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New Jersey's grade for emergency medicine lowered by troubling lack of support for emergency care and hostile medical liability environment

TRENTON, N.J., January 16, 2014 – The state of New Jersey received a D+ for its emergency care environment in the 2014 National Report Card on the State of Emergency Medicine, dropping 13 places in national rankings since the last Report Card in 2009. The grade represents high marks for *Public Health and Injury Prevention*; fair grades in *Quality and Patient Safety Environment* and *Disaster Preparedness*, but dismal assessments of the state's *Access to Emergency Care* and *Medical Liability Environment*.

The report, findings of a comprehensive three-year study conducted by the American College of Emergency Physicians (ACEP), measures the efforts of states to develop policies and legislation in support of emergency medicine systems. New Jersey received two Fs, two C+s, and a B in the five categories, ranking the state 30th nationally in how well states' laws and legislators support emergency care for residents.

Dr. David Adinaro, president of the New Jersey Chapter of the American College of Emergency Physicians, is not surprised by the report's findings.

"The 2014 Report Card highlights the concerns that emergency physicians have been raising with our legislators for years," Dr. Adinaro said. "We want to work with New Jersey policy makers to prioritize emergency medicine. We are here for anyone, anytime; providing care with the pressures of shrinking resources and increasing demands."

Below average numbers of emergency physicians, extremely high emergency room wait times, and a hostile liability environment are among the factors cited by the report for New Jersey's low rankings – 36th in *Access to Emergency Care* and 44th in *Medical Liability Environment*. The state's best grade, a B, is for *Public Health and Injury Prevention*.

"The health and wellbeing of our residents are at stake, but the things we are doing right – laws that preserve our low traffic fatality rate, and disaster preparedness – indicate our challenges are not insurmountable," said Dr. Adinaro. "We have to continue to focus on strong medical liability reform and fair Medicaid reimbursement. Taking these actions would strengthen emergency care in New Jersey."

The American College of Emergency Medicine, which issues the report, is the national medical specialty society representing emergency medicine with more than 27,000 members, and chapters in every state including New Jersey.

# # #

New Jersey

D+

New Jersey fell 13 places, to 30th, due to worsening scores in *Access to Emergency Care* and the *Quality and Patient Safety Environment*. At the same time, the state has failed to significantly improve its poor *Medical Liability Environment*.

Strengths. New Jersey's strongest performance was in *Public Health and Injury Prevention*, in part because of strong state policies that require child safety seat and adult seatbelt use, prohibit texting and cell phone use while driving, prohibit smoking at worksites and in bars and restaurants, and require helmets for all motorcycle riders. These policies have likely played a critical role in the low traffic fatality rate (4.6 per 100,000 people), high rate of seat belt use (94.5%), and low proportion of adult smokers (16.8%) in the state.

While New Jersey's *Disaster Preparedness* grade has remained the same since 2009, the state's ranking has moved up 13 places due to improvements in a number of areas. The state has incorporated special needs patients, patients dependent on dialysis, and mental health patients into its medical response plans, and bed surge capacity has significantly improved since 2009 (from 201.2 to 655.6 per 1 million people). New Jersey is one of only 11 states that have a state budget line item for disaster preparedness funding specific to health care surge.

New Jersey must work harder to attract providers of all types to meet growing health care needs of its population.

Challenges. New Jersey's *Access to Emergency Care* has hit a tipping point. The state ranks among the lowest for many measures related to hospital capacity, financial barriers, and availability of providers. It has below-average rates of emergency physicians (11.8 per 100,000 people), ranking 33rd in the nation. The state has below-average rates of neurosurgeons; ear, nose, and throat specialists; and registered nurses. Additionally, New Jersey has one of the highest hospital occupancy rates (74.5%) and a below-average number of staffed inpatient beds (287.2 per 100,000). These factors have likely contributed to the long wait times in the emergency department (ED): The median time from ED arrival to ED departure for admitted patients is 355 minutes, or 5.9 hours, putting New Jersey at 47th nationally.

Despite the persistent need to recruit and retain health care providers, New Jersey's *Medical Liability Environment* has changed little since 2009. The state has some of the highest average medical liability insurance premiums for physicians and specialists and falls well below average in the number of insurers writing policies (3.7 compared with 11.0 insurers per 1,000 physicians nationally). In addition, the number of malpractice award payments has increased more than threefold since the previous Report Card (3.5 versus 1.0 per 100,000 people). New Jersey lacks pretrial screening panels, periodic payments, and medical liability caps on non-economic damages, all of which would contribute to lessening the burden on physicians and increasing access to care.

