

ACEP STATE OF EMERGENCY MEDICINE REPORT CARD

METHODOLOGY

The report card was assembled in four steps. First, ACEP appointed a task force of experts, which developed 50 appropriate criteria for evaluation through careful consideration of all the available data. The most difficult constraint was finding data collected in a consistent manner for all the states. In some cases, additional and more effective metrics could have been used, but these data were not available in all states and therefore would not allow for comparison. In fact, federal and state governments could help the cause of emergency medicine through better and more consistent data collection. In a few cases, data sets were used, despite having gaps in a few states, because government officials in those states were able to fill in the gaps. In the end there were less than 20 gaps out of thousands of data points, which did not have a significant effect on the final grades.

Second, the task force divided the criteria into the four broad categories for which grades would be calculated. It was recognized that not all categories or criteria are equal, so percentage weightings were assigned to reflect this. The four categories and their percentage of the final grade are as follows: access (40%); quality and patient safety (25%); public health and safety (10%); and medical liability environment (25%). Each of the 50 criteria was also assigned percentage weightings, which sum to the weighting of their category. These percentages are shown in the list of criteria in the next section below. A state's overall grade is the average of these four grades

Third, the performance of each state for each of the 50 criteria was compared and points awarded. In most cases, states were ranked from top to bottom, with the top state receiving 51 points (51 because the District of Columbia is included with the states). In the case of criteria that involve a yes/no answer, 51 points were awarded for a "yes" answer. Points for each criterion then were multiplied by the percentage weightings, and then added to determine each state's total points in each of the four categories.

Fourth, the states' point totals then were compared on a modified "curve" basis. Each state's total was compared with the total of the highest state in that category. This means that no state has been judged on the basis of an abstract "ideal" performance, but rather on the basis of what has been achieved by the best state.

The grades then were allocated as follows:

- States within 80% of the top state score received an "A"
- States within 70% of the top state score received a "B"
- States within 50% of the top state score received a "C"
- States within 30% of the top state score received a "D"
- States below 30% of the top state score received an "F"

The above scale was chosen to be consistent across all of the four categories and to offer a generous range in which states could earn a good grade. States in the top or bottom third of each letter grade range received a "+" or "-" grade, accordingly.

In summary, the report card grading methodology was developed objectively, using data from governments and major medical associations and collecting it consistently across all states. State support for emergency medicine was not judged based on an abstract ideal, but on the basis of support provided by the highest scoring state. The percentage grade allocations were generous. For example, a state within 50 percent of what the highest scoring state achieved would still receive a “C.” Grade allocations were applied in the same way to all four categories. All the data used in the evaluation were included in the state’s report card, and all the sources for this data are listed in the table at the end of this report.

ACEP gathered the best data available, but there were shortcomings. For example, there were many metrics that could have been measured for which data simply were not available. In a few cases, the most recent data were several years old . To maintain consistency of the report card, the data published in official government reports were used, even though a state-by-state review might have led to updating specific data points in the government reports.

Finally, all states have unique circumstances worthy of consideration when grading the four categories. Discussion of these circumstances are included in the narrative sections of the report cards, but space constraints made it impossible to include them all.

Understanding the Criteria and Weightings

Individual criteria were given percentage allocations, as follows:

Access 40%

- Number of emergency departments per 1 million people
- Annual visits per emergency department
- Board certified emergency physicians per 100,000 people
(Note: Physicians must be board certified; osteopathic doctors certified in emergency medicine are included.)
- Number of registered nurses per 1,000 population
- Number of hospital staffed beds per 1,000 population
- ✕ • Annual per capital expenditure on hospital care
- ✕ • Percentage of population that does not have health insurance
- ✕ • Annual payments per fee-for-service enrollee in Medicare
- ✕ • Annual state Medicaid expenditures per population under 65
- ✕ • Annual SCHIP state contribution per 1,000 population under 18
- Trauma centers per 1 million population
(Note: Includes Level 1 and 2 trauma centers.)

Quality and Patient Safety 25%

- Emergency medicine residents per 1,000,000 people:
(Note: Osteopathic residents in emergency medicine are included.)
- Emergency medicine programs at medical schools and osteopathic programs in emergency medicine:
- Percentage of population with access to Advanced Life Support ambulance services:
- Percentage of pre-hospital personnel with access to online medical direction:

- Percentage of population with access to Enhanced 9-1-1 services (location identification from where the call is placed)
- Use of CDC Preventative Health and Health Services Block Grants for Emergency Medical Services
- Training offered statewide to hospital personnel for response to: (a) disasters, (b) biological attacks, and (c) chemical attacks
- State requirements for hospitals to submit data on diversions

Public Health and Safety 10%

Traffic Safety and Drunk Driving:

- Primary seatbelt law
- Traffic fatalities per 100,000 licensed drivers
- Percentage of fatalities in which no restraint was used
- Helmet use required for all motorcycle riders?
- Total killed in alcohol-related crashes per 100,000 population
- Alcohol-related fatalities as a percentage of all auto crash fatalities
- Substance abuse clients in specialty treatment units (per 100,000 population)

Immunization:

- Percent of children age 19-35 months who are immunized
- Percent of adults aged 65 and over who received an influenza vaccine in the last 12 months (2002)
- Percent of adults aged 65 and over who have ever received a pneumococcal vaccine

Early Prenatal Care:

- Percent of live births with early prenatal care (beginning in the 1st trimester)

Injury Rates:

Fatal occupational injuries per 1 million population

Injury Prevention Programs:

Unintentional injury prevention programs

- Fall Prevention Program
- Fire-related Injury Prevention Program
- Child Safety Seat Non-Users Intervention Program

Intentional injury prevention programs

- Violence Prevention Program for High-Risk Youth
- Intimate Partner Violence and Sexual Violence Prevention Program

State law enforcement special unit or designated personnel to address

- (a) domestic violence
- (b) child abuse

Medical Liability Environment 25%

Caps on non-economic damages:

Breakdown:

- \$250,000 hard cap on non-economic damages
- \$250,001 - \$350,000 hard cap on non-economic damages
- \$350,001- \$500,000 hard cap on non-economic damages
- Any other kind of cap on non-economic damages

Liability protection for emergency care

Pretrial screening panels

Expert witness rules

Joint liability reform

Collateral source reform

Patient compensation reform (extra credit amount)

Increase in physicians' medical liability insurance rates 2001-2004

Increase in specialists' medical liability insurance rates 2001-2004

Notes on the criteria – Most of the above criteria are self-explanatory, but in a few cases it is important to clarify meanings of terms and how the criteria grades were counted:

- “Emergency physicians” are defined as emergency physicians who are board certified by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine..
- “SCHIP” is the State Children's Health Insurance Program.
- “Trauma centers” are defined as Level 1 and 2 trauma centers.
- “Non-economic damages” are damages awarded in a medical liability lawsuit, other than for quantifiable costs, such as medical bills and lost wages – also called “pain and suffering.” Only “hard” caps are counted, which means that caps with exceptions are not included. An example of a cap that is not “hard” is when a judge or jury may allow the cap to be exceeded in severe cases. Also, caps in states that require physicians to contribute to patients' compensation funds are not counted as hard caps, since these often-expensive contributions are, in effect, insurance for claims payments that exceed the caps. States with these funds do receive credit for having “any other kind of cap” plus an extra credit point.
- “Expert witness rules” are a legal requirement that says any expert testimony against a board certified physician may only come from another physician who is board certified in the same area.
- “Increases in medical liability insurance rates” are the unweighted average of all insurance companies rates for that type of physician, for all regions, for a given year. The “specialists” rate is the unweighted average of rates for general surgeons and obstetricians.

State of Emergency Medicine Questions and Answers

NATIONAL

Q: Why did ACEP develop a Report Card? What was the real goal?

- ACEP's mission is to improve emergency care across the United States. The Report Card provides a comprehensive view of the state of emergency medicine in all 50 states and the District of Columbia.
- The Report Card is a tool for understanding the problems, so that effective solutions can be targeted.
- The Report Card establishes a baseline for measuring future progress over time.

Q: Why hasn't ACEP – or anyone - done this kind of report before?

- ACEP has conducted issue-specific research and reported on those findings. This Report Card is the first comprehensive and objective analysis of state support for emergency care.
- The development of a report card is a massive undertaking. The data collection involved literally hundreds of sources. The data analysis took hundreds of hours.

Q: Explain how the grades were developed? What standards did you measure against? Why are some measures given more value than others?

- ACEP convened a blue-ribbon task force of experts to examine the issues. They categorized four areas for measurement: access to emergency care, quality and patient safety, public health and safety, and the medical liability environment.
- The task force decided some categories were more critical than others and weighted the categories:
 - Access: 40%
 - Quality and patient safety: 25%
 - Public health and safety: 10%
 - Medical liability environment: 25%
- Grades were calculated in each category, and each state's overall grade is the average of the category grades. States were compared with each other, on the basis of what has been achieved by the best state, not an abstract "ideal." Each state's total points were compared with the total of *the highest state in that category*.
- States in the top or bottom third of each letter grade range also received a "+" or "-" grade.
- The grades were objectively calculated by an independent consultant and not subject to review.

Q: What trends did you see? Any surprises?

- We were not surprised to find that wealthier states had some advantages in providing emergency care; however, the advantage was not as large as one might assume. Several lower-income states showed strong support for emergency care and earned high grades.
- The Report Card revealed significant challenges, as well as positive signs in every category measured.

State of Emergency Medicine Questions and Answers

Q: Are you saying emergency departments are not safe?

- Emergency physicians provide high-quality care for their patients. They are dedicated to improving patient safety, which is why ACEP developed this Report Card.
- The Report Card focuses on whether state laws and policies are supporting emergency care systems, not on specific emergency departments or physicians.
- Emergency physicians ARE concerned when most emergency departments are operating “at” or “over capacity, when emergency departments are closing, and on-call specialists or nurses are no longer available.

Q: What’s new? Everyone knows emergency departments are overcrowded and lack resources.

