AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 204
(A-24)

Introduced by: Florida

Subject: Staffing Ratios in the Emergency Department

Referred to: Reference Committee B

Whereas, the Emergency Department is the medical safety net for the nation and provides care to vulnerable patients who may not otherwise have access to primary or specialty medical care; and

Whereas, in many states, physicians are the only health professionals authorized to practice medicine in the Emergency Department without limitation; and

Whereas, every patient presenting to an Emergency Department should be under the direct, real-time care of a licensed physician, including the on-site and real-time supervision of non-physician practitioners (NPPs); and

Whereas, state laws vary on the number of nurse practitioners and physician assistants that a physician can supervise, with some states having no limits at all; and

Whereas, a 2022 NBER paper using data from the VA shows that nurse practitioners working without supervision in the Emergency Department resulted in increased lengths of stay, increased costs, increased 30-day re-admissions, and increased mortality rates among the higher acuity patients. Nursing literature also supports that NPs should not be working unsupervised in the ED; and

Whereas, in an increasing number of states, most Emergency Physicians are employed by corporate staffing groups with private equity backing seeking to maximize profit through understaffing physicians and replacing them with non-physician practitioners (NPPs); and

Whereas, the staffing ratio of NPPs to physicians at any given time in the Emergency Department determines whether a physician has time to adequately supervise and see the patients being cared for by the NPPs; therefore be it

RESOLVED, that our American Medical Association seek federal legislation or regulation prohibiting staffing ratios that do not allow for proper supervision of NPPs in the Emergency Department (Directive to Take Action); and be it further

RESOLVED, that our AMA seek federal legislation or regulation that would require all Emergency Departments to be staffed 24-7 by a qualified physician. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 4/9/2024

References:

1. Chan, D. and Chen, Y. The Productivity of Professions: Evidence from the Emergency Department, National Bureau of Economic Research, Working Paper 30608, Oct 2022. https://www.nber.org/papers/w30608
2. Proffitt Lavin, R PhD FNP-BC FAAN, et al. Analysis of Nurse Practitioners' Educational Preparation, Credentialing, and Scope of Practice in U.S. Emergency Departments. Journal of Nursing Regulation, Vol 12, Issue 4, P50-62, Jan 01, 2022. https://www.journalofnursingregulation.com/article/S2155-8256(22)00010-2/fulltext
3. Updated Position Statement on Non-Physician Practitioners. AAEM - American Academy of Emergency Medicine. Accessed April 12, 2023. https://www.aaem.org/resources/statements/position/updated-advanced-practice-providers
4. American Academy of Emergency Medicine (AAEM) paper on guidelines for safe patients per hour and NPP supervision limits…in process

Relevant AMA Policy

Promoting Supervision of Emergency Care Services in Emergency Departments by Physicians D-35.976
Our AMA will advocate for the establishment and enforcement of legislation and/or regulations that ensure only physicians supervise the provision of emergency care services in an emergency department. [Res. 218, A-23]

Principles for Strengthening the Physician-Hospital Relationship H-225.957
The following twelve principles are AMA policy:

PRINCIPLES FOR STRENGTHENING THE PHYSICIAN-HOSPITAL RELATIONSHIP

1. The organized medical staff and the hospital governing body are responsible for the provision of quality care, providing a safe environment for patients, staff and visitors, and working continuously to improve patient care and outcomes, with the primary responsibility for the quality of care rendered and for patient safety vested with the organized medical staff. These activities depend on mutual accountability, interdependence, and responsibility of the organized medical staff and the hospital governing body for the proper performance of their respective obligations.
2. The organized medical staff, a self-governing organization of professionals, possessing special expertise, knowledge and training, discharges certain inherent professional responsibilities by virtue of its authority to regulate the professional practice and standards of its members, and assumes primary responsibility for many functions, including but not limited to: the determination of organized medical staff membership; performance of credentialing, privileging and other peer review; and timely oversight of clinical quality and patient safety.
3. The leaders of the organized medical staff, with input from the hospital governing body and senior hospital managers, develop goals to address the healthcare needs of the community and are involved in hospital strategic planning as described in the medical staff bylaws.
4. Ongoing, timely and effective communication, by and between the hospital governing body and the organized medical staff, is critical to a constructive working relationship between the organized medical staff and the hospital governing body.
5. The organized medical staff bylaws are a binding, mutually enforceable agreement between the organized medical staff and the hospital governing body. The organized medical staff and hospital bylaws, rules and regulations should be aligned, current with all applicable law and accreditation body requirements and not conflict with one another. The hospital bylaws, policies and other governing documents do not conflict with the organized medical staff bylaws, rules, regulations and policies, nor with the organized medical staff's autonomy and authority to self govern, as that authority is set forth in the governing documents of the organized medical staff. The organized medical staff, and the hospital governing body/administration, shall, respectively, comply with the bylaws, rules, regulations, policies and procedures of one another. Neither party is authorized to, nor shall unilaterally amend the bylaws, rules, regulations, policies or procedures of the other.
6. The organized medical staff has inherent rights of self governance, which include but are not limited to:

