "downgrade" as any hospital whose EMS level had changed from basic or comprehensive to no emergency services or standby emergency services, respectively, between January 1, 1990, and December 31, 1999. By this definition, closures represent permanent termination of emergency services at that facility.

In assessing the impact of ED closures' on nearby facilities, we identified all facilities that had reported basic or comprehensive emergency services on January 1, 1995, and then determined which of those had changed their status between 1995 and 1999 using the OSHPD data and verifying the results using the telephone survey. We defined the year of closure as the last year that the hospital reported EMS visits and staffed EMS beds to OSHPD.

We classified severity on the basis of the 3 categories of severity of ED patient illness or injury reported to OSHPD[20]: nonurgent, urgent, and critical. In the OSHPD instruction manual, a nonurgent visit is defined as "a

patient with a non-emergency injury, illness, or condition, sometimes chronic; that can be treated in a non-eme-gency setting and not necessarily on the same day they are seen in the EMS department (eg, pregnancy tests, toothache, minor cold, ingrown toenail)."An urgent visit is defined as "a patient with an acute injury or illness where loss of life or limb is not an immediate threat to their well-being, or patient who needs a timely evaluation (eg, fracture or laceration)." A critical visit is "a patient who presents an acute injury or illness that could result in perrr anent damage, injury, or death (eg, head injury, vehicular accident, a shooting)." To assist hospitals in completing the form, OSHPD suggests Current Procedural *Terminology* codes for each severity level. However, at all 6 sites where we investigated data collection procedures, respondents used triage or administrative data, rather than claims data, to obtain data for the OSHPD report.

In the OSHPD database, ED beds are referred to as EMS treatment stations. These stations are defined as specific placer within EDs that are adequate to treat 1 patient at a time. OSHPD specifically instructs hospitals not to include holding or observation beds in their count of ED beds.

We considered facilities to be public hospitals if they reported state, county, or city ownership to OSHPD between 1990 and 1999. We considered all other facilities to be private hospitals.

The hospitals reported their teaching status to OSHPD. The only year for which these data were available is 1999.

We defined hospitals as "closed adjacent" if they were located in the same health service area (HSA) as an ED that closed between January 1, 1995, and August 31, 2001. HSAs represent Local health care markets for community-based inpatient care. They were identified by the Dartmouth Atlas of the Health Care Working Group using 1993 Medicare provider files and 1992 to 1993 utilization data.[21] Their analysis resulted in the identification of 3,436 HSAs throughout the United States, serving populations ranging in size from 627 (Turtle Lake, ND) *to* 2,949,506 (Houston, TX) in the 1998 edition of the Dartmouth Atlas. California has 192 HSAs ranging in size from 1 to 15 hospitals. Because closed adjacent data were derived from our August 2000 telephone survey, it includes data on closures occurring after December 31, 1999 (the time limit for our OSHPD data.)

We first computed descriptive statistics for the aforementioned specified measures for all of the EDs from 1990 through 1999. We next conducted statistical analyses and modeling focusing on changes in the ED characteristics over time. Specifically, we tested 2 main hypotheses: (1) Did statewide ED visits, ED beds, visits per ED, and visits per bed change (increase or decrease) between 1990 and 1999? and (2) Did severity of patient illness or injury, as reported to OSHPD, change over the past decade?

For measures at the individual ED level, we analyzed the data using repeated measures models.[22] In the analysis, the first optimal covariance structure was selected using the Akaike Information Criteria (AIC), the penalized likelihood to determine which model would best fit the data. We then fit the repeated measures models with the best covariance structure to estimate the change in ED characteristics over time.

For measures at the state level, we used ordinary least squares regression models to estimate the change in ED characteristics over time, with the independent variable being the year in which the data were collected (ie, time). The change across time also was analyzed by adjusting for severity of patient injury or illness, which was estimated using the percentage of critical, urgent, and nonurgent patient visits. We used the 1990 patient severity distribution as the reference year. Possible interactions between independent variables were evaluated.

Next, we created a multivariate, repeated measures model to compare changes over time based on ownership (public versus private), teaching status (teaching versus nonteaching), and proximity to closure (closed–adjacent versus not closed–adjacent), controlling for annual ED visits, percentage of urban areas in the hospital zip code, per capita income in the hospital zip code, percentage of population older than age 65 in the hospital zip code, percentage of critical visits reported to OSHPD, and percentage of nonurgent visits reported to OSHPD.

We evaluated the overall goodness of fit of the models by R-squares for cross-sectional ordinary least squares models and maximum likelihood for repeated measures longitudinal models. These goodness of fit measures were used in assisting model selection process. We did not conduct residual analysis because, although they could be used for goodness of fit analysis, they are mainly used for detecting biased mean structure of the model and Outliers, which we do not believe we have.

All analyses were performed using Stata (version 6, Stata Corporation, College Station, TX) or SAS (version 6, SAS Inc., Cary, NC) software.

This project is exempt from review by the human subjects protection office at our institution.

RESULTS

Of the 731 facilities that reported to OSHPD between 1990 and 1999, we excluded from our analysis 96 acute

psychiatric facilities, 36 psychiatric health facilities, 27 federal hospitals (primarily Veteran's Administration hospitals), and 20 chemical dependency recovery hospitals. Of the remaining 552 facilities, according to the OSHPD data, as of January 1, 1999, there were 357 EDs statewide. Of these, 301 were basic, 47 were standby, and 9 were comprehensive facilities.

On the basis of the results of our telephone survey, we reclassified 6 EDs: 2 EDs were reported incorrectly as closed between 1996 and 1998, so we reclassified these as being closed before 1995; 4 facilities closed and reopened immediately in the same HSA with the same staff and patients, so we reclassified these as being "not closed." Of the 320 facilities reporting basic or comprehensive emergency services in December 1998, the telephone survey confirmed that all were classified correctly. These 320 basic and comprehensive facilities included 310 EDs reflected in the 1999 OSHPD database and 10 EDs that closed after December 1998. There were no facilities that reported a change in ownership type to OSHPD during the study period.

As the Figure illustrates, the total number of EDs (standby, basic, and comprehensive) in California decreased by 12.3% between 1990 and 1999, from 407 to 357 ($P<.0001$). The number of basic and comprehensive EDs decreased by 8.6% ($P<.0001$); 48% of these closures occurred between 1996 and 1999. Despite these decreases, the total number of ED beds increased by 687 (16%), from 4,015 in 1990 to 4,777 in 1999, with an annual average increase of 79 beds per year ($P=.0001$). Adjusting for the growth in California's population between 1990 and 1999, the number of ED beds per 100,000 persons increased from 14.5 to 15.3, representing an increase of 0.08 beds per 100,000 persons per year ($P<.0001$).

A disproportionate number of ED closures were among standby EDs. In 1990, standbys represented only 17% of all EDs in the state but represented 42% of closures. Of the 19 basic and comprehensive EDs that closed between 1995 and 2000, the mean and median distances from closed ED to nearest open ED were 3.0 and 2.4 miles (range 0.2 to 10.5 miles). Three quarters of ED closures were less than 3.0 miles from the nearest open ED.

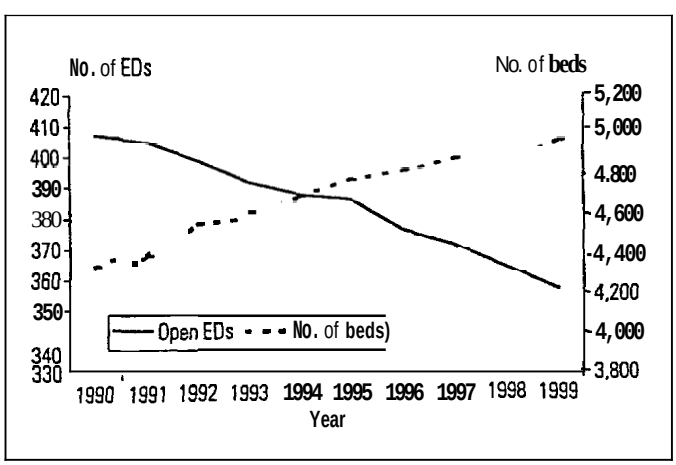
The total number of ED visits statewide increased from 8.4 million in 1990 to 9.4 million in 1999, representing an overall growth of 12% ($P=.5$). Most of this increase occurred nonlinearly, primarily at the beginning and end of the decade. However, when we controlled for population growth, the total number of visits per 100,000 persons decreased during the decade, with an average overall decline of 275 visits per 100,000 persons per year, representing a decline of just under 1% per year ($P=.0498$).

The total number of visits per ED increased by 27%, from an average of 20,377 in 1990 to 25,778 in 1999 ($P<.0001$). When we stratified these findings by type of visit, we found that (1) critical visits increased by 59%, from an average of 2,161 in 1990 to 3,433 in 1999, representing an average increase of 91 critical visits per ED per year ($P<.0001$); (2) urgent visits increased by 36%, from an average of 9,719 in 1990 to 13,190 in 1999, representing an average increase of 203 urgent visits per ED per year ($P<.0001$); and (3) nonurgent visits decreased 8%, or an average of 129 nonurgent patients per ED per year ($P<.0001$).

Visits per bed also changed during the 1990s, with increases between 1990 and 1991, steady decreases between 1991 and 1996, and increases again through 1999. Across the decade, total visits per bed decreased by 4.5%, or approximately 0.16 visits per bed per year ($P=.002$). When we considered the type of visit per bed, we found that over the decade the number of (1) critical visits did not change significantly ($P=.4$), (2) urgent visits decreased nonsignificantly ($P=.4$), and (3) nonurgent visits decreased significantly by 30% ($P<.0001$).

From 1990 to 1999, the total number and proportion of critical and urgent visits increased significantly. On the other hand, the number and proportion of nonurgent

Figure.
Number of open California EDs and aggregate ED beds, 1990 to 1999. The number of open EDs was determined from the number of open hospitals reporting to OSHPD that they provide emergency services, Free-standing urgent care centers and EDs not part of a hospital are excluded. ED beds are defined as specific places within the ED adequate to treat 1 patient at a time. Holding or observation beds are not included.



patients decreased significantly. Critical visits increased from approximately 880,000 to 1.2 million, a growth of 43% (P=.0014), and the proportion of such visits increased from 10% to 12% of all ED visits (P=.0002). Likewise, the number of urgent visits increased 20% from 3.9 to 4.8 million (P=.0001), and the proportion of these visits increased from 44% to 50% of all ED visits (P<.0001). In contrast, the number of nonurgent visits decreased by 6% (P=.005), and the proportion of such visits decreased from 46% to 38% of total ED visits (P<.0001). Controlling for population growth, we found that critical and urgent visits per 100,000 persons increased, although not significantly, and the number of nonurgent visits per 100,000 persons decreased by approximately 348 visits (P=.0005).

The following independent variables were examined in multivariate models predicting visits per ED, visits per bed, and beds per ED: ownership (public versus private), teaching status (teaching versus nonteaching), and proximity to a closed ED (closed–adjacent versus not closed–adjacent). These models controlled for the following: per capita income in the hospital zip code, percentage of urban areas in the hospital zip code, percentage of population older than 65 years in the hospital zip code, percentage of ED patients reported to OSHPD as critical, and percentage of ED patients reported to OSHPD as nonurgent.

Between 1990 and 1999, the total number of visits per ED increased by an average of 512 visits per ED per year at private hospitals (SE=367) and decreased by 1,085 visits per ED per year at public hospitals (SE=359). The difference in these trends was significant (P<.0001). There were no significant differences between public and private hospitals in terms of visits per bed or beds per ED.

During the 1990s, total visits per bed decreased at teaching hospitals by an average of 46 visits per bed per year (SE=22), whereas they increased at nonteaching hospitals by an average of 13 visits per bed per year (SE=2.5; P=.01). Although the number of ED beds at teaching hospitals did not change significantly across the decade, the number of ED beds at nonteaching hospitals increased by an average of 0.23 beds per ED per year (SE=0.1); however, the difference in these trends was not significant. The number of visits per ED was not significantly different at teaching and nonteaching facilities.

Those hospitals adjacent to recently closed EDs experienced an average increase of 3,242 visits per ED per year (SE=502), whereas other facilities had an average increase of only 354 visits per ED per year (SE=86; P<.0001). Likewise EDs adjacent to a closed ED had an increase of 1.2 beds per ED per year (SE=0.22), whereas other EDs experienced an increase of 0.2 beds per ED per year (SE=.04; P<.0001). There were no significant differences in visits per bed.

DISCUSSION

From 1990 to 1999, the number of EDs in California decreased by 12%. During this same period, the number of visits per ED increased by 27%, the number of ED beds increased by 16%, and severity of patient illness or injury intensified, with a 59% increase in patients categorized as critical and an 8% decrease in patients categorized as nonurgent per ED. However, this increase was not consistent across the decade: visits per ED increased markedly between 1990 and 1993, stabilized in the mid-1990s, and then continued to increase again from 1996 to 1999. The increases during the early and latter parts of the decade mirror physician and media concerns about ED capacity during those same time periods. In the early 1990s, the issue received significant attention from the media[23,24] and professional organizations,[25-28] but this interest waned during the mid-1990s, only to resurge as visits per bed began to increase again at the end of the decade.[1,2,4-7,9,10,13,18,19,29,30]

Compared with national statistics, our findings revealed that the increase in visits to California EDs was lower than that of the United States as a whole. Total annual ED visits in California changed from 26.9 to 26.8 visits per 100 persons between 1996 and 1998, whereas National Hospital Ambulatory Medical Care Survey data indicate that nationwide visits increased from 35.6 to 37.3 visits per 100 persons, or 90.3 to 100.4 million.[16,17] These data indicate that more than 1 in 3 people in the United States visit the ED each year.

We also found that the patient severity levels in California's EDs were not markedly different from those of the United States as a whole. In 1998, 14% of California ED visits were categorized as critical, 50% were urgent, and 36% were nonurgent. Likewise, national estimates for the same year show that 19.2% of ED visits were emergency (should be seen in <15 minutes), 31.2% were urgent (should be seen in 15 to 60 minutes), 13.7% were semiurgent (should be seen in 1 to 2 hours), 9.0% were nonurgent (should be seen in 2 to 24 hours), and 27% were categorized as "no triage/unknown."[17] Unlike the OSHPD database, which is administrative and uses a 3-tiered severity system, the national data were collected via a survey of emergency care providers and are based on 5-tiered triage-based categories.

Despite these findings, our analysis has several limitations. First, to determine the annual change in the number of open EDs in California, we counted only those that were open on January 1 of each year. Because these estimates of point prevalence do not account for EDs that were open for only part of the year, we may have underestimated the total amount of available emergency services in any given year of the study period. However, our estimates did include EDs that were open on January 1 and subsequently closed; therefore, they provide a reasonable estimate of capacity. In addition, our telephone survey of ED staff revealed that the operating status reported to OSHPD was correct for all 320 EDs providing basic or comprehensive emergency services on December 31, 1998, and in 18 of the 24 EDs that had reported a closure or downgrade between January 1, 1996, and December 31, 1998. Thus, it is reasonable to assume that our estimates of capacity were fairly accurate for the remaining years of the study.

A second limitation stems from the lack of standardization evident in the reporting of ED beds and severity of illness or injury. Data on severity of patient illness or injury were not collected uniformly throughout the sample hospitals. Although all 6 hospitals surveyed used triage or administrative data to determine seventy of patient illness or injury, in some facilities, this was derived directly from the triage category, and in others, a physician, nurse, or administrator made the judgment based on both triage assessment and the medical record. We did not survey all hospitals, and it is possible other sites might use claims data to ascertain severity of patient illness or injury. If this is so, part of the increase in the number of critical patients may be caused by incentives to increase physician reimbursement or nursing full-time equivalents, rather than a true rise in the proportion of critical patients. However, given the size and the incremental, unidirectional nature of the increase, it seems unlikely it is entirely attributable to upcoding.

In reporting ED beds, it is possible that some facilities designated standard ED beds as "holding" or "observation" beds in a marketing move and that this does not reflect the true use of the beds. Given that OSHPD specifically excludes observation beds, such a bias would have led us to underestimate the increase in ED beds statewide. Thus, if ED observation beds are widely being used for acute care, the true increase in ED beds may be greater than the 16% reported to OSHPD. In addition, we have no data on whether respondents understood what the OSHPD instruction manual was looking for. Despite these limitations with the database, when we validated 2 other OSHPD variables (operational status and level of service) at all open EDs in the state, the data error rate was 1.7%.