While New Jersey continues to support the same practices and policies that resulted in a positive showing in 2009, the addition of new indicators in *Quality and Patient Safety* has revealed that the state is about average for many quality measures, such as the percentage of hospitals with computerized practitioner order entry (81.3%) and with electronic medical records (91%). More than half of New Jersey's hospitals collect data on patient race or ethnicity and primary language (65.3%).

Recommendations. New Jersey must work harder to attract providers of all types to meet the growing health care needs of its population and improve overall *Access to Emergency Care*. The state needs to act immediately to alleviate those issues that contribute to crowding and boarding in the ED, including high hospital occupancy rates, hospital closures, and lack of specialists. Compounding these problems, New Jersey has failed to increase Medicaid fees to an adequate level, as currently it pays only 40% of the national average, representing a slight increase since 2007. Grossly inadequate Medicaid fees will continue to make it difficult to recruit and retain vital specialists in the state.

	2009		2014	
	Rank	Grade	Rank	Grade
Access to Emergency Care	16	C	36	F
Quality & Patient Safety Environment	11	A-	19	C+
Medical Liability Environment	50	F	44	F
Public Health & Injury Prevention	13	B	11	B
Disaster Preparedness	26	C+	13	C+
OVERALL	17	C+	30	D+

To aid in addressing issues of access to quality emergency care, New Jersey needs to implement medical liability reforms aimed at lowering insurance premiums and reducing excessive malpractice award payments. The state should enact special liability protection for providers of emergency care mandated by the Emergency Medical Treatment and Labor Act who assume significant risks in providing immediate, lifesaving care to patients, often with no knowledge of their medical history. New Jersey should also consider apology inadmissibility laws, pretrial screening panels, and required periodic payments of awards.

While New Jersey fared well in *Public Health and Injury Prevention* overall, racial and ethnic health disparities persist in infant mortality rates, cardiovascular disease, and HIV diagnoses. For instance, the state has the fourth highest infant mortality disparity ratio, despite having the eighth lowest infant mortality rate, with non-Hispanic black infants 4.5 times more likely to die in their first year than Asians and Pacific Islanders (who had the lowest rate). The state should consider taking action to improve health equity and reduce disparities for these and all racial and ethnic groups.

ACCESS TO EMERGENCY CARE	F
Board-certified emergency physicians per 100,000 pop.	9.5
Emergency physicians per 100,000 pop.	11.8
Neurosurgeons per 100,000 pop.	1.5
Orthopedists and hand surgeon specialists per 100,000 pop.	9.7
Plastic surgeons per 100,000 pop.	2.7
ENT specialists per 100,000 pop.	3.1
Registered nurses per 100,000 pop.	884.9
Additional primary care FTEs needed per 100,000 pop.	0.1
Additional mental health FTEs needed per 100,000 pop.	0.0
% of children able to see provider	94.2
Level I or II trauma centers per 1M pop.	1.1
% of population within 60 minutes of Level I or II trauma center	100.0
Accredited chest pain centers per 1M pop.	1.1
% of population with an unmet need for substance abuse treatment	6.6
Pediatric specialty centers per 1M pop.	2.6
Physicians accepting Medicare per 100 beneficiaries	2.9
Medicaid fee levels for office visits as a % of the national average	40.0
% change in Medicaid fees for office visits (2007 to 2012)	16.8
% of adults with no health insurance	17.3
% of adults underinsured	8.0
% of children with no health insurance	9.4
% of children underinsured	20.7
% of adults with Medicaid	8.2
Emergency departments per 1M pop.	7.6
Hospital closures in 2011	1
Staffed inpatient beds per 100,000 pop.	287.2
Hospital occupancy rate per 100 staffed beds	74.5
Psychiatric care beds per 100,000 pop.	25.3
Median minutes from ED arrival to ED departure for admitted patients	355
State collects data on diversion	N/A