a) Initiating, developing and adopting organized medical staff bylaws, rules and regulations, and amendments thereto, subject to the approval of the hospital governing body, which approval shall not be unreasonably withheld. The organized medical staff bylaws shall be adopted or amended only by a vote of the voting membership of the medical staff.
b) Identifying in the medical staff bylaws those categories of medical staff members that have voting rights.
c) Identifying the indications for automatic or summary suspension, or termination or reduction of privileges or membership in the organized medical staff bylaws, restricting the use of summary suspension strictly for patient safety and never for purposes of punishment, retaliation or strategic advantage in a peer review matter. No summary suspension, termination or reduction of privileges can be imposed without organized medical staff action as authorized in the medical staff bylaws and under the law.
d) Identifying a fair hearing and appeals process, including that hearing committees shall be composed of peers, and identifying the composition of an impartial appeals committee. These processes, contained within the organized medical staff bylaws, are adopted by the organized medical staff and approved by the hospital governing board, which approval cannot be unreasonably withheld nor unilaterally amended or altered by the hospital governing board or administration. The voting members of the organized medical staff decide any proposed changes.
e) Establishing within the medical staff bylaws: 1) the qualifications for holding office, 2) the procedures for electing and removing its organized medical staff officers and all organized medical staff members elected to serve as voting members of the Medical Executive Committee, and 3) the qualifications for election and/or appointment to committees, department and other leadership positions.
f) Assessing and maintaining sole control over the access and use of organized medical staff dues and assessments, and utilizing organized medical staff funds as appropriate for the purposes of the organized medical staff.
g) Retaining and being represented by legal counsel at the option and expense of the organized medical staff.
h) Establishing in the organized medical staff bylaws, the structure of the organized medical staff, the duties and prerogatives of organized medical staff categories, and criteria and standards for organized medical staff membership application, reapplication credentialing and criteria and processing for privileging. The standards and criteria for membership, credentialing and privileging shall be based only on quality of care criteria related to clinical qualifications and professional responsibilities, and not on economic credentialing, conflicts of interest or other non-clinical credentialing factors.
i) Establishing in the organized medical staff bylaws, rules and regulations, clinical criteria and standards to oversee and manage quality assurance, utilization review and other organized medical staff activities, and engaging in all activities necessary and proper to implement those bylaw provisions including, but not limited to, periodic meetings of the organized medical staff and its committees and departments and review and analysis of patient medical records.
j) The right to define and delegate clearly specific authority to an elected Medical Executive Committee to act on behalf of the organized medical staff. In addition, the organized medical staff defines indications and mechanisms for delegation of authority to the Medical Executive Committee and the removal of this authority. These matters are specified in the organized medical staff bylaws.
k) Identifying within the organized medical staff bylaws a process for election and removal of elected Medical Executive Committee members.
l) Defining within the organized medical staff bylaws the election process and the qualifications, roles and responsibilities of clinical department chairs. The Medical Executive Committee must appoint any clinical chair that is not otherwise elected by the vote of the general medical staff.
m) Enforcing the organized medical staff bylaws, regulations and policies and procedures.
n) Establishing in medical staff bylaws, medical staff involvement in contracting relationships, including exclusive contracting, medical directorships and all hospital-based physician contracts, that affect the functioning of the medical staff.