Another limitation is that we were restricted to the data collected by OSHPD. During the study period, OSHPD monitored 3 measures of ED capacity (open EDs, their level of service, and ED beds) and 2 measures of ED use (total visits and severity of patient illness or injury). There are arguably many more components to use and capacity. The study does not describe ED conditions for patients, physicians, and staff; the extent to which resources are stretched at any given facility; or the impact that these factors might have on the quality of care. Nor does the study explore the impact that increased patient volume and severity of illness or injury might have on available resources, including physician and staff hours, physical space, on-call physicians, satellite labs, and radiography machines. However, we are in the process of collecting such data for a sample of EDs in California and will address these issues in a future report.

Our findings suggest that an increase in visits per ED, beds per ED, and the proportion of patients categorized as critical may be responsible for perceived inadequate capacity. This is in contrast to recent reports from New York City[31,32] and remarks by Surgeon General David Satcher[33] that ED inadequate capacity is the result of an increase in the use of EDs for lower severity conditions. We also found a small but significant decrease in the number of visits per ED bed. This change is difficult to interpret in the face of increases in the proportion of patients categorized as critical and in the absence of data on how additional ED beds are supported (eg, staffing, ancillary services, physical space, inpatient capacity, on-call services).

Future studies in this area should focus on an evaluation of ED waiting times statewide and other factors to help better define ED use and capacity and its consequences for patients. We are in the process of collecting these data for a sample of EDs in California, and we hope to use our results to better characterize the ED experience for patients and staff. In addition, given our results regarding the reported increase in seventy of patient illness or injury, additional efforts should be undertaken to examine the process of emergency care to the increasing proportion of patients categorized as critical being treated in California's EDs.

Author contributions: DLW, SMA, AF, and SL conceived the project and developed the study methodology. SL, DLW, AF, SMA, and JSF supervised the conduct of the study, data collection, quality control, and analysis. HL provided statistical advice and analysis. KH provided expertise in geoencoding and medical geography. SL drafted the manuscript, and all authors contributed substantially to its revision. SL takes responsibility for the paper as a whole.

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Editorial

Overcrowding in Emergency Departments: Increased Demand and Decreased Capacity

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Overcrowding in Emergency Departments: Increased Demand and Decreased Capacity

See related article, p. 389.

[Derlet RW. Overcrowding in emergency departments: increased demand and decreased capacity. *Ann Emerg Med.* April 2002;39:430-432.]

The past decade has been an extraordinary one foremergency medicine. Nationally, tremendous growth has occurred in emergency department visits to more than 100 millionvisits per year. This increased demand forED services has resulted in overcrowding, which in some areas of the country has reached a critical state.[1,2] Unlike 10 years ago, overcrowding is no longer unique to teaching hospitals, but has now spread to many community, suburban, and rural hospitals.[3] Overcrowding has led to a number ofproblems, includingprolonged waiting times, increased suffering for those in pain, unpleasant therapeutic environments, and, in some cases, poor clinical outcomes.[4] In response, some hospitals have periodically closed their ED doors to ambulance traffic, causing ambulances to scramble to nearby hospital EDs and further compounding the problem.[5] Insurance companies, health maintenance organizations (HMOs), and some health care policy advisors have been quick to blame the EDs for this problem, arguing that EDs attract and encourage patients with nonurgent problems. Is this really the case?

In this issue of *Annals*, Lambe et al[6] shed some light on ED use and capacity in California. The study has several important findings, most notably that critical visits to EDs increased by 59% from 1990 to 1999 and that urgent visits increased by 36%. This very significant increase in patients who truly need emergency care leaves little room in the ED for others with less urgent conditions to be cared for. In fact, the study showed an 8% decline in nonurgent visits. As the population of the United States ages and life

expectancy increases, higher numbers of patients with multiple and complex underlying medical problems present to the ED (eg, the chemotherapy patient who is diabetic, on dialysis, has had a coronary artery bypass graph, and now has a fever). These types of patients require a higher level of care than younger patients and take more physician and nursing time to diagnose and treat. Furthermore, when inpatient telemetry or ICUs are filled, the ED becomes the defacto ICU and may have very limited ability to provide service to new patients presenting to the ED. These situations have the potential for danger, as the ED staff becomes overwhelmed with caring for critical or high-risk patients who have no hospital bed while ambulances continue to arrive with seriously ill or injured patients.

Providing care to an increasing number of critically ill patients has contributed significantly to ED overcrowding. Increased severity of patient illness or injury means decreased turnaround time for beds. Imagine how many times an ED bed could be used during a 24-hour period if all that we needed to do was look in a patient's ears and prescribe an antibiotic. Now, how many times during a 24-hour period could that same ED bed be used if 1 patient had multiple medical problems including dyspnea, abdominal pain, headache, and underlying conditions of congestive heart failure, chronic obstructive pulmonary disease, diabetes, renal failure, and hepatitis C–induced liver failure? Imagine also that this patient required a central line, a chest tube, intubation, and computed tomography scans of the head, chest, and abdomen. Conversely, imagine the difference in utilization for a bed that could be used by as many as 3 patients an hour continuously for quick visits during a 24-hour period. In other words, 72 patients in a 24-hour period could be seen, compared with only 2 or 3 patients who had critical and serious conditions occupying the same bed.

Although some hospital EDs in California have closed in the past decade, this loss of beds has been made up by the creation of additional ED beds in existing hospitals. According to the study by Lambe et al,[6] the number of ED beds per population in California has remained relatively stable in the past 10 years, at around 15 ED beds per 100,000 persons per year. But, because these beds are now being occupied by more "labor intensive" patients, the true capacity has actually decreased. This real decrease in capacity of EDs occurs in the face of increased national demand.

Not surprisingly, the study found no change in ED volume over the decade at teaching hospitals. This is not because of lack of demand, but because capacity has already been reached. Consider the analogy of a glass filled with water. If additional water is poured into the glass, it simply overflows. In the case of EDs, when they are filled with critically, urgently ill, and injured patients, other patients, mostly nonurgent, leave after waiting what may be long periods of time in overcrowded waiting rooms.

Why don't hospitals increase the capacity of EDs? I am aware that some hospitals are reluctant to provide additional resources, citing the excuse that the census has not increased significantly in 10 years and ignoring the overflow. The real reason is that many EDs are no longer profit centers. Institutions are unwilling to expand EDs for fear of attracting additional indigent or uninsured patients, as federal law (the Emergency Medical Treatment and Active Labor Act [EMTALA]) requires that all patients with emergency medical conditions receive stabilization in EDs.

Many additional issues related to ED capacity are beyond the scope of the design and methods of the study by Lambe et al.[6] However, these additional issues are critical to any discussion on the topic of ED overcrowding and capacity. The most serious and significant issue is the increased risk for poor outcomes as a result of overcrowded conditions. Sick patients have been forced to wait on gurneys in hallways without appropriate nursing or physician evaluation. Some of these patients have had poor outcomes, such as delays in diagnosing myocardial infarction, intracerebral bleeding, or sepsis.[7]

In some areas of the country, particularly the East Coast, the leading causes of ED congestion and overcrowding relate to filled inpatient hospital beds.[8] Patients who are in need of admission from the ED must wait for hours before being moved to inpatient beds of the main hospital. During this time, these patients occupy physical bed space and require constant monitoring by nursing and physician staff. Until the problem of insufficient inpatient beds is addressed, the ED overcrowding problem will remain.

Avoiding hospitalization through extensive therapy in the ED has also contributed to overcrowding by increasing the time patients occupy an ED bed. Patients who, in the past, may have been expediently admitted to hospital beds now undergo long and thorough therapy and observation in the ED to avoid hospitalization. Patients who have moderate asthma, those who have mild or moderate poisoning or overdoses, or those with mild infections may find that they occupy an ED bed for long periods and then are discharged home in lieu of admission. Prolonged ED bed occupancy is also aggravated by the problem of accessing on-call specialists.[9]

One of the effects of ED overcrowding and congestion s ambulance diversion. In many cities in the United States, hospitals have closed their EDs and diverted ambulance traffic away to other EDs. In some cases, closure is necessitated by a hospital with no inpatient beds and with patients being boarded in the ED. In other cases, the ED itself is overwhelmed. Diverting patients from one hospital to another simply shifts the overcrowding problem from one hospital to its neighbor. Indeed, if one hospital ED closes to ambulance traffic, its neighboring hospital is Frequently overwhelmed by the increase in patients arriving by ambulance, and it too must close. In some localities, when a significant number of EDs close to ambulance traffic, they reopen on an alternating basis to take patients, sometimes referred to as "round robin."

Another overcrowding-induced problem relates to the number of patients who come to hospital EDs, register, and then leave without being seen (LWBS) after waiting several hours. These data should be reported to state regulatory agencies, but are not reported in California. At this author's hospital, the LWBS population has increased steadily as the number of critically ill patients has increased. Now, more than 500 patients each month LWBS, nearly 10% of the actual ED census. Poor outcome and need for hospitalization of patients who LWBS has been documented elsewhere.[10]

In the 1990s, the United States experienced unprecedented economic growth. The US stock market experienced billions of dollars in increased capitalization. Yet, while the country was investing heavily in Wall Street, it did not invest in expanding the infrastructure of health care. Hospitals and EDs were expected to run at full capacity to be "economically efficient." This has eliminated any reserve capacity and places the health care of the entire country at danger. Should there be a major infectious disease epidemic or national catastrophe, EDs and hospitals could not accommodate the demand, undoubtedly leading to incredible suffering and excess mortality.

Recently, increased discussion has occurred in the emergency medicine scientific community and in the public media on ED overcrowding and capacity. Major television networks have covered the story, as have leading news magazines and newspapers throughout the country.[11-13] Furthermore, the Society for Academic Emergency Medicine's official journal devoted an entire issue to ED access and the ED safety net.[14] However, it is disturbing that federal, state, and local legislative bodies and regulators have not reacted to these calls for help. Hopefully, continued publication of studies, such as the one by Lambe et al,[6] will help contribute to the overwhelming tide of evidence necessary to influence those who are in position to help solve the problem of inadequate ED capacity.

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Health Net®

HEALTH news

FOR MEMBERS AND FRIENDS

SPRING 2002

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Do you know the difference between an emergency and an urgent situation?

As part of our commitment to provide you with around-the-clock access to medical care, we at Health Net of California want to make sure you get the appropriate medical services when you need them.

Whether it's during the day when doctors' offices are typically open, or in the middle of the night when you're not sure where to go for care, the right medical attention is always available to you.

Knowing where to get the right care can be the difference between knowing what is an "emergency" and what is "urgent."

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To find out if your medical group teams with an urgent care center, call your medical group. If you have any questions, please call our Member Services representatives at **1-800-522-0088.** (Healthy Families' members, please call **1-888-231-9473.**) You also may call Health Net's nurse advice line with health-related questions 24 hours a day, seven days a week. Learn more about the nurse advice line on page 3. ■

Do you have a **health-related** question? Call Health Net's nurse advice line at **1-800-474-6515.**

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Commonly Asked Questions

About Antidepressant Medications

How do antidepressants work?

A Antidepressants work on the chemicals in your brain that improve your mood, energy, and outlook.

How long do I have to take antidepressants?

A Antidepressants can take two to four weeks to start working. You may need to take them for six to 12 months.

Do antidepressants have side effects?

A Not everyone experiences side effects from antidepressants. Most side effects last only a few days and then fade as you adapt to the medicine. Side effects can include feeling sedated or agitated, insomnia, dizziness, nausea, headache, sweating, dry mouth, or tremors. If side effects last longer than a few days, talk with your doctor abbut trying a new prescription.

Can I become addicted to them?

A No. You cannot get "hooked on antidepressants because they do not cause your body to become physically dependent on them. However, anti-anxiety medications, like Xanax, Ativan, and Valium, can cause physical dependency. You should check with your doctor if you're worried that you may be taking too much of these medications.

How often should I see my doctor?

A You should return for follow-up visits once a month for the first three months. Remember to follow your doctor's instructions. You need to take the proper dose every day to feel better. Call your doctor if you have questions or concerns. ■

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CALIFORNIA Healthline
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Today in California Healthline

AROUND CALIFORNIA

Number of Patients Treated in State Emergency Rooms Increased 27% from 1990 to 1999, UCSF Study Finds

03/29/2002

State emergency rooms have seen a 27% rise in the number of patients that they have treated from 1990 to 1999, according to a study published yesterday in the April issue of the *Annals of Emergency Medicine*. The *Los Angeles Times* reports that in the study, researchers at the University of California-San Francisco analyzed data from the California Office of Statewide Health Planning and Development, which monitors hospitals and health service facilities in the state (Abdur-Rahman, *Los Angeles Times,* 3/29). The study found that while the number of patients who visited state emergency rooms went up, the number of state emergency departments dropped from 407 to 357 -- a 12% decrease -- over the same period (Liddane/Luna, *Orange County Register,* 3/29). In addition, the study found that the number of critically ill patients who visited state emergency rooms increased 59% from 1990 to 1999. Urgent visits to state emergency rooms increased 36% from 1990 to 1999, while non-urgent visits (those which require care in two to 24 hours) decreased 8% over the same period, the study found (*San Francisco Chronicle*, 3/29). The study also found that the ratio of emergency department beds increased from 14.5 to 15.3 per 100,000 state residents from 1990 to 1999, but UCSF professor Dr. Susan Lambe, lead author of the study, said, "From a practical standpoint, [the increase in the number of beds] certainly doesn't do much" *(Los Angeles Times,* 3/29).

Urgent Patients Account for Increase

The study "takes issue with a common perception" that overcrowding in state emergency rooms results from non-urgent patients, the *AP/Contra Cosfa Times* reports. Lambe said, "Urgent patients accounted for the largest group of visits in 1999. That is contrary to the claim that non-urgent patients clog the system" (Sherman, *AP/Contra Costa Times,* 3/29).

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EMERGENCY

CODE RED!

Your *Access* to Medical Care in Santa Cruz County is in Jeopardy.

Ask your Doctor for Information and What *you can do* about this Crisis.

Support Increases in Medicare and Medi-Cal Funding to Salvage our Healthcare System

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March 25, 2002

Dear doctor: What's behind a Code Red?

Dear Doctor is a monthly column in which local doctors answer health questions from readers.

Q I have heard that when the Emergency Room at the hospital is Code Red, they may not be able to care for my mother, who is ill, if I have to call the ambulance. What is Code Red, and what can I do about it?

A Code Red is the designation used by a hospital Emergency Department when they cannot accept critical patients by ambulance, and the ambulance must be redirected to the closest hospital (unless the patient is "in extremis").

As an example, if the Emergency Department at Dominican Hospital is Code Red, ambulances must be diverted to Watsonville Community Hospital.

If hospitalization is required and the personal physician is not on staff at that hospital, then an on-call physician will be asked to care for your loved one.

The reverse would be true if Watsonville Hospital was Code Red and Dominican was open to critical ambulance cases.

Family members may be uncomfortable about this situation, due to proximity issues and physician unfamiliarity with a relative's medical condition.

There are many reasons Code Red is occurring more frequently. It is often due to lack of beds for patients due to limited nursing staff.

Fewer people are entering the nursing field due to reduced reimbursement and reduced job satisfaction.

Hospitals are contracting with temporary staff from other areas and using new methods for recruitment, but this is not enough.

It is especially difficult to cover critical-care beds due to the specialized nursing care required. More older and sicker people to care for with complex medical conditions puts a greater burden on the health care system.

Government regulations may result in longer hospital stays, adding to the census impact.

In the Emergency Department, there are also a number of factors that result in reduced bed capacity. If the hospital critical-care section is full, critical or unstable cases must be managed in the ED. This reduces the Emergency physicians' ability to move patients through the ED efficiently

Reduced staffing in the ED is also a factor. Noncritical cases will also significantly impact the ED. For example, the common cold that cannot be evaluated by the local physician's office will end up in the ED. This may occur because the patient is uninsured and can't get an appointment.

All physicians provide uncompensated care, but frankly there are limits to this.

Some patients go to the ED because federal law mandates a medical screening examination in the

ED without need for financial disclosure.

The same rules make it cumbersome to transfer patients to another hospital, resulting in long wait times (4-6 hours) in the ED.

Add to this a busy weekend, holiday or other times where ED census is affected, and you have the perfect scenario for the ED to go Code Red, until the problem is alleviated.

This scenario is happening more frequently and affects all of us. Our county emergency medical system and the hospitals are working hard to find solutions to the situation, but the resolution will not be easy.

Obviously, greater funding for hospitals and EDs would be helpful, but this will not be forthcoming from the state or federal level, due to budget constraints.

The California Medical Association is in the process of a legislative initiative to help provide funding through surcharges on vehicle moving violations and violent criminal acts to augment the emergency services fund.