MEDICAL LIABILITY ENVIRONMENT	F
Lawyers per 10,000 pop.	22.7
Lawyers per physician	0.7
Lawyers per emergency physician	19.2
ATRA judicial hellholes (range 2 to -6)	-1
Malpractice award payments/ 100,000 pop.	3.5
Average malpractice award payments	$352,610
Databank reports per 1,000 physicians	23.7
Provider apology is inadmissible as evidence	No
Patient compensation fund	No
Number of insurers writing medical liability policies per 1,000 physicians	3.7
Average medical liability insurance premium for primary care physicians	$19,724
Average medical liability insurance premium for specialists	$83,053
Presence of pretrial screening panels	No
Pretrial screening panel's findings admissible as evidence	N/A
Periodic payments	No
Medical liability cap on non-economic damages	None
Additional liability protection for EMTALA-mandated emergency care	No
Joint and several liability abolished	Yes
Collateral source rule, provides for awards to be offset	Yes
State provides for case certification	Yes
Expert witness must be of the same specialty as the defendant	Yes
Expert witness must be licensed to practice medicine in the state	No

QUALITY & PATIENT SAFETY ENVIRONMENT	C+
Funding for quality improvement within the EMS system	No
Funded state EMS medical director	No
Emergency medicine residents per 1M pop.	20.9
Adverse event reporting required	Yes
% of counties with E-911 capability	100.0
Uniform system for providing pre-arrival instructions	Yes
CDC guidelines are basis for state field triage protocols	Yes (2011)
State has or is working on a stroke system of care	Yes
Triage and destination policy in place for stroke patients	Yes
State has or is working on a PCI network or a STEMI system of care	Yes
Triage and destination policy in place for STEMI patients	Yes
Statewide trauma registry	No
Triage and destination policy in place for trauma patients	Yes
Prescription drug monitoring program (range 0-4)	2
% of hospitals with computerized practitioner order entry	83.1
% of hospitals with electronic medical records	91.0
% of patients with AMI given PCI within 90 minutes of arrival	91
Median time to transfer to another facility for acute coronary intervention	81
% of patients with AMI who received aspirin within 24 hours	99
% of hospitals collecting data on race/ ethnicity and primary language	65.3
% of hospitals having or planning to develop a diversity strategy/plan	51.6

PUBLIC HEALTH & INJURY PREVENTION	B
Traffic fatalities per 100,000 pop.	4.6
Bicyclist fatalities per 100,000 cyclists	5.6
Pedestrian fatalities per 100,000 pedestrians	5.1
% of traffic fatalities alcohol related	36
Front occupant restraint use (%)	94.5
Helmet use required for all motorcycle riders	Yes
Child safety seat/seat belt legislation (range 0-10)	8
Distracted driving legislation (range 0-4)	4
Graduated drivers' license legislation (range 0-5)	2
% of children immunized, aged 19-35 months	79.1
% of adults aged 65+ who received flu vaccine in past year	61.3
% of adults aged 65+ who ever received pneumococcal vaccine	65.6
Fatal occupational injuries per 1M workers	19.7
Homicides and suicides (non-motor vehicle) per 100,000 pop.	11.4
Unintentional fall-related fatal injuries per 100,000 pop.	4.7
Unintentional fire/burn-related fatal injuries per 100,000 pop.	0.7
Unintentional firearm-related fatal injuries per 100,000 pop.	0.1
Unintentional poisoning-related fatal injuries per 100,000 pop.	9.3
Total injury prevention funds per 1,000 pop.	$35.74
Dedicated child injury prevention funding	No
Dedicated elderly injury prevention funding	No
Dedicated occupational injury prevention funding	No
Gun-purchasing legislation (range 0-6)	4.5
Anti-smoking legislation (range 0-3)	3
Infant mortality rate per 1,000 live births	4.8
Binge alcohol drinkers, % of adults	18.2
Current smokers, % of adults	16.8
% of adults with BMI >30	23.7
% of children obese	10.0
Cardiovascular disease disparity ratio	2.9
HIV diagnoses disparity ratio	21.0
Infant mortality disparity ratio	4.5