7. Organized medical staff bylaws are a binding, mutually enforceable agreement between the organized medical staff and the hospital governing body, as well as between those two entities and the individual members of the organized medical staff.
8. The self-governing organized medical staff determines the resources and financial support it requires to effectively discharge its responsibilities. The organized medical staff works with the hospital governing board to develop a budget to satisfy those requirements and related administrative activities, which the hospital shall fund, based upon the financial resources available to the hospital.
9. The organized medical staff has elected appropriate medical staff member representation to attend hospital governing board meetings, with rights of voice and vote, to ensure appropriate organized medical staff input into hospital governance. These members should be elected only after full disclosure to the medical staff of any personal and financial interests that may have a bearing on their representation of the medical staff at such meetings. The members of the organized medical staff define the process of election and removal of these representatives.
10. Individual members of the organized medical staff, if they meet the established criteria that are applicable to hospital governing body members, are eligible for full membership on the hospital governing body. Conflict of interest policies developed for members of the organized medical staff who serve on the hospital's governing body are to apply equally to all individuals serving on the hospital governing body.
11. Well-defined disclosure and conflict of interest policies are developed by the organized medical staff which relate exclusively to their functions as officers of the organized medical staff, as members and chairs of any medical staff committee, as chairs of departments and services, and as members who participate in conducting peer review or who serve in any other positions of leadership of the medical staff.
12. Areas of dispute and concern, arising between the organized medical staff and the hospital governing body, are addressed by well-defined processes in which the organized medical staff and hospital governing body are equally represented. These processes are determined by agreement between the organized medical staff and the hospital governing body. [Res. 828, I-07 Reaffirmed in lieu of Res. 730, A-09 Modified: Res. 820, I-09 Reaffirmed: Res. 725, A-10Reaffirmation A-12 Reaffirmed: CMS Rep. 6, I-13 Reaffirmed: CMS Rep. 5, A-21]

Supervision and Proctoring by Facility Medical Staff H-375.967
Our AMA advocates that the conduct of medical staff supervision be included in medical staff bylaws and be guided by the following principles:
(1) Physicians serving as medical staff supervisors should be indemnified at the facility's expense from malpractice claims and other litigation arising out of the supervision function.
(2) Physicians being supervised should be indemnified at the facility's expense for any damages that might occur as a result of implementing interventions recommended by medical staff supervisors.
(3) AMA principles of peer review as found in Policies H-320.968 [2,d], H-285.998 [5], and H-320.982 [2c,d] should be adhered to in the conduct of medical staff supervision.
(4) The medical staff member serving as supervisor should be determined through a formal process by the department chair or medical staff executive committee.
(5) The scope of the medical staff supervision should be limited to the provision of services that have been restricted, are clearly questionable, or are under question, as determined by the department chair or medical staff executive committee.
(6) The duration of the medical staff supervision should be limited to the amount of time necessary to adequately assess the degree of clinical competence in the area of skill being assessed.
(7) Medical staff supervision should include a sufficient volume of procedures or admissions for meaningful assessment.
(8) Medical staff supervisors should provide periodic performance reports on each patient to the appropriate designated medical staff committee. The reports should be transcribed or transcripted by the medical staff office to assure confidentiality. The confidentiality of medical staff supervision reports must be strictly maintained.
(9) Physicians whose performance is supervised should have access to the performance reports submitted by medical staff supervisors and should be given the opportunity to comment on the contents of the reports. [CMS Rep. 3, A-99 Reaffirmed: CLRPD Rep. 1, A-09 Reaffirmed: CMS Rep. 01, A-19]

Medical Staff Development Plans H-225.961
All hospitals/health systems incorporate the following principles for the development of medical staff development plans: (a) The medical staff and hospital/health system leaders have a mutual responsibility to: cooperate and work together to meet the overall health and medical needs of the community and preserve quality patient care; acknowledge the constraints imposed on the two by limited financial resources; recognize the need to preserve the hospital/health system's economic viability; and respect the autonomy, practice prerogatives, and professional responsibilities of physicians. (b) The medical staff and its elected leaders must be involved in the hospital/health system's leadership function, including: the process to develop a mission that is reflected in the long-range, strategic, and operational plans; service design; resource allocation; and organizational policies. (c) Medical staffs must ensure that quality patient care is not harmed by economic motivations. (d) The medical staff should review and approve and make recommendations to the governing body prior to any decision being made to close the medical staff and/or a clinical department. (e) The best interests of patients should be the predominant consideration in granting staff membership and clinical privileges. (f) The medical staff must be responsible for professional/quality criteria related to appointment/reappointment to the medical staff and granting/renewing clinical privileges. The professional/quality criteria should be based on objective standards and the standards should be disclosed. (g) The medical staff should be consulted in establishing and implementing institutional/community criteria. Institutional/community criteria should not be used .inappropriately to prevent a particular practitioner or group of practitioners from gaining access to staff membership. (h) Staff privileges for physicians should be based on training, experience, demonstrated competence, and adherence to medical staff bylaws. No aspect of medical staff membership or particular clinical privileges shall be denied on the basis of sex, race, age, creed, color, national origin, religion, disability, ethnic origin sexual orientation, gender identity or physical or mental impairment that does not pose a threat to the quality of patient care. (i) Physician profiling must be adjusted to recognize case mix, severity of illness, age of patients and other aspects of the physician's practice that may account for higher or lower than expected costs. Profiles of physicians must be made available to the physicians at regular intervals. [BOT Rep. 14, A-98Modified: BOT Rep. 11, A-07Reaffirmation A-10Modified: CMS Rep. 01, A-20]