This initiative is called the Maddy Emergency and Trauma Services Act. Watch for it in the next few months.

Your assembly representative, congressman and senator need to hear from you about these so that we can get help for the uninsured.

Medicare mandated a reduction in physician reimbursement this year by 5.4 percent. This is likely to result in some physicians not being able to afford to care for additional Medicare patients, thus affecting the system even more.

We know that reduced reimbursements and increased cost of living in our area has resulted in physicians retiring early or leaving the area. This situation needs to be corrected, so that patient access to physicians is improved and the ED safety net is not frayed.

A common-sense approach can help. Good preventative-medicine strategies will help avoid a sudden deterioration in a medical condition, allowing for timely intervention by the private physician — before the situation becomes an emergency.

Simple things like getting prescriptions filled before they run out can save a trip to the ED.

Working together we can help avoid the problems impacting the hospitals and ultimately developing into a Code Red situation. Your actions and voice in these issues will be essential in their resolution.

Alan Buchwald is an emergency physician at Dominican Hospital and president of the Santa Cruz County Medical Society. Contact him by e-mail at albuchwald955@pol.net. Dear Doctor is a contribution of the Santa Cruz County Medical Society.

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New Research on Low-Income Health Issues in California

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Healthy Families
Managed Care
Medi-Cal
Race & Language
Special Populations
The Uninsured

Children

The Hepatitis Burden in California's Latino Children (The Center for the Study of Latino Health & Culture, April 2002)

Children's Eligibility for Medicaid and SCHIP: A View from 2000 (Urban Institute, March 2002)

Evaluation of the Los Angeles CalKids Program (California Healthcare Foundation, February 2002)

The Right Start for America's Newborns: A Decade of City and State Trends (1990-1999) (Kids Count program of the Annie E. Casey Foundation, February 2002) [California Profile] [Fresno] [Los Angeles] [Sacramento] [San Diego] [San Francisco]

California Report Card 2001 and California County Data Book 2001 (Children Now, November 2001) [including chart of Children Without Health Insurance]

Track. Monitor, and Respond: Three Keys to Better Lead Screening for Children in Medicaid (Alliance to End Childhood Lead Poisoning, October 2001)

Young Hearts & Minds: Making a Commitment to Children's Mental Health (State of California Little Hoover Commission, October 2001)

States' Enrollment and Payment Policies Can Affect Children's Access to Care (General Accounting Office, September 2001)

A First Glance at the Children's Health Initiative in Santa Clara County, California (The Kaiser Commission on Medicaid and the Uninsured, August 2001)

Survey of American Families: Comparison of Households with Insured Children vs. Uninsured Children Eligible for SCHIP/Medicaid Coverage ["21% of parents of eligible but uninsured children delayed or skipped medical care for their children because they believed they could not pay for it"] (Robert Wood Johnson Foundation, August 2001)

Does SCHIP Spell Better Dental Care Access for Children? An Early Look at New Initiatives (Urban Institute, July 2001)

Medicaid: Stronger Efforts Needed to Ensure Children's Access to Health Screening Services (Government Accounting Office, July 2001)

Health Insurance: A Family Affair. A National Profile and State-by-State Analysis of Uninsured Parents and Their Children (The Commonwealth Fund, May 2001)

A Special Report on Policy Implications from the 1999 California Children's Healthy Eating and Exercise Practices Survey (CalCHEEPS) (Public Health Institute and The California Endowment May 2001)

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Department of Health Services: Additional Improvements Are Needed to Ensure Children Are Adequately Protected From Lead Poisoning (California State Auditor/Bureau of State Audits, May 2001)

CHDP Fails as Gateway To Affordable Health Care (Legislative Analyst's Office, January 2001)

Parents' Views of Children's Health Insurance Programs: A Survey of Denied Applicants for Kaiser Permanente's Child Health Plan (Kaiser Family Foundation, January 2001)

Kids Count (showing status of America's children and assessing trends in their well-being) (Annie E. Casey Foundation, 2000) (California data)

Golden Opportunity: Improving Children's Health Through California Schools-(Consumer's Union, 2000)

Comparison of Medi-Cal and Healthy Families Programs for Children in California (Kaiser Family Foundation, October 2000)

HMO Marketing to Children: Risky Questions, Important Answers (Health Consumer Alliance, June 2000)

California's Ailing System of Caring for Children with Special Health Care Needs (California Senate Office of Research, May 2000)

Consumer Assistance

The Health Consumer Alliance Annual Report 2000-2001 (Health Consumer Alliance, November 2001)

Consumers and Health Care Quality Information: Need, Availability, Utility (conducted by RAND for the California Healthcare Foundation, Oct. 2001)

The Impact of the Health Rights Hotline - Making a Difference for Health Care Consumers Through Direct Service, Advocacy and Systemic Change (Health Rights Hotline, June 2001)

Designing A Health Care Consumer Assistance Program (Families USA, June 2001)

When What's Ailing You Isn't Only Your Health: A Report on Different Problems Experienced by Persons with Specific Health Conditions as They Navigate the Health Care System (Health Rights Hotline, August 2000)

Real Problems and Real Solutions: Making the Voices of Health Care Consumers Count (Health Rights Hotline, December 1999)

Making The Consumers' Voice Heard in Medicaid Managed Care: Increasing; Participation. Protection and Satisfaction Report on Required and Voluntary Mechanisms (National Health Law Program, January 1997)

Healthy Families

California Medicaid and ***CHIP*** State Health Facts Online (Henry J. Kaiser Family Foundation)

Recent Changes in Health Policy for Low-Income People in California (Urban Institute, March 2002)

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Health Policy Changes in the 2001-02 California Budget (California Budget Policy for the Medi-Cal Policy Institute, July 2001)

Health Insurance: A Family Affair. A National Profile and State-by-State Analysis of Uninsured Parents and Their Children (The Commonwealth Fund, May 2001) ("in states that have expanded Medicaid and CHIP coverage to parents as well as children, uninsured rates for eligible children are far lower than in states that have not expanded coverage to parents.")

Medi-Cal and Healthy Families: Focus Groups with California Parents to Evaluate the Medi-Cal and Healthy Families P r o m (Kaiser Family Foundation, January 2001)

Comparison of Medi-Cal and Healthy Families Program for Children in California (Kaiser Family Foundation, October 2000)

HMO Marketing to Children: Risky Questions. Important Answers (Health Consumer Alliance, June 2000)

healthfacts.kff.org

Managed Care

California Managed Care and Health Insurance State Health Facts Online (Henry J. Kaiser Family Foundation)

Assessing State External Review Programs and the Effects of Pending Federal Rights Legislation (Kaiser Family Foundation, March 2002)

Making Sense of Managed Care Regulation in California (California Healthcare Foundation, November 2001)

National Survey on Consumer Experiences With and Attitudes Towards Health Plans (Kaiser Family Foundation/Harvard School of Public Health, August 2001)

Geographic Managed Care Dental Program Evaluation (Medi-Cal Policy Institute, April 2001) [comparison to Denti-Call

From Provider to Policymaker: The Rocky Path of Medi-Cal Managed Care Data (Medi-Cal Policy Institute, March 2001)

Mapping the Flow of Eligibility and Encounter Data in Medi-Cal Managed Care (Medi-Cal Policy Institute, March 2001)

DHS: Despite Shortcomings in the Department's Monitoring Efforts, Limited Data Suggest Its Two-Plan Model Does Not Adversely Affect Quality of and Access to Health Care (California State Auditor/Bureau of State Audits, July 2000)

Women and Managed Care in California: An Examination of Selected Services (UCLA Center for Health Policy Research, July 2000)

Managed Care Reform in California: Passing the Patient's Bill of Rights (Health Access Foundation, April 2000)

Los Angeles County Medi-Cal Managed Care 1999 Report Card (California Health Councils, Inc., August 1999)

healthconsumer.org

Medi-Cal

California Medicaid and CHIP State Health Facts Online (Henry J. Kaiser Family Foundation)

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Prescription Drug Access: Not Just a Medicare Problem (Center for Studying Health System Change (The Robert Wood Johnson Foundation/Mathematica Policy Research, Inc.), April 2002)

Recent Changes in Health Policy for Low-Income People in California (Urban Institute, March 2002)

The Medi-Cal Budget: Cost Drivers and Policy Considerations (Medi-Cal Policy Institute, March 2002)

The Impact of the Proposed 2002-03 Budget on Medi-Cal and the Healthy Families Program (Medi-Cal Policy Institute, March 2002)

Physician Participation in Medi-Cal, 1996-1998 (Center for CA Health Workforce Studies and Primary Care Research Center at UCSF and the Medi-Cal Policy Institute, February 2002)

Medicaid Coverage of Family Planning Services: Results of a National Survey (Kaiser Family Foundation, November 2001)

Medicaid Coverage of Perinatal Services: Results of a National Survey (Kaiser Family Foundation, 2001)

Losing Ground: Declining Medi-Cal Enrollment After Welfare Reform (California Budget Project, October 2001)

Health Policy Changes in the 2001-02 California Budget (California Budget Project for the Medi-Cal Policy Institute, July 2001)

Comparing Physician and Dentist Fees Among Medicaid Programs (Medi-Cal Policy Institute, June 2001) [Appendices]

Health Insurance: A Family Affair. A National Profile and State-by-State Analysis of Uninsured Parents and Their Children (The Commonwealth Fund, May 2001) ("in states that have expanded Medicaid and CHIP coverage to parents as well as children, uninsured rates for eligible children are far lower than in states that have not expanded coverage to parents.")

Geographic Managed Care Dental Program Evaluation (Medi-Cal Policy Institute, April 2001) [comparison to Denti-Call

Medi-Cal and Healthy Families: Focus Groups with California Parents to Evaluate the Medi-Cal and Healthy Families Programs (Kaiser Family Foundation, January 2001)

Medi-Cal Audit Crosswalk: A Comparison of the NCQA Accreditation Standards and Medi-Cal Regulatory Oversight Requirements for Managed Care Organizations (Medi-Cal Policy Institute, January 2001)

Comparison of Medi-Cal and Healthy Families Programs for Children in California (Kaiser Family Foundation, October 2000)

HMO Marketing to Children: Risky Questions, Important Answers (Health Consumer Alliance, June 2000)

Go Directly to Work, Do Not Collect Health Insurance: Low Income Parents Lose Medicaid (Families USA, June 2000) [California one of several states studied]

Managed Care and Low-Income Populations: A Case Study of Managed Care in California (Kaiser Family Foundation, May 2000)

Speaking Out...What Beneficiaries Say About the Medi-Cal Program (Medi-Cal Policy Institute, March 2000)

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Managing Mental Health Care: A Report on California's Medi-Cal Mental Health System, 1997-1999 (Protection and Advocacy, Inc. January 2000)

Race & Language

California Minority Health State Health Facts Online (Henry J. Kaiser Family Foundation)

The Hepatitis Burden in California's Latino Children (The Center for the Study of Latino Health & Culture, April 2002)

California Health Plans and Language Access (APIAH, CPEHN, CHCR, Health Access, Latino Issues Forum, NHeLP, WCLP, November 2001)

Shortage of California Dentists in Rural. Poor, Minority Communities (UCSF Center for the Health Professions, September 2001)

Mental Health: Culture. Race. and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General (Department of Health and Human Services, U.S. Public Health Service, 2001)

Inland Losing Black Infants at Higher Rate. More Die in their First Year than Babies of Whites or Latinos. But Experts Ask Why? (Riverside Press-Enterprise, Tues., Aug. 5,2001)

A Portrait of Race and Ethnicity in California: An Assessment of Social and Economic Well-Being (Public Policy Institute of California, February 2001) (Health Outcomes) (African Americans and Hispanics in California have less access to health care than other racial and ethnic groups)

Special Populations

California Women's Health State Health Facts Online (Henry J. Kaiser Family Foundation)

California HIV/AIDS State Health Facts Online (Henry J. Kaiser Family Foundation)

County Health Status Profiles 2002 [citing progress in several key health status indicators, including prenatal care and **AIDS,** syphilis and measles rates] (California Department of Health Services and California Conference of Local Health Officers, April 2002)

Shortage of California Dentists in Rural. Poor, Minority Communities (UCSF Center for the Health Professions, September 2001)

Diagnosing Disparities in Health Insurance for Women: A Prescription for Change (The Commonwealth Fund, August 2001)

The Health of Poor Urban Women: Findings from the Project on Devolution and Urban Change [examines the health and health care of current and former welfare recipients in four major urban counties, including **Los** Angeles] (Manpower Demonstration Research Corp., May 2001)

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has decreased] (Department of Health Services and the California Conference of Local Health Officers, April 2001)

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Disability and Access to Health and Support Services Among California's Immigrant Populations (UCLA Center for Health Policy Research, January 2000)

The Uninsured

California Health Coverage & Uninsured State Health Facts Online (Henry J. Kaiser Family Foundation)

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County Efforts to Expand Health Coverage among the Uninsured in Six California Counties (Medi-Cal Policy Institute, February 2002)

Health Insurance Coverage in America: 2000 Data Update (The Kaiser Commission on Medicaid and the Uninsured, February 2002)

Health Care Access for Uninsured Adults: A Strong Safety Net Is Not the Same as Insurance (Urban Institute, January 2002)

Health Insurance. Access. and Use: California [tabulations from the 1999 National Survey of American Families] (Urban Institute, December 2001)

Federal Economic Stimulus Dollars for Health Care: A $1.8 Billion Lifeline for Californians (FamiliesUSA, December 2001)

Advancing Universal Health Care Coverage in Alameda County: Results of the County of Alameda Uninsured Survey (UCLA Center for Health Policy Research and Community Voices Project - Oakland, September 2001)

Children Without Health Insurance Chart (Children Now, November 2001)

Insuring the Uninsurable: An Overview of State High-Risk Health Insurance Pools (The Commonwealth Fund, August 2001)

Survey of American Families: Comparison of Households with Insured Children vs. Uninsured Children Eligible for SCHIP/Medicaid Coverage ["21% of parents of eligible but uninsured children delayed or skipped medical care for their children because they believed they could not pay **for** it"] (Robert Wood Johnson Foundation, August 2001)

The Health Care Safety Net: Millions of Low Income Peoule Left

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Uninsured (Families USA, July 2001)

Health Insurance: A Family Affair. A National Profile and State-by-State Analysis of Uninsured Parents and Their Children (The Commonwealth Fund, May 2001)

Uninsured Californians in Assembly and Senate Districts, 2000 (UCLA Center for Health Policy Research and The California Endowment, May 2001)

California Employer Health Benefits Survey (60% of California's employers offered health insurance coverage last year, up from 48% in 1999, but job-based coverage still remains lower in the state than the nationwide average) (Kaiser Family Foundation and Health Research and Educational Trust, March 2001)

The State of Health Insurance in California: Recent Trends, Future Prospects (health insurance coverage of Californians improved in 1999 -- but 6.8 million remained uninsured) (UCLA Center for Health Policy Research, March 2001)

Expanding Health Care Coverage to the Uninsured: An Analysis of California's Fiscal Year 1999-2000 Budget (Health Access Foundation, April 2000)

Health Care Trends and Indicators in California and the United States (showing Californians, compared to other Americans, are far more likely to be uninsured) (Kaiser Family Foundation & the Center for Health and Public Policy Studies at the University of California, Berkeley, June 2000)

Providing Affordable Health Care for Low Income Californians (California Citizens Budget Commission, 1999) (Introduction and Summary).

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HEALTH POLICY fact sheet

Number of Uninsured Californians Declines to 6.2 Million—2 Million Are Eligible for Medi-Cal or Healthy Families

E. Richard Brown, Shana Alex, Lida Becerra

March 2002

A total of 6.2 million Californians had no health insurance coverage of any kind in 2000 — a fifth of the state's population under age 65. The number of uninsured Californians in 2000 is about 375,000 lower than in 1998.

This fact sheet provides an update on health insurance coverage in California for the nonelderly population. (We exclude persons 65 and older because less than 2% are uninsured.) It is based on data from the Current Population Survey (CPS), which recently incorporated changes to more effectively measure health insurance coverage. These are the most recent data available; newer data from the 2001 California Health Interview Survey (CHIS) will be available in mid-2002 from UCLA.

Strong Economy Helped Reduce Uninsurance

The decline in the number of uninsured was due mainly to gains in employment-based health insurance, the result of the then-strong economy. The proportion of the nonelderly population with job-based insurance rose from 58.9% in 1999 to 60.8% in 2000, an impressive and statistically significant increase in just one year (see Exhibit 1). Both adult and children benefited from these gains (Exhibit 2).