DISASTER PREPAREDNESS	C+
Per capita federal disaster preparedness funds	$6.98
State budget line item for health care surge	Yes
ESF-8 plan shared with all EMS and essential hospital personnel	Yes
Emergency physician input into the state planning process	Yes
Public health and emergency physician input during an ESF-8 response	Yes
Drills, exercises conducted with hospital personnel, equipment, facilities per hospital	0.4
Accredited by the Emergency Management Accreditation Program	Yes
Special needs patients in medical response plan	Yes
Patients on medication for chronic conditions in medical response plan	No
Medical response plan for supplying dialysis	Yes
Mental health patients in medical response plan	Yes
Medical response plan for supplying psychotropic medication	No
Mutual aid agreements with behavioral health providers	None
Long-term care and nursing home facilities must have written disaster plan	Yes
State able to report number of exercises with long-term care or nursing home facilities	Yes
"Just-in-time" training systems in place	Statewide
Statewide medical communication system with one layer of redundancy	Yes
Statewide patient tracking system	No
Statewide real-time or near real-time syndromic surveillance system	Yes
Real-time surveillance system in place for common ED presentations	Statewide
Bed surge capacity per 1M pop.	655.6
ICU beds per 1M pop.	225.4
Burn unit beds per 1M pop.	3.2
Verified burn centers per 1M pop.	0.1
Physicians in ESAR-VHP per 1M pop.	34.6
Nurses in ESAR-VHP per 1M pop.	279.2
Behavioral health professionals in ESAR-VHP per 1M pop.	14.8
Strike teams or medical assistance teams	Yes
Disaster training required for essential hospital, EMS personnel	No
Liability protections for health care workers during a disaster (range 0-4)	3
% of RNs received disaster training	34.9

NR = Not reported
N/A = Not applicable

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NATIONAL REPORT CARD ON THE STATE OF EMERGENCY MEDICINE Q & A SHEET

- **What grade did the State of New Jersey receive in the 2014 Report Card?** New Jersey was given a D+.

- **Who gives the grade?** The American College of Emergency Physicians is the national organization dedicated to the advancement of quality emergency care in the United States and the foremost authority on developments and trend in the field.

- **What does the grade mean?** ***The Report Card is NOT an assessment of the work emergency physicians do.*** It is an excellent tool to measure if and how our lawmakers are supporting emergency care in New Jersey.

  - It contains recommendations at the state and national levels to address critical problems and improve support for emergency patients.

  - It contains 136 measures that reflect the most recent data available from high-quality sources, such as the CDC and HHS.

  - It evaluates conditions under which emergency care is being delivered — not the quality of care provided by hospitals and emergency providers.

  - It was developed by a task force of emergency physicians and other experts who gathered and analyzed data for more than 2 years.

  - It reviews environments in all 50 states and the District of Columbia, plus Puerto Rico and Government Services, which includes military and veteran's health care systems.

- **What does the Report Card measure?** The Report Card measures are organized in 5 categories:

  - **Access to emergency care (30 percent of the grade)** Access is a large percentage of the total grade because it measures capacity and barriers to care that directly affect patients. Indicators include:

    - Number of emergency physicians and emergency departments in the state
    - Number of staffed inpatient beds
    - The extent of resources states have for primary care and mental health

- Emergency department wait times and hospitals closures

- **Quality and patient safety (20 percent)** Increasing pressures on the emergency care system are affecting quality of patient care. Indicators include:

  - Whether states are funding quality improvements
  - Percentage of hospitals with electronic medical records
  - Whether states have operational and effective prescription drug monitoring programs
  - Percentage of hospitals with computerized practitioner order entry
  - Whether states have trauma registries
  - How states are faring with national quality measures, such as the percentage of heart attack patients receiving aspirin within 24 hours.

- **Medical liability environment (20 percent)** Billions of dollars in defensive medicine are driving up the costs of health care for everyone and harming patients. Indicators include:

  - Average malpractice awards, and whether states have medical liability caps on non-economic damages
  - The number of lawyers, and whether states have liability protections for EMTALA-related care
  - Whether states are considered "judicial hellholes." "Hellholes" are defined by the American Tort Reform Association as "places where judges systematically apply laws and court procedures in an unfair and unbalanced manner, generally against defendants in civil lawsuits."

- **Public health and injury prevention (15 percent)** Nearly one-third of all emergency visits are for injury-related causes. Indicators include:
  - Whether states are funding injury prevention efforts
  - Numbers of traffic and pedestrian fatalities and fatal falls and unintentional poisonings, including drug overdoses.
  - Whether states have distracted driver legislation and how comprehensive their laws are regarding child safety seat/seat belt legislation.
  - Number of fatal fire/burn-related injuries and number of unintentional firearm-related fatal injuries

- **Disaster preparedness (15 percent)** The threat of terrorism or an ordinary flu season can suddenly and dramatically flood the nation's ERs. The medical response after the bombings in Boston highlighted the very best of emergency medicine and the extraordinary value that it provides. Indicators include:

  - Levels of federal funding received by each state for disaster preparedness
  - Number of training and drills, bed surge capacity, including burn beds and intensive care beds
  - Whether states have disaster plans to care for special needs patients and long-term care patients
  - Whether emergency physician have input into state planning
  - Whether states have communication and tracking systems.