Credentialing and the Quality of Care H-225.971
It is the policy of the AMA: (1) that the hospital medical staff be recognized within the hospital as the entity with the overall responsibility for the quality of medical care; (2) that hospital medical staff bylaws reaffirm The Joint Commission standard that medical staffs have "overall responsibility for the quality of the professional services provided by individuals with clinical privileges"; (3) that each hospital's quality assurance, quality improvement, and other quality-related activities be coordinated with the hospital medical staff's overall responsibility for quality of medical care; (4) that the hospital governing body, management, and medical staff should jointly establish the purpose, duties, and responsibilities of the hospital administrative personnel involved in quality assurance and other quality-related activities; establish the qualifications for these positions; and provide a mechanism for medical staff participation in the selection, evaluation, and credentialing of these individuals; (5) that the hospital administrative personnel performing quality assurance and other quality activities related to patient care report to and be accountable to the medical staff committee responsible for quality improvement activities; (6) that the purpose, duties, responsibilities, and reporting relationships of the hospital administrative personnel performing quality assurance and other quality-related activities be included in the medical staff and hospital corporate bylaws; (7) that the general processes and policies related to patient care and used in a hospital quality assurance system and other quality-related activities should be developed, approved, and controlled by the hospital medical staff; and (8) that any physician hired or retained by a hospital to be involved solely in medical staff quality of care issues be credentialed by the medical staff prior to employment in the hospital. [BOT Rep. T, I-92Reaffirmed: CMS Rep. 10, A-03Modified: CMS Rep. 4, A-13 Reaffirmed: CMS Rep. 5, A-21]

On-Call Physicians H-130.948
Our AMA:

(1) strongly encourages physicians and hospitals to work collaboratively to develop solutions based on adequate compensation or other appropriate incentives as the preferred method of ensuring on-call coverage and will monitor and oppose any state legislative or regulatory efforts mandating emergency room on-call coverage as a requirement for medical staff privileges and state licensure that are not supported by the state medical association;
(2) advocates that physician on-call coverage for emergency departments be guided by the following principles:
(a) The hospital and physicians should jointly share the responsibility for the provision of care of emergency department patients.
(b) Every hospital that provides emergency services should maintain policies to ensure appropriate on-call coverage of the emergency department by medical staff specialists that are available for consultation and treatment of patients.
(c) The organization and function of on-call services should be determined through hospital policy and medical staff by-laws, and include methods for monitoring and assuring appropriate on-call performance.
(d) Physicians should be provided adequate compensation for being available and providing on-call and emergency services.
(e) Hospital medical staff by-laws and emergency department policies regarding on-call physicians' responsibilities must be consistent with Emergency Medical Treatment and Active Labor Act (EMTALA) requirements.
(f) Medical staffs should determine and adopt protocols for appropriate, fair, and responsible medical staff on-call coverage.
(g) Hospitals with specialized emergency care capabilities need to have a means to ensure medical staff responsibility for patient transfer acceptance and care.
(h) Hospitals that lack the staff to provide on-call coverage for a particular specialty should have a plan that specifies how such care will be obtained.
(i) The decision to operate or close an emergency department should be made jointly by the hospital and medical staff;
(3) supports the enforcement of existing laws and regulations that require physicians under contract with health plans to be adequately compensated for emergency services provided to the health plans' enrollees; and
(4) supports the enactment of legislation that would require health plans to adequately compensate out-of-plan physicians for emergency services provided to the health plans' enrollees or be subject to significant fines similar to the civil monetary penalties that can be imposed on hospitals and physicians for violation of EMTALA. [CMS Rep. 3, I-99 Reaffirmation A-00Modified: Sub. Res. 217, I-00 Reaffirmation I-01Reaffirmation A-07Appended and Reaffirmed: CMS Rep. 1, I-09 Modified: Res. 818, I-17]