The proportion of nonelderly and non-institutionalized Californians who reported being covered by Medi-Cal or Healthy Families remained statistically unchanged — 12.9% in 1999 and 13.1% in 2000 (Exhibit 1). While *not* statistically significant, the increase represents an improvement over the period 1994-1999 when such coverage fell nearly 4 percentage points, driving up uninsurance in California.[1] About one in four children was covered by Medi-Cal or Healthy Families in 2000, approximately three times the proportion of nonelderly adults who were covered by Medi-Cal (Exhibit 2).

As a result of these changes in coverage, the proportion of nonelderly Californians who were uninsured (without public coverage or employment-based or other private health insurance) declined significantly from 21.0% in 1999 to 20.0% in 2000 (Exhibit 1). A total of 6,216,000 persons were uninsured in 2000, including 1,617,000 children and 4,599,000 adults. The proportions of children and adults who are uninsured dropped during this period (a statistically significant drop for children; Exhibit 2).

EXHIBIT 1: *Health Insurance Coverage of Nonelderly Californians, Ages 0-64, California. 1999 and 2000*

	1999	2000	Change 1999-2000
Uninsured	21.0%	20.0%	-1.0*
Medi-Cal/Healthy Families	12.9%	13.1%	+0.2
Job-based insurance	58.9%	60.8%	+1.9*
Privately Purchased Insurance	4.8%	4.2%	-0.6*
Other Public Coverage	2.4%	2.0%	-0.4*

* Change is statistically significant at ≤ .05.
Source: March 2000 and 2001 Current Population Surveys

2 Million Could Be Eligible For Medi-Cal or Healthy Families

California has received federal approval to extend enrollment in Healthy Families to parents of eligible children in families with incomes up to 200% of the federal poverty level. With this important expansion, more than 2 million uninsured Californians — one in three of the state's uninsured residents — will be eligible for Medical or Healthy Families.

This number includes more than 1.1 million uninsured children who could be enrolled in one of these programs: approximately 768,000 (range: 690,000 to 845,000) who are eligible for Medi-Cal and 404,000 (range: 348,000 to 460,000) eligible for Healthy Families (Exhibit 3).[2] Thus, California has the opportunity to

	Children Ages 0-18		Adults Ages 19-64	
	Percent in 2000	Change 1999-2000	Percent in 2000	Change 1999-2000
Uninsured	15.7%	-1.4*	22.1%	-0.8
Medi-Cal/Healthy Families	24.2%	+0.9	7.6%	-0.2
Job-based insurance	55.6%	+2.7*	63.3%	+1.5*
Privately Purchased Insurance	3.1%	-1.3*	4.7%	-0.3
Other Public Coverage	1.4%	-0.9*	2.3%	-0.2

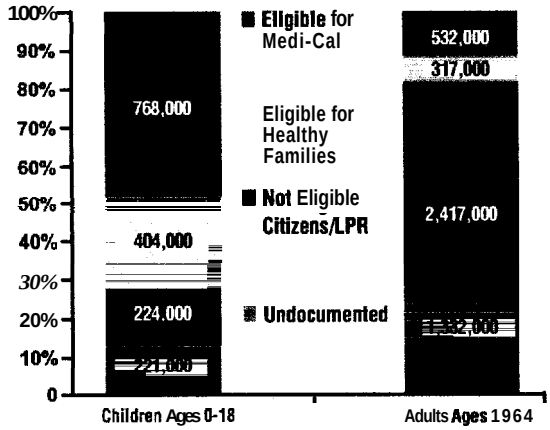
* Change is statistically significant at ≤ .05.
Source: March 2000 and 2001 Current Population Surveys

EXHIBIT 2: *Health Insurance Coverage of Nonelderly Californians, Ages 0-18 and 19-64, California, 2000*

cover nearly three out of four uninsured children through these two programs.

Even with this expansion of Healthy Families to parents, only one in five uninsured adults will be eligible for coverage: 532,000 uninsured adults (range: 468,000 to 597,000) are eligible for Medi-Cal, and another 317,000 (range: 267,000 to 367,000) will be eligible for Healthy Families when the state implements this expansion. More than half of uninsured adults — 2.4 million persons — are citizens or documented immigrants with no opportunities to obtain coverage if their employer does not offer insurance or they cannot afford the premiums. More than 1.5 million undocumented children and adults also are uninsured and have no opportunities to obtain coverage through California's public programs.

EXHIBIT 3: *Eligibility of Uninsured Children and Adults for Medi-Cal and Healthy Families*



Source: Estimates of eligibility calculated by the UCLA Center for Health Policy Research based on data from March 2001 Current Population Survey

Will These Improvements Last?

The decrease in uninsurance resulted mainly from growing employment-based insurance, reflecting California's strong economy in the late 1990s and 2000. Efforts by state, county, and community-based agencies to enroll and retain more eligible persons in Medi-Cal and Healthy Families also contributed. However, an economic downturn has occurred since the March 2001 CPS was conducted. Increasing unemployment coupled with the rising cost of health insurance will make coverage less affordable for employers and their employees. These two factors are likely to cut short the improvements in health insurance coverage in California and nationally. This will increase the importance of expanding public coverage opportunities for children and adults.

Note: A report on *The State of Health Insurance in California, 2001*, based on data from the new California Health Interview Survey and funded by The California Wellness Foundation, will be published in mid-2002.

Authors

E. Richard Brown, PhD, is director of the UCLA Center for Health Policy Research and professor at the UCLA School of Public Health; Shana Alex, MPP, is a project manager at the Center; and Lida Becerra, MS, is a statistician/senior programmer at the Center

References

[1] *Brown ER, Ponce N, Rice T,* The State of Health Insurance in California: Recent Trends, Future Prospects, *Los Angeles: UCLA Center for Health Policy Research, March 2001. Medi-Cal is California's joint state-federal Medicaid program that covers families with children, disabled adults, and the elderly who meet eligibility requirements. The Healthy Families Program is California's state-federal Children's Health Insurance Program (CHIP), which covers children with family incomes above Medicaid's income limits. The number of persons who report being covered by Medicaid or CHIP is generally lower in surveys than estimates based on the programs' administrative data.*

[2] *These estimates are based on small sample sizes, which reduce precision and reliability. The range (called a "95% confidence interval") provides a more reliable estimate of the numbers of persons in the population who are eligible.*

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4.8

ATTACHMENT B

PRIOR BOARD LETTER ON LOCAL EMERGENCY DEPARTMENT UTILIZATION AND AMBULANCE DIVERSIONS

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0225

County of Santa Cruz

HEALTH SERVICES AGENCY

P.O. BOX 962, 1080 EMELINE AVENUE
SANTA CRUZ, CA 95061
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HEALTH SERVICES AGENCY
ADMINISTRATION

April 6, 2001

AGENDA: April 24,2001

Honorable Board of Supervisors
County of Santa Cruz
701 Ocean Street
Santa Cruz, CA 95060

Subject: Report on Hospital Restricted Status (Code Yellow/Code Red) and Emergency Department Access in Santa Cruz County

Dear Members of the Board:

Introduction

The Health Services Agency and the Emergency Medical Care Commission (EMCC) have completed a review of the issue of Emergency Medical Services system-wide access to hospital Emergency Departments in the County. The purpose of the review was to ascertain the number of times and total time that hospital Emergency Departments in the EMS system were on restricted status, and to develop a perspective on broader issues regarding Emergency Department access.

A Report on Hospital Restricted Status (Code Yellow/Code Red) and Emergency Department Access in Santa Cruz County was prepared and presented for discussion at the March 14, 2001 EMCC Meeting. The report noted that hospitals are sometimes overwhelmed by circumstances beyond their control and must request a restricted status within the EMS system in order to provide for the care and safety of all their patients. However, the total amount of time hospitals in Santa Cruz County were on restricted status was less than three days in the entire Calendar Year 2000.

Background

Code Green is a status that means the hospital is open to all ambulance traffic.

Code Yellow is a status that reflects a temporary condition that impacts the reception of certain types of patients. **For** example, if the Computed Tomography (CT) scanner is out of service for repair, a hospital will advise the Santa Cruz Consolidated Emergency Communication Center (SCCECC) and a medical information page will be disseminated to place the hospital on Code Yellow status. Another example of a Code Yellow condition would be a lack of intensive care or CCU beds when the hospital inpatient monitored beds are at full census. In these cases, ambulances would check with the affected hospital to determine if they should proceed to that location with patients who might require diagnostic imaging or potentially critical patients who might require an inpatient specialty unit bed.

Code Red is a status that reflects a temporary condition in which the Emergency Department (ED) is *so* busy that reception of an additional critical patient might adversely affect the care of patients already being treated. For example, an ED which just received several trauma victims from a multiple casualty incident motor vehicle crash might need to declare Code Red until the victims are stabilized. In this case, incoming ambulance traffic would divert to another hospital unless their patient was in extremis and required care for an immediately life-threatening condition such as cardiac and respiratory arrest or occluded airway. All hospitals receive patients in extremis at all times.

The County's EMS Program policy number 1230 details the hospital diversion procedure. This policy is undergoing review in conjunction with both hospitals in order to enhance communication between the hospitals when restricted status conditions occur and will be presented to the Prehospital Advisory Committee **for** review at their May 2001 meeting.

Hospital Restricted Status Review

Each month the Technical Advisory Group (TAG) reviews the Hospital Restricted Status Report prepared by the Santa Cruz Consolidated Emergency Communications Center SCCECC. In Calendar Year 2000, the total number of hours of hospital restricted status in the Santa Cruz EMS System was 71 hours and 32 minutes.

Dominican Hospital was Code Yellow on 5 occasions for a total of 27 hours and **52** minutes. Watsonville Community Hospital was Code Yellow on 3 occasions for a total of 22 hours and 53 minutes, and Code Red on 4 occasions for a total **of** 20 hours and 47 minutes.

The TAG further reviews the Ambulance Reroute Report prepared by the SCCECC which was designed to detect any ambulance traffic which begins to travel towards one hospital destination and which arrives at another hospital destination. No ambulance diversions were recorded by this report in Calendar Year 2000, however, the TAG recognized that this report returned imperfect data on the issue. A new procedure went into effect March **1,** 2001 to flag ambulance diversions with a delay code. The TAG routinely reviews every delay code each month. Paramedic liaison nurses at each hospital also advise the EMS medical director about problems with ambulance diversions.

The results of the TAG review are reflected in the TAG minutes and are disseminated to the Board of Supervisors, the Emergency Medical Care Commission (EMCC) and the Prehospital Advisory Commission (PAC) monthly.

Hospital Emergency Medical Services

Emergency Departments (EDs) are hospital departments providing immediate initial evaluation and treatment of acutely ill or injured patients on a 24-hour basis. EDs have evolved into the principal safety net for health care, providing universal access to emergency, acute, chronic, and episodic medical care for all persons regardless of their insurance coverage or lack of coverage.

The idea of EDs serving as a safety net derives from the philosophy of the healing professions and the societal view that emergency care is an essential public service. In addition, under state and federal law, everyone who presents to an emergency department must be provided with emergency care. The Health Maintenance Organization (HMO) model has failed to reduce the number of uninsured, and emergency medical care continues to be the health service in greatest demand by the public, insured or not. Uninsured patients are continuing to increase and use the emergency department for their primary source of medical care. Because of low bed availability in intensive care and other units, patients remain in the emergency department for longer periods of time. High acuity patients, primary care patients whose lack of routine care has exacerbated their problems into higher **acuities,** nursing shortages, ancillary care staff shortages, very low reimbursement rates, slow payment, and downgrading of service charges has damaged the emergency care system.

Nationwide, the result has been emergency department overcrowding, long waits, ambulance diversions, a lack of specialty physicians for on-call rosters, and facilities which downgrade services or close emergency departments.

Physician Recruitment and Specialty Physicians On-Call

Hospitals are experiencing increasing challenges recruiting physicians. As the medical staff ages and enters retirement, new physicians are not entering the area to build practices because of the cost of living and because reimbursement rates are not comparable to areas like Santa Clara County or San Francisco. The sheer volume of patients has increased demands on physicians at the same time that reimbursement has decreased and workloads have increased. Delayed or non-payment by health plans for emergency services is decreasing physician ability or desire to serve on-call. The EMS Fund (Maddy Fund) that is used to compensate physicians for care provided to the uninsured pays about **15** cents on the dollar, according to the California Medical Association.

Solutions

Santa Cruz County hospitals are meeting to promote good communication and develop contingency plans to provide hospital ED access when faced with pressures of increased patient demand and limited physician and nurse resources. The Prehospital Advisory Committee will review the EMS Program policy on hospital diversion. The Emergency Medical Care Commission and the Health Services Agency are tracking legislative efforts to improve trauma and EMS care and setting advocacy priorities.

Broader solutions to the problems of Emergency Department access must include better access to outpatient care for patients, advocacy for legislation to improve coverage for the under-insured and uninsured, increased hospital specialty bed capacities, increased numbers of

critical care nurses and increased specialty physician coverage, better reimbursement, and public education about the appropriate use of the emergency department.

As the attached letters from the EMCC, Dominican Hospital, Watsonville Community Hospital, the Santa Cruz County Medical Society, and Dr. Ira Lubell show, community facilities and providers are concerned about the need for continued Emergency Department access and care, the impact of uninsured patients on the emergency care system, and the need for support for on-call specialty physicians.

Legislative Initiatives

EMS and trauma legislation has been introduced in the California Legislature, including Assembly Bills **424** (Aroner), AB **686** (Thomson/Hertzberg), AB **687** (Thomson), AB **740** (Runner) and AB **778** (Romero), and Senate Bills **117** (Speier), SB **254** (Dunn), SB **447** (Vasconcellos) and SB **851** (Oller). Those bills which have the most specific application to the impact of uninsured patients on the emergency care system and the need for support for on-call specialty physicians are discussed below.

Senate Bill **254** (Dunn) would set forth additional requirements to existing EMS law to provide reimbursement for initial stabilizing medical services, implement a critical emergency service provider program, and establish the Critical Emergency Service Facility Fund. Existing law distributes Maddy Fund dollars to certain physicians and surgeons, and to hospitals providing disproportionate trauma and **EMS** services. This bill would maintain the Maddy Fund distribution to physicians and surgeons, delete the distributions to hospitals and revise the distribution formula upon funding of the critical emergency services program provided under the bill. New schedules of reimbursement would be established for Advanced Life Support (ALS) and Basic Life Support (BLS) transportation services, and for ALS and BLS initial stabilization services. These initial stabilizing medical services would also be covered benefits under Medi-cal. The bill would appropriate **$200,000,000** from the General Fund for the purposes of the critical emergency medical services program, and **$100,000,000** from the General Fund to distribute to counties. The county distribution is **40%** among counties with a designated critical emergency service facility and **60%** according to population.

Assembly Bill 686 (Hertzberg/Thomson) would establish a Trauma Care Fund in the State Treasury to allocate unspecified General Fund dollars to local EMS agencies that operate eligible trauma care systems. Local EMS agencies would disburse funds received to agency-designated trauma centers. Both public and private hospitals designated as trauma centers would be eligible for funding. Funds would be used to maintain trauma center financial viability and to reimburse the care of uninsured patients.

Assembly Bill **687 (Thomson/Hertzberg)** would create the EMS and Trauma Care Fund to pay for uncompensated care provided by trauma facilities. The funds would be an amount equal to **25.70%** of the State Penalty Fund which collects **$10** penalties imposed by the courts for each criminal offense.

IT **IS** THEREFORE RECOMMENDED THAT YOUR BOARD:

1) Accept and file the attached report, and

2) Approve and adopt the attached resolution supporting SB 254 (Dunn), AB 686 (Hertzberg/Thomson), and AB 687 (Thomson/Hertzberg).

Sincerely,

Rama Khalsa, Ph.D.
Agency Administrator

Attachments: EMCC Letter
Dominican Hospital Letter
Watsonville Community Hospital Letter
Santa Cruz County Medical Society Letter
Dr. Ira Lubell Letter
Code Yellow/Code Red Report
Resolution
Senate Bill **254** (Dunn)
Assembly Bill 686 (Hertzberg/Thomson)
Assembly Bill 687 (Thomson/Hertzberg)

RECOMMENDED

Susan A. Mauriello
County Administrative Officer

CC: County Administrative Office
County Counsel
Auditor-Controller
HSA Administration

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County of Santa Cruz

0230

HEALTH SERVICES AGENCY

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EMERGENCY MEDICAL SERVICES

April 3, 2001

Rama Khalsa
HSA Administrator
1080 Emeline Ave.
Santa Cruz, CA 95060

Dear Ms. Khalsa:

This letter is in regard to the issue of Emergency Department closures or diversions in the County of Santa Cruz. As you know this issue was discussed at length at the last EMCC meeting. The issue is not an issue that can be resolved in one broad-brush stroke.