- **What are the issues of primary importance to New Jersey emergency physicians?** While all the issues raised in the Report Card are of grave importance to our ability to serve our patients, some are specific to our state.

  - Access to emergency care
  - Medical liability environment

- **Why are these issues important?**
  - There is a lot of uncertainty about health care reform in the US.

  - Emergency departments are the ONLY departments of the health care system that are ALWAYS open.

  - Health insurance coverage does NOT equal access to medical care. Millions are being added to Medicaid, but where will they go, given shortages in primary care and that many physicians do not see Medicaid patients?

  - Emergency visits are going to increase, despite health care reform. Emergency visits have increased at twice the rate of the U.S. population, and the need for emergency care will grow as our population ages and lives longer. From 1995 to 2010, there has been a 34-percent increase in emergency visits

  - Medicaid enrollment will be affected by the number of states that choose NOT to expand coverage.

- **What is the desired outcome?** Members of Congress need to hold a hearing about the findings of this Report Card.

  - The nation's emergency physicians are calling on President Obama and Congress to make emergency patients a top priority.

  - The Institute of Medicine reports in 2006 confirmed that emergency departments are fragmented and stretched to the breaking point. Research from the United States Government Accountability Office and the CDC and many other sources have confirmed these issues and proposed solutions. The RAND report in 2012 said that emergency physicians are coordinating patient care and filling critical gaps in our health care system. It's time for Congress to address these issues.

  - It is taken for granted that emergency care will always be available, but it is the number one service that everyone depends on in their hour of need.

  - Policymakers must make it a national priority to strengthen emergency departments. There were more than 130 million emergency visits in 2010 or 247 visits per minute.

  - The passing of the following pieces of legislation in New Jersey:

  - The raising of the following issues in the New Jersey Legislature:

  - The two previous Report Cards made a significant difference in many states. For example, they contributed to:
    - New emergency medicine residency programs in Oklahoma and Kansas
    - Funding for a statewide trauma system in Arkansas

- Enactment of liability protections for EMTALA-related care in Arizona
- Passage of a motorcycle helmet law in Maine
- Increased awareness of emergency medicine issues among state lawmakers

- **How do this year's Report Card measures compare to the 2009 Report Card?** There are many direct comparisons between the 2014 Report Card and the 2009 Report Card.

  - The methods used to grade the states are the same, and states are graded in both Report Cards in relation to other states, so the grades are not an absolute measure.

  - 108 of 116 measures in the 2009 Report Card are retained in the 2014 Report Card. (A few measures were retired because data were no longer available or they were no longer pertinent to the overall Report Card. There also are 28 new measures.)

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David Adinaro MD, MAEd, FACEP
Chief of Adult Emergency Services, St. Joseph's Regional Medical Center

Dr. Adinaro is an emergency physician and the Chief of Adult Emergency Services at St. Joseph's Regional Medical Center in Paterson, NJ. In addition he is actively involved in medical education as a Clinical Assistant Professor at New York Medical College and as the Residency Research Director at St. Joseph's.

He is the current President of the New Jersey chapter of the American College of Emergency Physicians and writes the blog: PatersonER.com.

Dr. Adinaro is a graduate of Lehigh University (BA), Seton Hall University (MAEd) and the University of Medicine and Dentistry-New Jersey Medical School (MD). He is currently enrolled in a Masters of Healthcare Systems Engineering at Lehigh University.

Shelley Greenman MD, FACEP
Assistant Professor of Emergency Medicine, Cooper University Hospital

Dr. Greenman is an Assistant Professor of Emergency Medicine at Cooper University Hospital. She joined the Cooper team in 1992. In addition she is actively teaching Emergency Medicine residents at the new Cooper Medical School of Rowan University.

She is the President-Elect of the New Jersey chapter of the American College of Emergency Physicians (NJ-ACEP) and administers the NJ-ACEP Facebook page. Dr. Greenman is actively involved in the National organization of ACEP. She is a current member of the Membership Committee, the Steering Committee, and past Chair and current member of the Wellness Committee.