Professional Nurse Staffing in Hospitals H-360.986
The AMA: (1) encourages medical and nursing staffs in each facility to closely monitor the quality of medical care to help guide hospital administrations toward the best use of resources for patients;
(2) encourages medical and nursing staffs to work together to develop and implement in-service education programs and promote compliance with established or pending guidelines for unlicensed assistive personnel and technicians that will help assure the highest and safest standards of patient care;
(3) encourages medical and nursing staffs to use identification mechanisms, e.g. badges, that provide the name, credentials, and/or title of the physicians, nurses, allied health personnel, and unlicensed assistive personnel in facilities to enable patients to easily note the level of personnel providing their care;
(4) encourages medical and nursing staffs to develop, promote, and implement educational guidelines for the training of all unlicensed personnel working in critical care units, according to the needs at each facility; and
(5) encourages medical and nursing staffs to work with hospital administrations to assure that patient care and safety are not compromised when a hospital's environment and staffing are restructured. [BOT Rep. 11, I-96Reaffirmed: CMS Rep. 8, A-06Reaffirmed: CMS Rep. 01, A-16]

Supervision of Non-Physician Practitioners by Physicians D-35.978

Our AMA will advocate: (1) to ensure physicians on staff receive written notification when their license is being used to document supervision of non-physician practitioners; (2) that physician supervision should be explicitly defined and mutually agreed upon; (3) for advanced notice and disclosure to the physician before they are hired or as soon as practicably known by provider organizations and institutions that anticipate physician supervision of non-physician practitioners as a condition for physician employment; (4) that organizations, institutions, and medical staffs that have physicians who participate in supervisory duties for non-physician practitioners have processes and procedures in place that have been developed with appropriate clinical physician input; and (5) that physicians be able to report professional concerns about care provided by the non-physician practitioners to the appropriate leadership with protections against retaliation. [
Res. 017, I-22]

Emergency Department Boarding and Crowding H-130.940
Our AMA:

1. congratulates the American College of Emergency Physicians for developing and promulgating solutions to the problem of emergency department boarding and crowding;
2. supports collaboration between organized medical staff and emergency department staff to reduce emergency department boarding and crowding;
3. supports dissemination of best practices in reducing emergency department boarding and crowding;
4. continues to encourage entities engaged in measuring emergency department performance (e.g., payers, licensing bodies, health systems) to use evidence-based, clinical performance measures that enable clinical quality improvement and capture variation such as those developed by the profession through the Physician Consortium for Performance Improvement;
5. continues to support physician and hospital use and reporting of emergency medicine performance measures developed by the Physician Consortium for Performance Improvement; and
6. continues to support the harmonization of individual physician, team-based, and facility emergency medicine performance metrics so there is consistency in evaluation, methodology, and limited burden associated with measurement. [CMS Rep. 3, A-09Reaffirmed: CMS Rep. 01, A-19Reaffirmed: BOT Rep. 16, A-19]

Managed Care Organizations' Use of Physicians to Provide Second Opinions to Physicians Providing Emergency Services H-285.950
The AMA adopts the following principles to guide the use by managed care plans of physicians employed or contracted with to specifically provide second opinions to physicians providing emergency services.
The AMA encourages managed care plans to follow these guidelines when employing or contracting with physicians to provide second opinions to physicians providing emergency services.
(1) All managed care plans shall disclose to their enrollees and prospective enrollees any plan requirements or the existence of contractual arrangements whereby physicians are required to provide second opinions to physicians providing emergency services regarding the care provided to patients presenting at emergency departments or facilities.
(2) The required use of physicians to provide second opinions to physicians providing emergency services regarding the care provided to patients presenting at emergency departments or facilities shall not impede the immediate diagnosis and therapy of acute cardiac, trauma, and other critical patient situations for which delay may result in death or an increase in severity of illness.
(3) Any physician with a contractual arrangement to provide second opinions to physicians providing emergency services regarding the care provided to patients presenting at emergency departments or facilities shall be licensed to practice medicine and actively practicing emergency medicine in the same state in which the second opinion is provided.
(4) Any physician with a contractual arrangement to provide second opinions to physicians providing emergency services regarding the care provided to patients presenting at emergency departments or facilities shall have active staff privileges in any facility in which the second opinion is provided.
(5) To the degree possible, patients presenting at an emergency department or facility should be involved in the decisions regarding the treatment, referral, and follow-up care for their condition.

(6) In the event of disagreements over second opinions, final decisions regarding the treatment, referral, and follow-up care provided to patients presenting at emergency departments or facilities shall be made by the attending emergency physician or other appropriate physicians on staff at the facility. [CMS Rep. 1, I-96Reaffirmed: CMS Rep. 8, A-06Reaffirmed: CMS Rep. 01, A-16]