I feel the issue was explained well in your report to the Board of Supervisors. In comparison to other counties and cities in California and the United States we are incredibly fortunate in our ability to maintain open status.

The problem is far more insidious and hidden. One issue in our county is that there are over 40,000+ uninsured patients. The responsibility for the medical care of this population falls on the 2 hospitals and the medical staffs of the facilities. The County Health system or resources do not cover them. These patients usually present with larger problems and concurrent problems that drain resources and the system.

Any hospital diversion is a statement of the system for health care delivery. It is multifactorial in nature and cause. Although our county is very fortunate, it is the tip of the iceberg in regard to the unraveling of the health care system and the safety net for the population.

Both Health Care facilities in the County work extremely hard to maintain this safety net. This is accomplished by incredibly hard work on the part of the nurses and physicians that serve our population.

I would hope that the Board of Supervisors looks at the whole system with an eye to fortifying the infrastructure of the safety net for health care to our citizens.

Sincerely,

Terry B. Lapid, M.D., FACEP
Chair, Emergency Medical Care Commission

5.6.

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Dominican **Hospital**
CHW

Dominican Hospital
1555 Soquel **Drive**
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83 1 **462 7700 Telephone**

Dominican
Rehabilitation Services
610 Frederick Street
Santa Cruz, **CA 95062**

April **4,2001**

Rama Khalsa, Ph.D.
Santa **Cruz** County Health Services Agency
Administrator
1080 Emeline Avenue
Santa Cruz CA 95062

Dear Dr. Khalsa:

I would like to take this opportunity to provide you with some comments on emergency medical services in Santa Cruz County as you submit your Report on Hospital Restricted Status and Emergency Department Access in Santa Cruz County to the Board of Supervisors. As outlined in your report, the frequency of instituting Code Red/Yellow hospital restricted status in Santa Cruz County in Calendar Year 2000 was infrequent for a very small percentage of annual hours of operation. Because of ongoing commitment of resources; highly trained staff and responsive physicians, **Dominican Hospital has experienced no incidences of code red status during Calendar Year 2000.** These results are contrary to the experiences in most other counties in California including Monterey and Santa Clara Counties where ambulances are frequently on diversion.

Although the number of diversions is relatively small in Santa Cruz County, it is important to not minimize the challenges faced by hospitals and prehospital care providers when diversion status is in effect. Because of the importance of accessing timely emergency care when needed, any delays in the care process such as rerouting ambulances are serious. Following the incidences when code red diversion is in effect at Watsonville Hospital or code yellow status at either Dominican or Watsonville Hospitals, Dominican staff review the episodes to access the impact of the diversion and what actions could be taken to avoid the reliance on ambulance diversion as a solution to care delivery difficulties. A recent review of occurrences resulted in our meeting with Watsonville Hospital staff to discuss better ways to address patient volume demands and communication procedures between the two hospitals during diversions.

As you know, Dominican Hospital has a very busy emergency department providing the full' service array of emergency care. We provided over 42,000 patient visits in Calendar Year **2000.** All patients are treated equally regardless of health insurance status. Patients requiring admission who do not have a physician are assigned the appropriate on-call physician(s) to render services. Dominican's Emergency Department is **a** critical safety net for the uninsured and patients covered by County insurance programs. Last year over 40% of the ED patients were covered by Medical, MediCruz, or uninsured.

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The use of ambulance diversion status is symptomatic of the growing challenges faced by hospitals in providing emergency medical services and trauma care in **our** communities. The provision **of** hospital emergency care is in trouble across California and the nation for a number of reasons, which are being felt locally to varying degrees. Some of those factors contributing to this crisis include:

- Inadequate reimbursement to cover the costs of care from both governmental and private payors.
- The rising number of uninsured needing care.
- Physicians who are unable/unwilling to meet all of the on-call demands.
- The lack of follow-up care options particularly for the uninsured and substance abuse patients.
- Workforce shortages for nurses, technicians, and other staff contributing to reduced capacity to handle the ED service demand.

Santa Cruz County is fortunate to have a coordinated, high quality **EMS** system of emergency care. It is Dominican Hospital's and its Medical Staffs goal to continue to maintain these high standards. However, given the fragility of the system, it is critical that all partners in **EMS** work together with local public policy decision makers and legislators to seek some relief from this growing crisis.

Sincerely,

Sister Julie Hyer OP

Sister Julie Hyer, O.P.
President/CEO

cc. Terry **Lapid,** M.D., Dominican Hospital ED Medical Director; Chair, EMCC
Carol Adams, Dominican Hospital, Vice President

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WATSONVILLE
COMMUNITY HOSPITAL

April 3, 2001

Rama Khalsa, Administrator
Health Services Agency
santa Cruz County
1080 Emeline Avenue
Santa Cruz, CA 95061-0962

Dear Rama:

I would like to take this opportunity to provide some clarification to the discussion at the recent bard of Supervisors Meeting regarding Hospital Restricted Status (code Yellow/Code Red), as well as express some concerns that I think you and the Board of Supervisorsshould be aware of-that will critically impact the ability of our hospital, and I *suspect* other hospitals, to serve the emergency needs of our population.

First, in regard to the facts of this past year regarding Hospital Restricted Status, I believe the Emergency Medical Care Commission has documented that fact that Watsonville Community Hospital was only on a form of restricted status for less than 10 **occasions and for a combined period of less than 24 hours each for** Code **Red and Code Yellow over the 366 days of the year. I think the County should be extremely proud of this track record as compared to most other communities and counties anywhere else** in the **State.**

This performance has been accomplished in *spite of* the fact that Watsonville Community **Hospital was nearly bankrupt merely three years ago, and in spite of the difficulty of recruiting** qualified nursing and *other* clinical personnel and physicians to Ws community because *of* **the** high *cost of* housing and living expenses, as well as the **high** percentage *of* uninsured and Medi-**Cal** and other low-paying insurers which further exacerbates our abilii **to attract** physicians and to provide emergency **room** back up coverage by the physician **specialists.**

At WCH, **we** pmvide two to six times the percentage *of* **Medi-Cal,** MediCruz and **Charity** Cam as compared to the other Santa **Cruz facilities,** in addition to providing $0.5 million to $1.0 million *of* tax revenues to local governments,

I **can unequivocally state that it is the policy and practice of our organization, from the Board, of Trustees** level through the caregiver **level,** that **we** cam for **every** person presenting to our emergency room **regardless of** any economic *status,* -and **likewise** that **we** *not* transfer any **patients** that we can safely and adequately **cam** for in our *own* institution **and** community. However, some *of* the **difficulties** that have **contributed** to these minimal amounts *of* **restricted.** status this past year focus around our continued **efforts** to upgrade our facilityand **equipment** to **accommodate additional** patients.

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Specifically, when this new hospital was built (prior to its current **for-profit ownership)** those responsible for planning reduced the number of critical cam beds **from** 10 *at* the **old hospital to a mere 6 at the new hospital. This has created the most significant bottleneck that led to** hospital **restricted status** during the past year. Community Health **Systems,** the current owner, **identified this** problem immediately upon acquisition and **has** been diligently pursuing a **renovation project to expand the number of critical care beds. As a result, at a** cost **in excess of $750,000,** we will begin **this** project to add **four additional** beds in our **Critical** Cam unit **that** can **serve as swing beds for critical care or intermediate care. We expect that to be completed by** November **2001.**

Similarly, our **hospital** is the *only* emergency **room** in the County that continues to **support** and provide 100% Board **Certified Emergency Trained** physicians for the **cam** for our patients. We **have also** *invested* over **$1** million in installing a **new, upgraded cardiac** cath lab that **will** enable us to **cam** for a broader **range** of cardiac **patients.** We believe **all** of these **issues will** enable us to continue to **receive** and cam for a broader base of patients **during** the future **years-without having** to have as much **restricted** ER *status.*

In **spite** of these additional **investments,** one of the **bigger** issues **facing all the'hospitals** in this area, and specifically Watsonville, is that with **declining** levels of reimbursement but yet tremendously escalating *costs,* many of the emergency back-up physicians, in the surgical specialties am dropping out of ER Call Coverage responsibilities because of the high mix of no-pay or low pay patients they am **required** to **treat.** Thus, I would **like** to **see** the County become **much more of a partner with the health care providers in exploring sources of new funds to** shore up the Emergency Room backup coverage.

The physicians are expecting to be paid for some of this time and, admittedly, with less and less physicians willing to provide this service, it means-that. many of them are taking 'call every second, third, or fourth night of the year which will lead to "burnout" and attrition from this community to somewhere else where the demands are less onerous. Thus, I **think we should work as partners between County Health Services and private health services to explore all State, Federal and local funding mechanisms to provide emergency physician back-up call capability.**

While I **am** comfortable in **reassuring** our **commitment** to continue to cam for **all** patients who present in cur Emergency Room and avoiding transfer of any patients we *can* **possibly** *safely* **treat** *at our* facility, and while we can put **new** capital and physical resources **into** our emergency **capability,** the physician and nursing/clinical personnel retention and recruitment **will** continue to be mapr **challenges** unless **them** *is* more funding to put **into** the *system* to ease the **lifestyle vs.** burnout **and cost of** living **issues.**

I **hope** that Ws has **provided** some insight for you to sham with the Board *of* Supervisors and **will** alleviate any **misinformed** or **misdirected concerns** or **challenges** as to our **meeting** our "'fair share" *of* caring for the under-funded **patients** in cur community. I would be happy **to** make myself available to anyone to further **discuss** or **elaborate** on these issues.

Sincerely,

Barry S. Schneider
Chief Executive Officer

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Santa Cruz County Medical Society

0236

March 29,2001

Santa Cruz County Board of Supervisors
701 Ocean Street, 5th floor
Santa Cruz, CA 95060

Re: Report on Hospital Retricted Status

Dear Board Members:

You recently received a report on Hospital Restricted Status and Emergency Department Access in Santa Cruz County. The report was prepared by Vol Ranger, Emergency Medical Services (EMS) Administrator for the Emergency Medical Care Commission (EMCC). The report accurately depicts emergency department restricted status (Code Yellow/Code Red) as an uncommon event in our county. This is in keeping with our experience that the emergency departments in Santa Cruz County do an outstandingjob of keeping themselves available to serve the public.

All is not well in emergency services however. The report is also accurate in the depiction of emergency departments which are overburdened, over utilized and under funded. (See sections on Hospital EMS and Emergency Department Volumes.) Physicians providing services in the emergency departments (emergency room physicians and physicians on-call to the ER) are adversely affected by these same issues. The combination of increased workload and dwindling reimbursement (or none at all) has led to increasing difficulty in recruiting physicians willing to serve on the on-call rosters for the hospitals. To quote the report:

> *. ..As the medical staff ages and enters retirement, new physicians are not entering the area to buildpractices because of the cost of living and because reimbursement rates are not comparable to areas like Santa Clara County or San Francisco. The sheer volume ofpatients have increased demands on physicians at the same time that reimbursement has decreased and workloads have increased. Delayed or nonpayment by healthplans for emergency services is decreasing physician ability or desire to serve on-call. The EMS Fund (Maddy Fund) that is used to compensate physicians for care provided to the uninsuredpays about 15 cents on the dollar, according to the California Medical Association.*

19065 Portola Drive, Suite M ◆ Salinas, CA 93908 ◆ (831) 426-1137 ◆ Fax: (831) 426-1131

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We are troubled and concerned about the current situation, and fear that a crisis is looming - one in which the public will no longer be able to be served by specialists and subspecialists who provide on-call services to the local emergency departments.

Senate Bill **254** (Dunn) has been introduced to help resolve the issues involving emergency on-call services. While the Santa **Cruz County** Medical Society supports the intent of this legislation, we have concerns that, as currently drafted, it will not fulfill its intended purpose. Some of the issues that we believe need to be further clarified include:

- **SB** 254 designates the county's Maddy **Fund** as the vehicle for reimbursing physicians. SCCMS has real concerns about the overly burdensome documentation and administrative responsibilities placed **on** physicians trying to access this fund.
- The bill does not obligate hospitals to use their allotted funds – in whole or in part – to compensating physicians for providing on-call emergency coverage.
- SCCMS recognizes the fact that there are two primary "problems" with physicians' providing emergency on-call services – compensation and time. **SB** 254 attempts to relieve just one of them – compensation. There is a great deal **of** personal time that every physician surrenders when he or she provides on-call coverage. **As** a result, physicians' quality of life suffers. The state must look at unique and creative ways to incentivize physicians to continue to provide on-call emergency coverage. Compensation is a good first step but it's only the beginning.

We remain hopeful that with work of the California Medical Association, the legislature, and the bill's author, SB **254** will be revised in such a way to alleviate our concerns.

Thank you for your concern regarding emergency medical services, and *thank* you for your specific attention to the issues regarding physician availability in providing emergency care.

Sincerely,

Rosalind Shorenstein

Rosalind Shorenstein, MD
President

19065 Portola Drive, Suite M ◆ Salinas, CA 93908 ◆ (831) 426-1137 ◆ Fax: (831) 426-1131

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Dedicated to the Health
of the Whole Community

SANTA CLARA VALLEY MEDICAL CENTER

0238

March 15,2001

Vol Ranger
EMS Administrator
P.O. Box 962 1080 Emeline Ave.
Santa Cruz, CA 95061-0962

Dear Vol Ranger:

I am in receipt of the draft report on hospital-restricted status and emergency department access in Santa Cruz County for the past year.

Either there is an error in your calculations or Santa Cruz is doing something incredibly fantastic. I can not believe that the total time for restricted access for the calendar year 2000 was 71 hours. A year of 365 days x 24 hours per day equals 8760. This means that access was restricted for less than 0.1% of the total year. Taking into account that anything including ER decontamination after a hazmat incident, major trauma, external disaster and the like can cause this, It is incredible to me that our hospitals have been able to maintain such a high level of availability.

There are few areas in the United States that can boasts of such records. You and the entire hospital and EMS community in this county our to be congratulated.

Very truly yours,

Ira Lubell, M.D., M.P.H.
Medical Director

cc: Rama Khalsa, Ph.D.
Santa Cruz HHS
1080 Emeline Avenue
Santa Cruz, CA 9506 l

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county of Santa Cruz 0239

HEALTH SERVICES AGENCY

POST OFFICE BOX 962, 1080 EMELINE AVENUE SANTA CRUZ, CA 95061-0962
(831) 454-4120 FAX: (831) 454-4272 TDD: (831) 454-4123

EMERGENCY MEDICAL SERVICES

MEMORANDUM

Date: March 14,200 1

To: Emergency Medical Care Commission

From: Vol Ranger VR
Santa Cruz County EMS Manager

Subject: Report on Hospital Restricted Status (Code Yellow/Code Red) and Emergency Department Access in Santa Cruz County

Introduction

The Emergency Medical Care Commission (EMCC) discussed reports of hospital restricted status at the February 14, **2001** meeting. The following information is presented for follow-up discussion at the March 14, **2001** meeting.

Hospitals are sometimes overwhelmed by circumstances beyond their control and must request a restricted status within the Emergency Medical Services (EMS) system in order to provide for the care and safety of all their patients.

Code Green is a status that means the hospital is open to all ambulance traffic.

Code Yellow is a status that reflects a temporary condition that impacts the reception of certain types of patients. For example, if the Computed Tomography (CT) scanner **is** out of service for repair, a hospital will advise the Santa **Cruz** Consolidated Emergency Communication Center (SCCECC) and a medical information page will be disseminated to place the hospital on Code Yellow status. Another example of a Code Yellow condition would be a lack of intensive care or CCU beds when the hospital inpatient monitored beds are at full census. In these cases, ambulances would check with the affected hospital to determine if they should proceed to that location with patients who might require diagnostic imaging **or** potentially critical patients who might require an inpatient specialty unit bed.

Code Red is a **status** that reflects a temporary condition in which the Emergency Department (ED) is so busy that reception of an additional critical patient might

adversely affect the care of patients already being treated. For example, an ED which just received several trauma victims from a multiple casualty incident motor vehicle crash might need to declare Code Red until the victims are stabilized. In this case, incoming ambulance traffic would divert to another hospital unless their patient was in extremis and required care for an immediately life-threatening condition such as cardiac and respiratory arrest or occluded airway. All hospitals receive patients in extremis at all times.

The County's EMS Program policy number 1230 details the hospital diversion procedure.

The SCCECC has a procedure in place to monitor Code Yellow/Code Red statuses at four hour intervals and will call the hospital to confirm that they are still on a restricted status or have resumed Code Green status if no additional information has been received four hours after the initial call.