Dr. Greenman is a graduate of Brandeis University (BA) and the University of Medicine and Dentistry-New Jersey Medical School (MD). She is dual boarded in internal medicine and emergency medicine completing her residencies in internal medicine at Montefiore Medical Center and Jacobi Medical Center both in the Bronx, NY.

Dr. Mark Rosenberg, DO, MBA, FACEP, FACOEP
Chair of Emergency Medicine, St. Joseph's Healthcare System

Dr. Mark Rosenberg, DO, MBA, FACEP, FACOEP-D is Chair of Emergency Medicine and Chief of Geriatric Emergency Medicine and Palliative Medicine at St Joseph's Healthcare System in Paterson, New Jersey. In those positions he oversees the emergency care of more than 150,000 adults and children annually. His department also supports several Emergency Medicine Fellowship programs including EMS/Disaster, Emergency Bedside Ultrasound, Administrative Management and a Pediatric EM Fellowship. In addition, Dr. Rosenberg created

the Emergency Department-based Resuscitation Center of Excellence, Geriatric Emergency Department, Emergency Department-based Palliative Care Program (Life Sustaining Management and Alternatives), Physician Incentive Plan, and the Physician Triage and Front End Patient flow management.

Dr. Rosenberg serves as an executive board member for the American College of Osteopathic Emergency Physicians, chairman of the Geriatric Emergency and the Palliative Medicine Sections of the American College of Emergency Physicians, and on the executive board of directors of the New Jersey Chapter of the American College of Emergency Physicians.

Dr. Rosenberg is board certified in Emergency Medicine by American Osteopathic Board of Emergency Medicine and the American Board of Emergency Medicine (ABEM), and certified in Hospice and Palliative Medicine by the ABEM. He received his MBA in Medical Management specializing in Physician Compensation Strategies.

What are the Biggest Drivers of Health Care Costs?

According to the Kaiser Family Foundation, the three biggest drivers of rising health care costs are (1) technology, (2) prescription drugs, and (3) chronic disease. In 2008, the Congressional Budget Office (CBO) stated:[14]

"... On the basis of a review of the economic literature, [the CBO] concludes that about half of all growth in health care spending in the past several decades was associated with changes in medical care made possible by advances in technology.... Major advances in medical science have allowed health care providers to diagnose and treat illnesses in ways that were previously impossible. Many new services are very costly; others are relatively inexpensive but raise aggregate costs quickly as ever-growing numbers of patients use them."

Spending on prescription drugs will continue to be a cost issue, related to the aging population and the costs of prescription drugs. According to the Kaiser Family Foundation, the increases in prescription drug costs *"have outpaced other categories of health care spending, rising rapidly throughout the latter half of the 1990s and early 2000s. While the rate of growth in spending has slowed somewhat, it is projected to exceed the growth rates for hospital care and other professional services in 2010 and through 2019."*[15]

According to the Milken Institute, *"More than 109 million Americans report having at least one of the seven [chronic] diseases, for a total of 162 million cases....The total impact of these diseases on the economy is $1.3 trillion annually....On our current path, in 2023 we project a 42 percent increase in cases of the seven chronic diseases....Lower obesity rates alone could produce productivity gains of $254 billion and avoid $60 billion in treatment expenditures per year."*[16]

Defensive Medicine in the ER

According to the PricewaterhouseCoopers' Health Research Institute,[17] the top three areas of waste in the health care system are (1) defensive medicine (estimated at $210 billion nationally/year), (2) inefficient claims processing (up to $210 billion nationally/year), and (3) care spent on preventable conditions related to obesity ($200 billion nationally/year).[18]

Reducing the practice of defensive medicine in emergency departments could result in significant cost savings. Emergency departments care for the most severely ill and injured patients who are most at risk of dying. In order to avoid potential lawsuits, physicians will order a test out of fear of being sued for NOT ordering the test. Nearly 50 percent of emergency physicians responding to an ACEP poll said diagnostic testing was the largest expense on a patient's emergency department bill, and nearly half (44 percent) said the fear of lawsuits is the biggest challenge to cutting emergency department costs.[19]

Medical liability reform would help cut costs by reducing the amount of defensive medicine practiced by emergency physicians and other physicians treating patients in emergency departments. Liability issues are especially relevant in New Jersey, as the American College of Emergency Physicians gave our state an "F" for its malpractice environment in The National Report Card on the State of Emergency Medicine.[20]

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Emergency Care: Preserving New Jersey's Safety Net

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It Must Be There When You Need It.