- The Report Card is the first state-by-state analysis of the state of emergency medicine in America.
- The problem is getting worse, and patients are suffering. [Insert patient story: For example, in Palm Beach, Florida, there are no more neurosurgeons in the county. A woman had a stroke, and it took 11 hours to identify a hospital in another county to treat her. She died.]

Q: If the situation is so dire, why aren’t more people concerned?

- People ARE concerned. A public opinion poll conducted earlier this year found that seven in 10 Americans believe emergency departments are approaching a crisis because of overcrowding. Another poll found almost three-quarters of Americans support legislation to reform the nation’s medical liability system.
- People expect emergency care to be there when they need it. Unfortunately, that is no longer true. But unless you’ve been to an emergency department in the past year, you may not know how these issues are affecting your ability to get care.
- We hope this Report Card serves as a “wake up” call to the public, as well as to our state and national leaders to reverse these trends and preserve emergency care for all.

Q: Who is responsible for the failures reported in ACEP’s report card?

- We all are responsible for fixing the system.
- ACEP is urging Congress to pass the *Access to Emergency Medical Services Act of 2005* (H.R. 3875), introduced by Rep. Bart Gordon (D-TN) and Rep. Pete Sessions (R-TX). The bill would:
 - Recognize hospital emergency departments as the backbone of our nation’s health care safety net.
 - Provide hospitals with incentives to end boarding of admitted patients in emergency departments — to help end gridlock and save lives during natural disasters and acts of terrorism.
 - Extend liability protection to on-call specialists and emergency physicians who provide EMTALA-mandated care.
- Consumers can show their support by going to www.acep.org and sending an electronic message to Congress in support of the legislation.

Q: Isn’t the real issue that doctors are not providing good care?

State of Emergency Medicine Questions and Answers

- The grades are not evaluations of physicians or hospital emergency departments. They reflect the policy efforts of states to support effective emergency medicine systems.
- Doctors provide excellent care – the question is, can patients access it?

Q: What are ACEP's solutions?

- ACEP supports the *Access to Emergency Medical Services Act of 2005*, H.R. 3875) that would:
 - Recognize hospital emergency departments as the backbone of our nation's health care safety net.
 - Provide hospitals with incentives to end boarding of admitted patients in emergency departments — help end gridlock and save lives during natural disasters and acts of terrorism.
 - Extend liability protection to on-call specialists and emergency physicians who provide EMTALA-mandated care to the uninsured.
- ACEP supports HR 5 (medical liability reform), which has passed the House and awaits Senate action.
- ACEP recognizes that state solutions are effective and supports efforts in all 50 states and the District of Columbia to improve emergency care.

Q: Why should Congress be involved? Can't hospitals fix these problems?

- Members of Congress care when their constituents are unable to obtain emergency care.
- The problem is national in scope and requires a Federal response. Members of Congress enacted the SCHIP program, Medicaid and Medicare. They have the responsibility to adequately fund these and other programs.
- Hospitals are our partners in finding solutions to these problems.
- We must all work together to ensure that every patient has access to emergency care when they need it.

Q: When will ACEP release the next Report Card?

- In about two to three years, when there is something new to report.
- State and national policymakers need time to improve their grades – for example, it can take several years to enact a law.

Q: What can the public do?

- Visit www.acep.org and send a message to Congress in support of H.R.3875.
- Emergency physicians are asking the public to urge their members of Congress to preserve their access to emergency care.

State of Emergency Medicine Questions and Answers

STATE QUESTIONS

Q: What does this mean in [State]?

- ACEP State Chapters will use the grades to support their advocacy efforts.
- Policy solutions will be different in each state, tailored to each Chapter's advocacy agenda.

Q: [State] scored in the bottom of three categories. Isn't this an indictment of our state[governor/legislator]?

- The Report Card is a wake up call to state and national leaders. It should motivate them to act. We look forward to working with them.
- The grades are not evaluations of people. They reflect the policy efforts of states to support effective emergency medicine systems.
- Because this data has not been collected or compared before, we expect people to be shocked by the results. And to act.
- [insert positive or negative statements about state key officials, depending on the Chapter advocacy agenda]

Q: Isn't it unfair to blame smaller states with fewer resources?

- ACEP compared state grades with state wealth and population density and looked for trends.
- While wealthier states had some advantages, it was not as large as one might assume. Several lower income states showed strong policy support for emergency care and earned high grades.
- ACEP expected areas with the most urban sprawl to be experiencing more strain in providing emergency medicine. Surprisingly, we found no correlation.
- There are many exceptions, but states with lower population densities generally faced greater deficits in emergency care.
- ACEP is urging state policymakers to carefully review their state's Report Card to identify problem areas and take steps.
- All states have ample room for improvement, and it is hoped this Report Card will motivate progress and promote improvement of emergency care across the United States.

Q: What advice can you give to a state with huge budget shortfalls, which can't provide more funding to Medicaid or the emergency care system?

- Emergency care is an essential public service that must be funded.
- ACEP is urging legislative solutions to save money – such as liability reform.
- Congress placed a federal responsibility on hospital emergency departments to care for all patients, regardless of ability to pay. This is an unfunded mandate that is affecting everyone's access to emergency care.