Hospital Restricted Status Review

Each month the Technical Advisory Group (TAG) reviews the Hospital Restricted Status Report prepared by the SCCECC. In Calendar Year 2000, the total number of hours of hospital restricted status in the Santa Cruz **EMS** System was 71 hours and 32 minutes.

Dominican Hospital was Code Yellow on **5** occasions for a total of 27 hours and 52 minutes. Watsonville Community Hospital was Code Yellow on **3** occasions for a total of **22** hours and **53** minutes, and Code Red on **4** occasions for a total of 20 hours and 47 minutes.

The TAG further reviews the Ambulance Reroute Report prepared by the SCCECC which was designed to detect any ambulance traffic which begins to travel towards one hospital destination and which arrives at another hospital destination. No ambulance diversions were recorded by this report in Calendar Year 2000, however, the TAG recognized that this report returned imperfect data on the issue. A new procedure will go into effect March 1,2001 to flag ambulance diversions with a delay code. The TAG routinely reviews every delay code each month. Paramedic liaison nurses at each hospital also advise the EMS medical director about problems with ambulance diversions.

The results of the TAG review are reflected in the TAG minutes and are disseminated to the Board of Supervisors, the Emergency Medical Care Commission **(EMCC)** and the Prehospital Advisory Commission (PAC) monthly.

A subcommittee of the PAC held a meeting on ambulance diversion on January 20,2000 to ensure that adequate communications protocols were in place between the two hospital EDs to assure early and consistent notification of hospital restricted status. Participants from both hospitals met again on March 2, **2001** to review the hospital diversion policy, assure good communication, brainstorm different ways to respond to pressures of decreased resources and increased demand, and to develop a contingency plan for the care and safety of all their patients.

Santa Cruz County has been fortunate not to have experienced any problems as a result of hospital restricted statuses. Other nearby counties have experienced great difficulties. At the last Monterey County Medical Advisory Committee meeting, their EMS Medical Director reminded the Monterey County hospitals that restricted status was a privilege, not a right, and that if abuse occurred he would rescind the privilege. In Santa Clara County, three hospitals have received their third and final warning about the use of hospital restricted status and are subject to peer review of plans to correct their use; if their corrective actions are not accepted by the peer review committee, they will be unable to go on restricted status for sixty days.

This year, San Francisco General Hospital has been forced to divert ambulance patients **3 1%** of the time. In national settings, in November **2000, 8** Cleveland hospitals went on diversion 57 times in one month. Twenty-seven Boston EDs closed for a total **of 63 1** hours in the same month, Kentucky had over **2,000** ambulance diversions last year.

Hospital Emergency Medical Services

Emergency Departments (EDs) are hospital departments providing immediate initial evaluation and treatment of acutely ill or injured patients on a 24-hour basis. EDs have evolved into the principal safety net for health care, providing universal access to emergency, acute, chronic, and episodic medical care for all persons regardless of their insurance coverage or lack of coverage.

The idea of EDs serving **as** a safety net derives from the philosophy of the healing professions and the societal view that emergency care is an essential public service. In addition, under state and federal law, everyone who presents to an emergency department must be provided with emergency care. The Health Maintenance Organization (HMO) model has failed to reduce the number of uninsured, and emergency medical care continues to be the health service in greatest demand by the public, insured or not. Uninsured patients are continuing to increase and use the emergency department for their primary source of medical care. Because **of** low bed availability in intensive care and other units, patients remain in the emergency department for longer periods of time. High acuity patients, primary care patients whose lack of routine care has exacerbated their problems into higher acuities, nursing shortages, ancillary care staff shortages, very low reimbursement rates, slow payment, and downgrading of service charges has damaged the emergency care system.

Nationwide, the result has been emergency department overcrowding, long waits, ambulance diversions, a lack of specialty physicians for on-call rosters, and facilities which downgrade services or close emergency departments.

Emergency Medical Treatment and Active Labor Act (EMTALA)

EMTALA, the federal "anti-dumping" law, requires that hospitals which receive Medicare and Medicaid payments must provide a medical screening examination to all individuals seeking emergency services prior to inquiring about the means of payment. Treatment must meet minimum health care quality standards. Unstable patients can be transferred to another facility if the transfer is in the best interests of the patient, and hospitals with specialized facilities are required to receive these patients from hospitals which lack specialized capabilities.

Emergency Department Volumes

In 1999, Dominican Hospital reported 36,250 ED visits. 6600 of these ED visits were uninsured (18.21%). Dominican Hospital ED visits also included 1,682 Medi-Cal (4.64%) and 892 County indigent (2.46%) visits. The average loss per ED visit was -$51.77 for a ED total annual loss of -$1,879,769 (Source: Office of Statewide Health Planning and Development, Hospital Financial Data Disclosure Report 1998-99.)

In 1999, Watsonville Community Hospital reported 20,983 ED visits. 1704 of these ED visits were uninsured (8.12%). Watsonville Community Hospital ED visits also included 4,794 Medi-Cal (22.85%) and 2,660 County indigent (12.68%) visits. The average loss per ED visit based on OSHPOD data was -$53.18 for an ED total annual loss of -$1, 115,876 (Source: **Barry** Schneider amendments to incomplete Office of Statewide Health Planning and Development, Hospital Financial Data Disclosure Report 1998-99 figures which included only one quarter of data prior to the sale of Watsonville Hospital.)

Statewide, **ED** losses totaled -$316,576,503.

Physician Recruitment and Specialty Physicians On-Call

The purpose **of** the on-call roster is to ensure that the emergency department is prospectively aware of which specialty physicians are available to stabilize persons with emergency conditions. The 24hour/7 day roster includes specialists and sub-specialists represented on the medical staff.

Hospitals are experiencing increasing challenges recruiting physicians. As the medical staff ages and enters retirement, new physicians are not entering the area to build practices because of the cost of living and because reimbursement rates are not comparable to areas like Santa Clara County or San Francisco. The sheer volume of patients has increased demands on physicians at the same time that reimbursement has decreased and workloads have increased. Delayed or non-payment by health plans for emergency services is decreasing physician ability or desire to serve on-call. The EMS Fund (Maddy Fund) that is used to compensate physicians for care provided to the uninsured pays about 15 cents on the dollar, according to the California Medical Association.

Policy for Hospital Services Downgrade or Closure

The EMCC approved the Santa **Cruz** County "Impact Evaluation Regarding Hospital Emergency Services Downgrade or Closure Policy" at its October 11,2000 meeting. This policy is required by the state Health and Safety Code Section 1300 (c) and specifies the criteria the County will use in conducting an impact evaluation of the effect of a downgrade or closure **of** any emergency services in County hospitals. Impact evaluation criteria include service area, Base Hospital designation, trauma care, specialty services, and patient volume. Public hearings are required. This policy was put in place to delineate the process should such an impact evaluation ever be needed.

Recently a hospital in Humboldt County abruptly ceased emergency department services without notice or process. Throughout California, hospitals are shutting down or scaling back emergency services because of decreased reimbursement, downgrading of service charges, inability to recruit physicians, shortages **of** nurses, and lack of specialty beds.

Solutions

Santa Cruz County hospitals are meeting to promote good communication and develop contingency plans to provide hospital **ED** access when faced with pressures of increased patient demand and limited physician and nurse resources. The Prehospital Advisory Committee will review the **EMS** Program policy on hospital diversion. The Emergency Medical Care Commission and the Health Services Agency are tracking legislative efforts to improve trauma and **EMS** care and setting advocacy priorities.

Broader solutions to the problems of Emergency Department access must include better access to outpatient care for patients, advocacy for legislation to improve coverage for the under-insured and uninsured, increased hospital specialty bed capacities, increased numbers **of** critical care nurses and increased specialty physician coverage, better reimbursement, and public education about the appropriate use **of** the emergency department.

BEFORE THE BOARD OF SUPERVISORS
OF THE *COUNTY* OF SANTA CRUZ, CALIFORNIA

RESOLUTION No.

On the motion of Supervisor
Duly seconded of Supervisor
The following resolution is adopted

RESOLUTION SUPPORTING THE PASSAGE OF SENATE BILL **254,**
ASSEMBLY BILL **686** AND ASSEMBLY BILL **687**

WHEREAS, Emergency Departments serve as the safety net for health care, providing universal access to emergency, acute, chronic, and episodic medical care for all persons; and

WHEREAS, emergency medical care continues to be the health service in greatest demand by the public; and

WHEREAS, the emergency care system has been damaged by the increase in high acuity patients, primary care patients with no routine source **of** care, nursing shortages, ancillary care staff shortages, low reimbursement rates, the impact of uninsured patients, and the challenges of recruiting physicians for staff and specialty on-call positions; and

WHEREAS, Senate Bill **254** would appropriate State General Fund dollars to provide reimbursement for initial stabilizing medical services, implement a critical emergency service provider program, and establish the Critical Emergency Service Facility Fund; and

WHEREAS, Assembly Bill **686** would establish a Trauma Care Fund in the State Treasury to allocate General Fund dollars to local EMS agencies that operate eligible trauma care systems; and

WHEREAS, Assembly Bill **687** would create the EMS and Trauma Care Fund to pay for uncompensated care provided by trauma facilities.

NOW, THEREFORE, **BE IT RESOLVED** that the Santa **Cruz** County Board of Supervisors support SB **254,** AB **686,** and ***AB*** **687** to decrease the impact of uninsured patients on the emergency care system and increase support for on-call specialty physicians.

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PASSED AND **ADOPTED, by the Board** of **Supervisors of the County of Santa Cruz, State of California, this 24th day of April,** 20001 **by the following vote:**

AYES: **SUPERVISORS**
NOES: **SUPERVISORS**
ABSTAIN: **SUPERVISORS**

_____
Chair of **the Board**

ATTEST: _____
Clerk of the Board

APPROVED AS TO FORM: _____
County Counsel

CC: **CAO**
Auditor-Controller
County Counsel
HSA Administration

BILL NUMBER: AB 687 INTRODUCED 0246
BILL TEXT

INTRODUCED BY Assembly Members Thomson and Hertsberg

FEBRUARY 22, 2001

An act to add Article 5 (commencing with Section 1798.190) to Chapter 2.6 of Division 2.5 of the Health and Safety Code, and to amend Section 1464 of the Penal Code, relating to the State Penalty Fund.

LEGISLATIVE COUNSEL'S DIGEST

AB 687, as introduced, Thomson. State penalty funds.

Existing law permits each county to establish an emergency medical services program in accordance with various requirements.

Existing law establishes the State Penalty Fund, the moneys in which are distributed on a monthly basis to various state funds, including the Driver Training Penalty Assessment Fund.

This bill would create the Emergency Medical Services and Trauma Care Fund to pay for uncompensated care provided by trauma facilities. This bill would further provide that the Driver Training Penalty Assessment Fund would no longer receive a percentage of the money in the State Penalty Fund each month, and that instead the Emergency Medical Services and Trauma Care Fund would receive the percentage of money that the Driver Training Penalty Fund receives each month.

The bill would prohibit any county from receiving moneys from the fund unless the county has an emergency medical services program.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Article 5 (commencing with Section 1798.190) is added to Chapter 2.6 of Division 2.5 of the Health and Safety Code, to read:

Article 5. Emergency Medical Services and Trauma Care Fund

1798.190. (a) There is hereby created in the State Treasury the Emergency Medical Services and Trauma Care Fund, the moneys in which may, upon appropriation by the Legislature, be expended for the purposes of funding uncompensated care.

(b) No moneys may be received from the Emergency Medical Services and Trauma Care Fund by a county unless the county has an emergency medical services program established pursuant to Section 1797.200.

SEC. 2. Section 1464 of the Penal Code is amended to read:

1464. (a) Subject to Chapter 12 (commencing with Section 76000) of Title 8 of the Government Code, there shall be levied a state penalty, in an amount equal to ten dollars ($10) for every ten dollars ($10) or fraction thereof, upon every fine, penalty, or forfeiture imposed and collected by the courts for criminal offenses, including all offenses, except parking offenses as defined in subdivision (i) of Section 1463, involving a violation of a section of the Vehicle Code or any local ordinance adopted pursuant to the Vehicle Code. Any bail schedule adopted pursuant to Section 1269b may include the necessary amount to pay the state penalties established by this section and Chapter 12 (commencing with Section 6) of Title 8 of the Government Code for all matters where a

personal appearance is not mandatory and the bail is posted primarily to guarantee payment of the fine.

(b) Where multiple offenses are involved, the state penalty shall be based upon the total fine or bail for each case. When a fine is suspended, in whole or in part, the state penalty shall be reduced in proportion to the suspension.

(c) When any deposited bail is made for an offense to which this section applies, and for which a court appearance is not mandatory, the person making the deposit shall also deposit a sufficient amount to include the state penalty prescribed by this section for forfeited bail. If bail is returned, the state penalty paid thereon pursuant to this section shall also be returned.

(d) In any case where a person convicted of any offense, to which this section applies, is in prison until the fine is satisfied, the judge may waive all or any part of the state penalty, the payment of which would work a hardship on the person convicted or his or her immediate family.

(e) After a determination by the court of the amount due, the clerk of the court shall collect the penalty and transmit it to the county treasury. The portion thereof attributable to Chapter 12 (commencing with Section 76000) of Title 8 of the Government Code shall be deposited in the appropriate county fund and 70 percent of the balance shall then be transmitted to the State Treasury, to be deposited in the State Penalty Fund, which is hereby created, and 30 percent to remain on deposit in the county general fund. The transmission to the State Treasury shall be carried out in the same manner as fines collected for the state by a county.

(f) The moneys so deposited in the State Penalty Fund shall be distributed as follows:

(1) Once a month there shall be transferred into the Fish and Game Preservation Fund an amount equal to 0.33 percent of the state penalty funds deposited in the State Penalty Fund during the preceding month, except that the total amount shall not be less than the state penalty levied on fines or forfeitures for violation of state laws relating to the protection or propagation of fish and game. These moneys shall be used for the education or training of department employees which fulfills a need consistent with the objectives of the Department of Fish and Game.

(2) Once a month there shall be transferred into the Restitution Fund an amount equal to 32.02 percent of the state penalty funds deposited in the State Penalty Fund during the preceding month. Those funds shall be made available in accordance with Section 13967 of the Government Code.

(3) Once a month there shall be transferred into the Peace Officers' Training Fund an amount equal to 23.99 percent of the state penalty funds deposited in the State Penalty Fund during the preceding month.

(4) Once a month there shall be transferred into the Driver Training Penalty Assessment Fund, Emergency Medical Services and Trauma Care Fund an amount equal to 25.70 percent of the state penalty funds deposited in the State Penalty Fund during the preceding month.

(5) Once a month there shall be transferred into the Corrections Training Fund an amount equal to 7.88 percent of the state penalty funds deposited in the State Penalty Fund during the preceding month. Money in the Corrections Training Fund is not continuously appropriated and shall be appropriated in the Budget Act.

(6) Once a month there shall be transferred into the Local Public Prosecutors and Public Defenders Training Fund established pursuant to Section 11503 an amount equal to 0.78 percent of the state penalty funds deposited in the State Penalty Fund during the preceding month. The amount so transferred shall not exceed the sum of eight hundred fifty thousand dollars ($850,000) in any fiscal year. The remainder in excess of eight hundred fifty thousand dollars ($850,000) shall be transferred to the Restitution Fund.

(7) Once a month there shall be transferred into the Victim-Witness Assistance Fund an amount equal to 8.64 percent of the state penalty funds deposited in the State Penalty Fund during the

preceding month.

(8) (A) Once a month there shall be transferred into the Traumatic Brain Injury Fund, created pursuant to Section 4358 of the Welfare and Institutions Code, an amount equal to 0.66 percent of the state penalty funds deposited into the State Penalty Fund during the preceding month. However, the amount of funds transferred into the Traumatic Brain Injury Fund for the 1996-97 fiscal year shall not exceed the amount of five hundred thousand dollars ($500,000). Thereafter, funds shall be transferred pursuant to the requirements of this section. Notwithstanding any other provision of law, the funds transferred into the Traumatic Brain Injury Fund for the 1997-98, 1998-99, and 1999-2000 fiscal years, may be expended by the State Department of Mental Health, in the current fiscal year or a subsequent fiscal year, to provide additional funding to the existing projects funded by the Traumatic Brain Injury Fund, to support new projects, or to do both.

(B) Any moneys deposited in the State Penalty Fund attributable to the assessments made pursuant to subdivision (i) of Section 27315 of the Vehicle Code on or after the date that Chapter 6.6 (commencing with Section 5564) of Part 1 of Division 5 of the Welfare and Institutions Code is repealed shall be utilized in accordance with paragraphs (1) to (8), inclusive, of this subdivision.