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SAFE PRACTICE, SAFE CARE
New Jersey State Council

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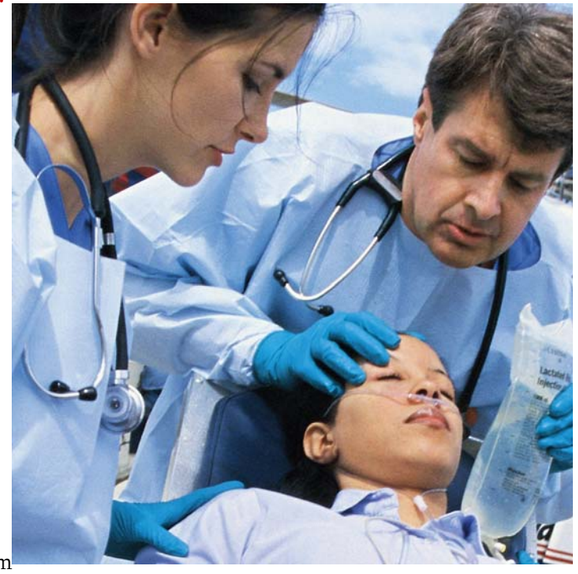
NEW JERSEY HOSPITAL ASSOCIATION

How is Emergency Care different?

Emergency care is a unique form of medical care, different from many other medical specialties. Emergency physicians utilize multiple resources on a daily basis within a hospital, such as diagnostic testing and consultation by other medical specialists, to respond to the emergency at hand. These physicians set the course of a patient's diagnosis and treatment, including what happens after a patient has been admitted to the hospital, and coordinate the further care of patients who can be discharged home directly from the emergency department.

However, the reality of the nation's population demographics, as well as physician shortages and an analysis of those seeking emergency care, show that dissuading patients from using emergency departments is not likely to be an effective strategy. Emergencies are *not* scheduled events. Policymakers and health care stakeholders must take patient needs into account during these emergencies as they develop new paradigms for how health care will be provided in the future.

Are Most Emergency Visits Really "Unnecessary"?

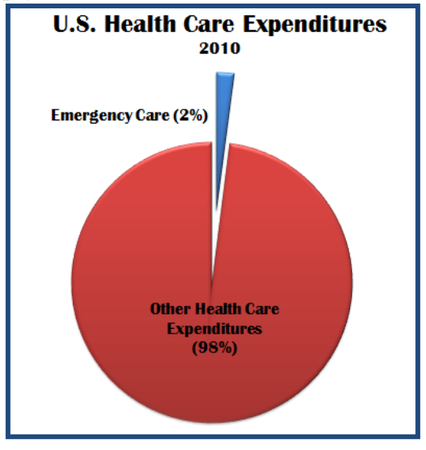


Emergency medicine is essential to New Jersey, providing lifesaving and critical care to millions of patients within the state each year, and most of the visits are necessary. In 2010, there were nearly 4 million visits to the state's 73 emergency departments. This was a 7% increase between 2009 and 2010.[1] Many of these visits occurred after business hours and on weekends and holidays when doctors' offices were closed.

In general, 92% of emergency visits are from very sick patients who need care within 1 minute to 2 hours.[2] The number of emergency patients seeking care for nonurgent medical conditions dropped to less than 8% in 2007 and has continued to drop since 2005 when it was at 13.9 percent. The Centers for Disease Control and Prevention (CDC) defines "nonurgent" as "needing care in 2 to 24 hours." According to the CDC, "The term 'nonurgent' does not imply an unnecessary visit."

The fastest-growing segment of the U.S. population is patients over age 85. The rates of emergency visits by the elderly are increasing more rapidly than for any other group, and research has predicted this will lead to catastrophic overcrowding within our emergency departments.[3] Elderly patients tend to be sicker and are more likely to be admitted from the emergency department to the hospital than other emergency patients.

Patients are often sent to the emergency department by their primary care doctors. Ninety-seven percent of emergency physicians responding to an ACEP poll reported that patients are referred daily to their ERs by primary care physicians.[4]



What Percentage of Health Care Expenditures is Emergency Care?

The need to reduce health care costs is clear. Health care expenditures currently represent more than 16 percent of the U.S. gross domestic product. Between 1990 and 2008, health care expenditures increased more than three times.

Yet there are misconceptions about the costs and efficiencies of emergency rooms and "unnecessary" care. According to U.S. government statistics, emergency care represents less than 2 percent (1.9 percent)[5] of the $2.4 trillion spent on health care. [6] While it may cost more for patients to visit an emergency department than to visit a physician's office, the total cost is small relative to the entire health care system. Unlike a physician's office, emergency departments have all the diagnostic resources available 24 hours a day, seven days a week, 365 days a year, and the availability and use of this equipment contribute to the costs of care.

Breaking Down the Costs of a Visit to the ER

The costs of providing emergency care correspond to the severity of a patient's illness or injury. The expenses will be higher when extensive diagnostic testing is necessary, such as when an emergency physician must treat a patient quickly without knowing the person's medical history (e.g., allergies, medical problems, recent medical procedures), which is often the case.

In New Jersey, over 58% of hospital inpatient admissions originated in the emergency department.[7] The resulting expenses may include fees for on-call specialists, the pharmacy and other hospital services involved in the diagnosis and treatment of a patient. Physician consultations and medical tests are expedited and conducted in a few hours (instead of a patient being referred to multiple medical providers over several days or weeks). With all of these components in mind, the major line items within an emergency department invoice is not directly comparable to an invoice from a primary care physician's office. The expenses will include charges for all services provided in the emergency department, including physician services. The fee for an emergency physician's services on an emergency department invoice is typically about 20 to 25 percent of the total charges for a visit. Hospital facility fees usually represent about two-thirds of the expense.

Charity Care and the Emergency Room

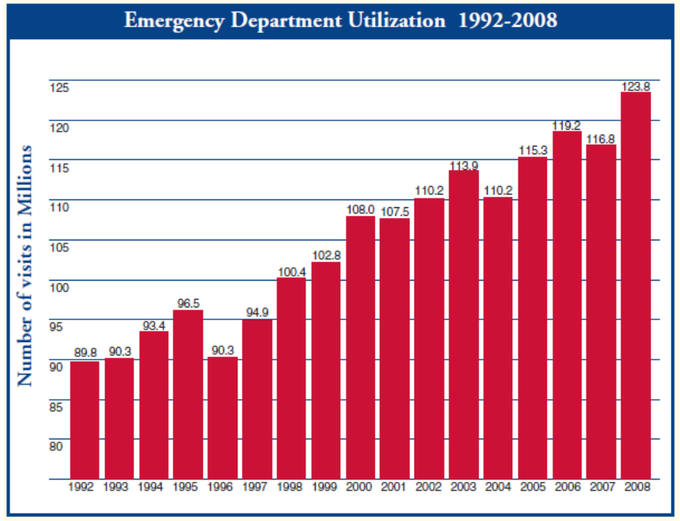
New Jersey has over 1,000 emergency medicine physicians[8] who treat patients of all ages and all incomes. Unlike other medical providers, emergency physicians never turn patients away, primarily because of a moral and ethical obligation — but also because the federal government mandates that all patients receive treatment regardless of their ability to pay.[9] Since the passage of the Emergency Medical Treatment and Labor Act in 1985,[10] the most significant economic issue in emergency medicine has been uncompensated care.

Emergency physicians provide 4 to 10 times more charity care than any other physician specialist

According to the American Medical Association, emergency physicians provide four to 10 times more charity care than any other physician specialist.[11] Charity care provided to uninsured patients and poor reimbursement by insurance plans, both private and public, strain ERs that care for increasing numbers of patients. In 2010, approximately 20.6% of nonelderly adults in New Jersey did not have health insurance.[12] Therefore, it is not surprising that nearly half of emergency services go uncompensated.[13]

How Does the Health Exchange Impact Emergency Patients?

The new health care reform law will add more people to the Medicaid rolls in New Jersey, which could reduce the rate of uninsured patients visiting emergency departments. However, since health insurance coverage does not guarantee access to medical care, many more people may seek care in emergency departments if they cannot find physicians who accept Medicaid. Finding physicians in any specialty who accept Medicaid will likely become more difficult due to New Jersey Medicaid low reimbursement rates.



Urgent Care Centers vs. Emergency Department

Despite the growth of urgent care centers in America, emergency visits continue to increase. Part of the reason is because urgent care centers are not substitutes for emergency care. While urgent care centers can treat common medical problems when a physician's office is closed or unable to provide an appointment, they don't have the same equipment or trained staff that emergency departments keep ready on demand.