0248

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BILL NUMBER: *AB* 686 INTRODUCED
BILL TEXT

0249

INTRODUCED BY Assembly Members Hertzberg and Thomson

FEBRUARY 22, 2001

An act to amend Section 1798.162 of, and to add Chapter 2.75 (commencing with Section 1797.99) to Division 2.5 of, the Health and Safety Code, relating to emergency medical services, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

AB 686, as introduced, Hertzberg. Emergency medical services: trauma centers: funding.

Existing law authorizes each county to develop an emergency medical services (EMS) program. Existing law authorizes a local EMS agency to implement a trauma care system only if the system conforms with regulations adopted by the state Emergency Medical Services Authority, and a plan developed by the trauma care system and submitted to the authority in accordance with those regulations. Existing law also permits the Santa Clara County Emergency Medical Services Agency to implement a trauma care system prior to the adoption of the authority's regulations, in accordance with specified conditions.

This bill would establish the Trauma Care Fund in the State Treasury, and would appropriate an unspecified sum from the General Fund to the fund, to be allocated by the authority to local EMS agencies that operate eligible trauma care systems. The bill would require each local EMS agency receiving funds pursuant to the bill, on March 1, 2002, and on each March 1 thereafter, to file a report with the authority regarding the distribution of funds pursuant to the bill.

This bill would eliminate the above provisions relating to the Santa Clara County Emergency Medical Services Authority. The bill would instead provide that a local emergency services agency that implements a trauma care system pursuant to the regulations and plan described above shall be eligible to receive funding in accordance with the funding provisions established in the bill. The bill would provide that it is not to be construed to require any local emergency medical services agency to include a designated trauma care system within its boundaries.

Vote: 2/3. Appropriation: yes. Fiscal committee: yea. State-mandated local program: no.

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. The Legislature finds and declares as follows:

(a) Trauma centers save lives by providing immediate coordination of highly specialized care for the most life-threatening injuries.

(b) Trauma centers save lives, and also save money, because access to trauma care can mean the difference between full recovery from a traumatic injury and serious disability necessitating expensive long-term care.

(c) Trauma centers do their job most effectively as part of a system that includes a local plan with a means of immediately identifying trauma cases and transporting those patients to the nearest trauma center.

(d) Trauma care is an essential public service.

(e) It is the intent of the Legislature in enacting this act to

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promote access to trauma care by ensuring the availability of services through EMS agency designated trauma centers, and by establishing an adequately funded statewide trauma system that is based on local planning and administration. 0250

SEC. 2. Chapter 2.75 (commencing with Section 1797.99) is added to Division 2.5 of the Health and Safety Code, to read:

CHAPTER 2.75. TRAUMA CARE FUND

1797.99. (a) (1) The Trauma Care Fund is hereby created in the State Treasury, from which moneys shall be allocated by the authority to local emergency medical services (EMS) agencies that implement a trauma care system meeting the requirements of Section 1798.162. Moneys in the Trauma Care Fund shall be distributed to agencies with designated trauma centers located in their service areas.

(2) The sum of ____ dollars ($) is hereby appropriated from the General Fund to the Trauma Care Fund for the purposes set forth in this chapter.

(b) (1) Local EMS agencies shall disburse funds received from the Trauma Care Fund to EMS agency-designated trauma centers. Both public and private hospitals designated as trauma centers shall be eligible for funding.

(2) ____ percent of funds shall be distributed to trauma centers to assist in maintaining trauma center viability. The remaining funds shall be distributed to trauma centers for reimbursement for uninsured patients meeting criteria defined by local EMS agencies pursuant to subdivision (a) of Section 1798.160 for whom data has been appropriately submitted to the local EMS agency's trauma registry.

(c) Local EMS agencies may reserve a maximum of one percent of their allocation pursuant to this section to assist in developing and maiptaining a trauma plan.

(d) On March 1, 2002, and on each March 1 thereafter, each local EMS agency receiving funds pursuant to this section shall file a report with the authority regarding the agency's distribution of funds pursuant to this section.

SEC. 3. Section 1798.162 of the Health and Safety Code is amended to read:

1798.162. (a) A local emergency medical services agency may implement a trauma care system only if the system meets the minimum standards set forth in the regulations for implementation established by the authority and the plan required by Section 1797.257 has been submitted to, and approved by, the authority. Prior to submitting the plan for the trauma care system to the authority, a local emergency medical services agency shall hold a public hearing and shall give adequate notice of the public hearing to all hospitals and other interested parties in the area proposed to be included in the system. This subdivision does not preclude a local EMS agency from adopting trauma care system standards which are more stringent than those established by the regulations.

(b) Notwithstanding subdivision (a) or any other provision of this article, the Santa Clara County Emergency Medical Services Agency may implement a trauma care system prior to the adoption of regulations by the authority pursuant to Section 1798.161. If the Santa Clara County Emergency Medical Services Agency implements a trauma care system pursuant to this subdivision prior to the adoption of those regulations by the authority, the agency shall prepare and submit to the authority a trauma care system plan which conforms to any regulations subsequently adopted by the authority. *A local emergency services agency that implements a trauma care system pursuant to subdivision (a) shall be eligible to receive funding in accordance with Chapter 2.75 (commencing with Section 1797.99).*

(c) Nothing in this section shall be construed to require the service area of any local emergency medical services agency to include a designated trauma center within its boundaries.

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BILL NUMBER: SB 254 AMENDED 0252
BILL TEXT

AMENDED IN SENATE MARCH 28, 2001

INTRODUCED BY ~~Senator Dunn~~ Senators Dunn *and* Speier
(Coauthors: Senators Escutia, *Figueroa,* Johannessen, *Romero, Sher,* and Vincent)
(Coauthors: *Assembly* Members Alquist, Bates, Xoretx, Robert Pacheco, *Richman,* Runner, and Strom-Martin)

FEBRUARY 15, 2001

An act to amend Sections 1797.98a, 1797.9833, 1797.100, 1797.101, 1797.107, 1797.108, 1797.200, 1797.254, and 1798.161 of, to add Sections 1275.9, 1367.13, 1797.87, 1797.115, and 1797.251 to, and to repeal Section 1798.166 of, the Health and Safety Code, to add Section 10126.7 to the Insurance Code, and to amend Section 14106.6 of, and to add Section 14106.65 to, the Welfare and Institutions Code, relating to emergency services, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

SB 254, as amended, Dum. Emergency medical services.

Existing law provides for the licensure and regulation of health facilities, including the provision of emergency medical services and care by those facilities.

This bill would require the State Department of Health Services, upon consultation with the Emergency Medical Services Authority and local EMS agencies, to revise regulations concerning the categorization and licensure of emergency departments on or before July 1, 2002.

Existing law regulates health care service plans and certain insurers that cover hospital, medical, and surgical expenses, and providers, in the reimbursement of claims of providers. Existing law sets forth requirements with respect to the reimbursement of claims for services rendered to a patient who is provided specified emergency services and care.

This bill would set forth additional requirements with respect to the reimbursement for initial stabilizing medical services, as defined, provided in response to medical emergencies.

By changing the definition of a crime relative to health care service plans, the bill would impose a state-mandated local program.

Under existing law, the Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act, the authority is responsible for the coordination and integration of state activities concerning emergency medical services and personnel.

This bill would require the authority to implement a critical emergency service provider program. The program would require a local EMS agency to designate within a county ~~a minimum of one~~ *sufficient number of* ~~department~~ departments or designated trauma ~~center~~ centers as a critical emergency service ~~facility~~ facilities . The bill would establish the Critical Emergency ~~Service~~ Services Facility Fund, the moneys from which, upon appropriation, would be expended by the authority for purposes of administering and funding the program in each county.

The bill would require the authority and the department to adopt, by December 31, 2002, certain regulations related to ensuring minimum

standards for a system of coordinated emergency medical care.

Existing law authorizes each county to designate an emergency medical services agency (local EMS agency) for the establishment and administration of an emergency medical services program in the county, and authorizes the establishment by a county of a Maddy Kmergency Medical Services (EMS) Fund for this purpose. The source of moneys in the fund are penalty assessments each county levies upon fines, penalties, and forfeitures imposed and collected by the courts for criminal offenses. A county establishing a fund under this provision is required to report certain information related to the fund to the Legislature through the authority.

This bill would require every county to designate a local EMS agency and establish a fund under these provisions.

Existing law provides. for specified percentage distributions of the money in a Maddy EMS Fund to certain physicians and surgeons, to hospitals providing disproportionate trauma and emergency medical services, and for other emergency medical services purposes as determined by each county.

This bill would delete the distributions to the hospitals and revise the distribution formula upon the implementation and funding of the critical emergency services program provided under this bill.

Existing law sets forth requirements of local EMS agencies, including the submission of an annual emergency medical services plan.

The bill would require the local EMS agency to evaluate and periodically inspect hospitals within its jurisdiction pursuant to regulations established by the authority. The bill would add to the requirements of a local EMS agency with regard to the submission of the annual emergency medical services plan.

By increasing the duties of counties and local EMS agencies, this bill would impose a state-mandated local program.

Existing law provides for the Medi-Cal program, which is administered by the department, pursuant to which medical benefits are provided to public assistance recipients and certain other low-income persons.

This bill would specify that initial stabilixing medical services in response to medical emergencies are a covered benefit under the Medi-Cal program.

Existing law requires the director to establish and update annually a rate schedule of reimbursement under the Medi-Cal program for paramedic services based on reasonable cost standards of the department.

This bill would instead require the director to establish and update annually separate specified schedules of reimbursement for (1) advanced life support and basic life support ambulance transportation services and (2) advanced life support and basic life support initial stabilizing medical services.

The bill would require *the Emergency* Medical *Services* Authority *to conduct an evaluation of this bill and report* to *certain committees of the Legislature by April 1, 2004.*

The bill would appropriate $200,000,000 from the General Fund to the authority for purposes of the critical emergency services program required under the bill. The bill would appropriate $100,000,000 from the General Fund to the authority to distribute to counties as provided under the bill.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement, including the creation of a State Mandates Claims Fund to pay the costs of mandates that do not exceed $1,000,000 statewide and other procedures for claims whose statewide costs exceed $1,000,000.

This bill would provide that with regard to certain mandates no reimbursement is required by this act for a specified reason.

With regard to any other mandates, this bill would provide that, if the Commission on State Mandates determines that the bill contains costs so mandated by the state, reimbursement for those costs shall

be made pursuant to the statutory provisions noted above.
Vote: 2/3. Appropriation: yes. Fiscal committee: yes. State-mandated local program: yes.

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THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. (a) This act shall be known and may be cited as the Essential Trauma and Emergency Care Act.

(b) The Legislature finds and declares all of the following:

(1) Access to trauma and emergency care is hindered by a decrease in the availability of trauma and emergency care services statewide, hospital diversions, a lack of on-call medical specialists, and an inability to provide advanced life support services by first responder agencies which could result in lower institutional costs.

(2) Eighty percent of licensed emergency departments reported losing money during the 1998-99 fiscal year. Losses for those hospitals exceeded $315 million statewide.

(3) Losses to physicians providing emergency and on-call specialty services exceeded $100 million during the 1998-99 fiscal year.

(4) Trauma and emergency care is an essential public service.

SEC. 2. Section 1275.9 is added to the Health and Safety Code, to read:

1275.9. The department, upon consultation with the Emergency Medical Services Authority and local EMS agencies, shall revise regulations concerning the categorization and licensure of emergency departments on or before July 1, 2002. These regulations shall ensure a minimum level of service for critical emergency services, including on-call physician services, provided by ~~an~~ *a* critical emergency service facility, as defined in Section 1797.87.

SEC. 3. Section 1367.13 is added to the Health and Safety Code, to read:

1367.13. (a) Every health care service plan issued, amended, or renewed on or after January 1, 2002, shall contain a provision requiring that reimbursement be provided for initial stabilizing medical services provided to subscribers and enrollees in response to medical emergencies.

(b) For purposes of this section, "initial stabilizing medical services" means that component of emergency medical services that is provided by the EMT-Is, EMT-IIs, and EMT-Ps who first arrive on the scene of the medical emergency and provide any emergency medical services needed to stabilize the medical emergency, other than transport services.

(c) The reimbursement for initial stabilizing medical services pursuant to this section shall be provided to the EMS provider of the services. This reimbursement shall be in addition to any reimbursement that might be provided to the providers of transportation services.

SEC. 4. Section 1797.87 is added to the Health and Safety Code, to read:

1797.87. "Critical emergency service facility" means an emergency department that may include a designated trauma center, designated by a local EMS agency as provided in subdivision (a) of Section 1797.251, that is necessary to meet the needs of the community by maintaining the availability of trauma and emergency services.

SEC. 5. Section 1797.98a of the Health and Safety Code is amended to read:

1797.98a. (a) The fund provided for in this chapter ehall be known as the Maddy Emergency Medical Services (EMS) Fund.

(b) Each county shall establish an emergency medical services fund. The money in the fund shall be available for the reimbursements required by this chapter. The fund shall be administered by each county, except that a county electing to have the state administer its medically indigent services program may also elect to have its emergency medical services fund administered by the state. Costs of administering the fund shall be reimbursed by the

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fund, up to 10 percent of the amount of the fund. All interest earned on moneys in the fund shall be deposited in the fund for disbursement as specified in this section.

(c) The fund shall be utilized to reimburse physicians and surgeons ___nd hospi t n l n_ except as provided in ___h (2),_ *and* hospitals for patients who do not make payment for emergency medical services and for other emergency medical services purposes as determined by each county ___as follows.

___(1) After_ . *After* costs of adminietration, 58 percent of the balance of the money in the fund shall be distributed to physicians and surgeons for emergency services provided by all physicians and surgeons, except those physicians and surgeons employed by county hospitals, in general acute care hospitals that provide basic or comprehensive emergency services up to the time the patient is stabilized, 25 percent of the balance of the fund shall be distributed only to hospitals providing disproportionate trauma and emergency medical care services, and 17 percent of the balance of the fund shall be distributed for other emergency medical services purposes as determined by each county, including, but not limited to, the funding of regional poison controf centers.

___(2) Upon the implementation and funding of t h e critical emergency services program for purposes nf Sectinn 1 7 9 7 251 the fund shall be distributed pursuant to this paragraph rather than paragraph (1) After costs of admini stration, 80 percent of the balance of the money in the fund shall be di stributed to physicians and surgeons, as described in paragraph (1), and the remaining balance of the fund shall he di stributed for other emergency medical service purposes as determined by each county, includi ng, but not limited to, the funding of regional poison control centers__

(d) The continuing source of the money in the fund shall be the penalty assessment made for this purpose, as provided in Section 76000 *of* the Government Code.

(e) A General Fund augmentation may supplement any continuing source of money.

SEC. 6. Section 1797.9833 of the Health and Safety Code is amended to read:

1797.98b. (a) *On* January 1, each county shall report to the Legislature on the implementation and status of the *Maddy* Emergency Medical Services Fund. The report shall include, but not be limited to, all of the following:

(1) The total amount of fines and forfeitures collected, the total amount of penalty assessments collected, and the total amount of penalty assessments deposited into the *Maddy* Emergency Medical Services Fund.

(2) The fund balance and the amount of moneys disbursed under the program to physicians and for other emergency medical services purposes.

(3) The pattern and distribution of claims and the percentage of claims paid to thoee submitted.

(4) The amount of moneys available to be disbursed to physicians, the dollar amount of the total allowable claims submitted, and the percentage at which _such_ these claims were reimbursed.

(5) A statement of the policies, procedures, and regulatory action taken to implement and run the program under this chapter.

(b) (1) Each county, upon request, shall make available to any member of the public the report required under subdivision (a).

(2) Each county, upon requeet, shall make available to any member of the public a lieting of physicians and hospitals that have received reimbursement from the *Maddy* Emergency Medical Services Fund and the amount of the reimbursement they have received. This listing shall be compiled on a semiannual baeis.

SEC. 7. Section 1797.100 of the Health and Safety Code is amended to read:

1797.100. There is in _the_ state government in the California Health and Human Services Agency, the Emergency Medical Services Authority.

SEC. 8. Section 1797.101 of the Health and Safety Code is amended to read:

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1797.101. The Emergency Medical Services Authority shall be headed by the Director of the Emergency Medical Services Authority who shall be appointed by the Governor upon nomination by the Secretary of the California Health and Human Services Agency. The director shall be a physician and surgeon licensed in California pursuant to the provisions of Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code, and who has substantial experience in the practice of emergency medicine.

SEC. 9. Section 1797.107 of the Health and Safety Code is amended to read:

1797.107. (a) The authority shall adopt, amend, or repeal, after approval by the commission and in accordance with the provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, such rules and regulations as may be reasonable and proper to carry out the purposes and intent of this division and to enable the authority to exercise the powers and perform the duties conferred upon it by this division not inconsistent with any of the provisions of any statute of this state.

(b) The authority and the department shall, jointly, adopt regulations to ensure minimum standards for a system of coordinated care by emergency departments, trauma centers, emergency transport services, and nontransport advanced life support services by December 31, 2002.

SEC. 10. Section 1797.108 of the Health and Safety Code is amended to read:

1797.108. (a) Subject to the availability of funds appropriated therefor, the authority may contract with local EMS agencies to provide funding assistance to those agencies for planning, organizing, implementing, and maintaining regional emergency medical services systems.

(b) In addition, the authority may provide special funding to multicounty EMS agencies that serve rural areas with extensive tourism, as determined by the authority, to reduce the burden on the rural EMS agency of providing the increased emergency medical services required due to that tourism.

(c) (1) Each local or multicounty EMS agency receiving funding pursuant to this section shall make a quarterly report to the authority on the functioning of the local EMS system. The authority may continue to transfer appropriated funds to the local EMS agency upon satisfactory operation.

(2) Any single or multicounty EMS agency receiving funds for critical emergency services shall report quarterly to the authority the disbursement of funds utilizing a simplified form developed by the authority.

(d) Subject to the availability of funds appropriated therefor, the authority shall annually contract with single or multicounty EMS agencies to prwide funding assistance to those agencies that designate critical emergency service facilities pursuant to subdivision (a) of Section 1797.251.

SEC. 11. Section 1797.115 is added to the Health and Safety Code, to read:

1797.115. (a) The Critical Emergency Services Facility Fund is hereby created in the State Treasury. The moneys in the fund, upon appropriation by the Legislature, shall be expended by the authority to implement a critical emergency service program in accordance with Section 1797.251.

(b) The total amount of funding for services authorized by this section shall not exceed two hundred million dollars ($200,000,000) annually.

(c) The authority shall allocate funds from the fund to each local EMS agency for designated critical emergency service facilities according to the following formula:

(1) Forty percent of the fund shall be distributed evenly among all counties with a designated critical emergency service facility.

(2) Sixty percent of the fund shall be distributed according to

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population statistics as published by the Department of Finance

local EMS agency *that has an approved plan* for coordinated emergency and trauma care, including designated critical emergency service facilities. Distribution shall be based *on* a statewide assessment by the authority of need after the authority reviews and approves local *EMS* agency designations and plans. The authority shall establish an advisory body comprised of representatives from hospital, physician, nurse, and paramedic associations to review local *EMS* agency plans.

(d) A local EMS agency may not use more than 10 percent of funds allocated to the agency for purposes of this section for the administration of its critical emergency service program.

(e) (1) A hospital, if designated as an a critical emergency service facility, may receive funding for the provision of emergency and trauma services from the local EMS agency. These funds may be uaed only for the continuation of critical emergency services and trauma care and may include reimbursements for on-call physician specialists.

(2) The authority shall establish a funding formula to ensure that emergency care services at a designated hospital are maintained. Factors to be considered in developing the funding formula shall include but not be limited to all of the following:

(A) Geographic isolation.

(B) Number of 911 transports.

(C) Number of paramedic contacts per month.

(D) Number of trauma patients received per month.

(E) Specialty emergency services provided by the hospital.

(F) Number of county indigent visits per month.

(3)

(2) A hospital receiving funding under this section shall demonstrate efficiency in operations to ensure the provision of emergency services to the public based upon minimum standards as established by regulation.

(4)

(3) In order to receive funding under this section, a hospital shall report to both the local EMS agency and the authority the number of patients served and the cost of providing services.

SEC. 12. Section 1797.200 of the Health and Safety Code is amended to read:

1797.200. Each county shall develop an emergency medical services program. Each county shall designate a local EMS agency which shall be the county health department, an agency established and operated by the county, an entity with which the county contracts for the purposes of local emergency medical services administration, or a joint powers agency created for the administration of emergency medical services by agreement between counties or cities and counties pursuant to the provisions of Chapter 5 (commencing with Section 6500) of Division 7 of Title 1 of the Government Code.

SEC. 13. Section 1797.251 is added to the Health and Safety Code, to read:

1797.251. (a) A local EMS agency shall designate a minimum of one sufficient number of hospital emergency department departments or designated trauma center as a critical emergency service centers as critical emergency service facilities necessary to meet the needs of the community. Any acute care hoapital shall be eligible to receive designation as a critical emergency service facility.

(b) *A* local *EMS* agency shall establish a public process to designate hospitals as critical emergency service facilities. Local *EMS* agencies shall consult with local interest groups, including groups that represent consumers, hospitals, physicians, nurses, and paramedics. Factors to be considered in the designation of a hospital as a critical emergency service facility shall include, but not be limited to, all of the following:

(1) Geographic isolation.

(2) Number *of* county indigent, uninsured, and Medi-Cal visits per month.

(3) Specialty emergency services provided by the hospital.
(4) Number of emergency department visits per month.
(5) Number of 911 transports.

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(c) A local EMS agency shall evaluate survey and study the capabilities of hospitals within its jurisdiction to meet emergency services and care needs and periodically review the hospital's capability based upon regulations established by the authority.

(c)

(d) A local EMS agency shall periodically evaluate the service demand of the community and the ability of providers of emergency services and care to meet the demand.

SEC. 14. Section 1797.254 of the Health and Safety Code is amended to read:

1797.254. (a) Local EMS agencies shall annually submit, no later than January 31 of each year, an emergency medical services plan for the EMS area to the authority, according to EMS Systems, Standards, and Guidelines established by the authority.

(b) The plan shall include, but not be limited to, all of the following:

(1) A designation of a minimum of one hospital emergency department or designated trauma center as a critical emergency service facility with the reasons for each designation and the criteria used *in* making each designation

(2) A process for the coordination of the emergency care and trauma system.

(3) A process *for* the distribution of funds to designated facilities, including a percentage allocation *to* each facility.

(4) Information requested from and submitted by hospitals, physicians, ambulance services, and first responders concerning the prior fiscal year that shall include, but not be limited to, the number of patients receiving emergency services and care and the cost of providing the care.

(c) The requirements of subdivision (b) shall become operative January 1, 2003.

SEC. 15. Section 1798.161 of the Health and Safety Code is amended to read:

1798.161. (a) The authority shall adopt regulations specifying minimum standards for the implementation of trauma care systems. These regulations shall provide specific requirements for the care of trauma cases and shall ensure that the trauma care system is fully coordinated with all elements of the existing emergency medical services system. The regulations shall be adopted as provided in Section 1799.50, and shall include, but not be limited to, all of the following:

(I) Prehospital care management guidelines for triage and transportation of trauma cases.

(2) Flow patterns of trauma cases and geographic boundaries regarding trauma and nontrauma cases.

(3) The number and type of trauma cases necessary to assure that trauma facilities will provide quality care to trauma cases referred to them.

(4) The resources and equipment needed by trauma facilities to treat trauma cases.

(5) The availability and qualifications of the health care personnel, including physicians and surgeons, treating trauma cases within a trauma facility.

(6) Data collection regarding system operation and patient outcome.

(7) Periodic performance evaluation of the trauma system and its components.

(b) The authority may grant an exception to a portion of the regulations adopted pursuant to subdivision (a) upon substantiation of need by a local EMS agency that, as defined in the regulations, compliance with that requirement would not be in the best interests of the persons served within the affected local EMS area.

SEC. 16. Section 1798.166 of the Health and Safety Code is repealed.

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SEC. 17. Section 10126.7 is added to the Insurance Code, to read:

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10126.7. (a) Every policy of disability insurance issued, amended, or renewed on or after January 1, 2002, that covers hospital, medical, or surgical benefits shall contain a provision requiring that reimbursement be provided for initial stabilizing medical services provided to any insured or other person covered in response to medical emergencies.

(b) For purposes of this section, "initial stabilizing medical services. means that component of emergency medical services that is prwided by the Em-Is, EMT-IIs, and EMT-Ps who first arrive on the scene of the medical emergency and provide any emergency medical services needed to stabilize the medical emergency, other than transport services.

(c) The reimbursement for initial stabilizing medical services pursuant to this section shall be provided to the EMS provider of the services. This reimbursement shall be in addition to any reimbursement that might be provided to the providers of transportation services.

SEC. 18. Section 14106.6 of the Welfare and Institutions Code is amended to read:

14106.6. (a) The director shall establish and update annually a separate schedule of reimbursement for advanced life support and basic life support ambulance transportation services that are based upon reasonable cost standards of the department and that are not less than 60 percent of the rate applicable to the medicare median allowable charge for the current year for all California providers of advanced life support and basic life support ambulance transportation services.

(b) Notwithstanding any other provision of law, and to the extent federal financial participation is available, any city, county, or special district providing paramedic services as set forth in subdivision (r) of Section 14132, shall reimburse the Health Care Deposit Fund for the state costs of paying the medical claims. Funds allocated to the county from the County Health Services Fund pursuant to former Part 4.5 (commencing with Section 16700) of Division 9 of the Welfare and Institutions Code, as that part read before January 1, 2000, may be utilized by the county or city to make the reimbursement. Nothing in this chapter shall be construed to require a city, county, or special district providing, or contracting for, paramedic services as part of a program established under Article 3 (commencing with Section 1480) of Chapter 2.5 of Division 2 of the Health and Safety Code, to seek Medi-Cal reimbursement for services rendered to eligible Medi-Cal recipients.

(c) This section shall be implemented only to the extent federal financial participation is available.

SEC. 19. Section 14106.65 is added to the Welfare and Institutions Code, to read:

14106.65. (a) Reimbursement shall be made pursuant to this chapter for initial stabilizing medical services in response to medical emergencies. The director shall establish and annually update a separate schedule of reimbursement rates for advanced life support and basic life support initial stabilizing medical services.

(b) The director shall seek the appropriate federal waivers or approval to apply federal funds to the reimbursement of initial stabilizing medical services in response to medical emergencies. Until these federal funds may be applied to reimburse these services, the director shall reduce the reimbursement rates provided under this section by 50 percent.

(c) For purposes of this section, "initial stabilizing medical services' means that component of emergency medical services that is provided by the EMT-Is, EMT-IIs, and EMT-Ps who first arrive on the scene of the medical emergency and provide any emergency medical services needed to stabilize the medical emergency, other than transport services.

(d) The reimbursement for initial stabilizing medical services pursuant to this section shall be provided to the EMS provider of the services. This reimbursement shall be in addition to any

reimbursement that might be provided to the providers of transportation services.

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(e) *Nothing* in this section shall expand or broaden the scope of practice for *paramedics* as prescribed *by* statute or regulation:

SEC. 20. The Emergency Medical Services Authority shall conduct an evaluation of this act to assess its effectiveness in improving and providing support to California's emergency medical and trauma *system.* The authority shall consider access to emergency *room cam and* services, average waiting times for emergency services, access to *oncall* physicians, frequency in which emergency departments practice diversion, the number of emergency department closures, geographic *access* to emergency services, and the financial stability of emergency medical and *trauma* service providers. The authority shall report the evaluation to the chairpersons of the Assembly Committee *on* Budget, the Assembly Health Committee, the Senate Health and Human *Services Committee,* and the Senate Committee on Budget and Fiscal Review by April *1, 2004.*

SEC. 21. (a) The sum of two hundred million dollars ($200,000,000)is hereby appropriated from the General Fund to the Emergency Medical Services Authority to provide funds to single and multicounty EMS agencies that designate critical emergency service facilities pursuant to Section 1797.251 of the Health and Safety Code for services provided by the designated critical emergency facility and the implementation of Section 1797.251 of the Health and Safety code.

(b) The sum of one hundred million dollars ($100,000,000)is hereby appropriated from the General Fund to the Emergency Medical Services Authority. The authority shall distribute the funds to each county that has established a Maddy Emergency Medical Services (EMS) Fund based on the number of county indigent emergency department visits reported during the prior fiscal year.

SEC. 22. No reimbursement is required by this act pursuant to Section *6* of Article XIIIB of the California Constitution for certain costs that may be incurred by a local agency or school district because in that regard this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section *6* of Article XIIIB of the California Constitution.

However, notwithstanding Section 17610 of the Government Code, if the Commission on State Mandates determines that this act contains other costs mandated by the state, reimbursement to local agencies

ATTACHMENT C

STATE FUNDING ACCOUNTS
FOR
PHYSICIANS FOR
EMERGENCY ROOM SERVICES TO
INDIVIDUALS WHO ARE NOT INSURED

There are three distinct funds available to pay physicians for uncompensated emergency services.

The **SB** 12 EMSF, commonly referred to as the Maddy fund, was the first fund. It was optional for the counties to establish this fund. Santa Cruz elected to do this on December 8, 1988. It is funded by surcharges on moving traffic violation fines. Money is collected by the county and deposited into a trust fund. Money in the trust fund is divided into four accounts. Ten percent of the money collected goes to cover overhead expenses. The balance is divided among EMS support (15.3%), physicians (52.2%), and hospitals (22.5%). The Physician Account funds are available to doctors that provide emergency services in a hospital with an emergency room after certain conditions are met. The basic conditions are that the physician has made a good faith billing effort, has not received any payment whatsoever, and 90 days have passed. These requirement are waived if the physician has specific information the account will not be paid or the account is unbillable, e.g., mail return for bad address. Physicians are paid on a percentage of charge basis up to a maximum of 50% of charges. Only services provided within the first 48 hours of the onset of the emergency condition qualify for reimbursement. Payments from the fund are not fiscal year specific. As a matter of policy, we only let allow claims for services provided within the previous 18 months of billing.

When Proposition 99 (tobacco tax) was passed, enabling legislation created the California Healthcare for Indigents Program. CHIP funds are divided into three accounts: Hospital, Physicians and Unallocated. Within the Physician Account, after allowing 10% for overhead, the remaining funds are divided into two subaccounts, one of which is an EMSF. These funds are deposited into the CHIP Trust Fund. The CHIP EMSF references the Maddy EMSF in its structure and purpose. However, the CHIP EMSF expanded coverage to non-emergency obstetric and pediatric services provided in any location. Providers were also required to provide patient demographic data with their claims so the information could be included in the Medically Indigent Care Reporting System (MICRS). However, a loophole was provided so demographic data submission is not mandatory. Nevertheless, all patients benefiting from CHIP EMSF must be registered on the COSTAR ana their services authorized to generate MICRS data. CHIP EMSF funds can only be used to reimburse physicians for services provided within the fiscal year the funds are allocated. Like the Maddy EMSF, payments are prorated based on available funds and cannot exceed 50% of the billed amount.

The Emergency Medical Services Appropriation (EMSA) was established during **FY** 00-01 as a one year effort to provided additional funding for uncompensated hospital-based emergency care provided by physicians. It was reauthorized for **FY** 01-02 but its future is not clear given the state's budgetary problems. This is an elective program in which the county chose to participate. Money from the EMSA must be deposited in the Maddy EMSF Trust Fund but accounted for separately. Unlike the Maddy EMSF, the EMSA money can only be spent on services provided during the fiscal year for which the money was allocated. Expenditures of EMSA funds must be reported under MICRS so all patients must be registered and services authorized. Additionally, trust fund reports and utilization statistics must be reported separately to the state. Because the state used Proposition 99 funds to support EMSA rather than general fund money, the EMSA financing is structured like CHIP with three separate accounts: Hospital, Physician and Unallocated. Nevertheless, all the accounts are used to pay physicians for hospital-based emergency services. Claims must be artificially allocated among the three accounts to satisfy state reporting requirements. There is no provision to pay for obstetric and pediatric services as with the CHIP EMSF. The **48** hour limitation on eligibility for reimbursement for emergency services imposed on the Maddy EMSF does not apply to the EMSA.

Management of the three funds has become increasing complex and cumbersome. CHIP EMSF and EMSF funds are generally not available until half way through the fiscal year because of the lag involved with execution of Standard Agreements and the release of funds by the Department of Finance. Maddy EMSF funds are more flexible because of their local availability and not being fiscal year specific. However, balancing of the payments levels between the funds is difficult because of the timing of state payments and fiscal year issues. Administratively, we try to balance payments across the funds to avoid advantaging or disadvantaging providers based the funding source. There is also a problem with tracking expenditures with the potential for payment having come from any of the three funds. With quarterly payment processing there has been a problem with providers rebilling uncompensated emergency services. This makes the system very vulnerable to duplicate payments. Tracking tracer claims is also a time consuming problem.