

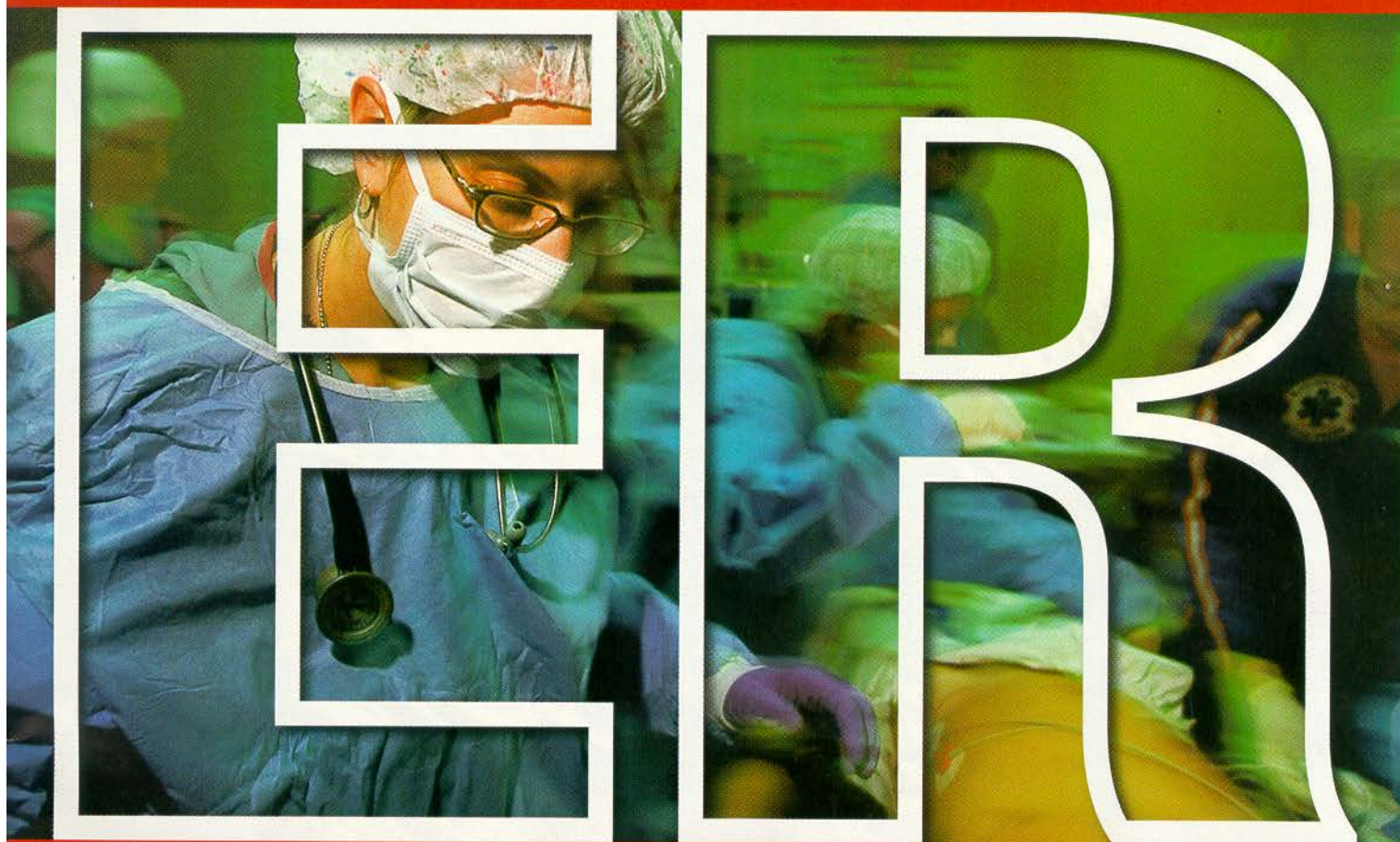
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U.S. News & WORLD REPORT

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CRISIS IN THE




Turnaways and huge delays are a surefire recipe for disaster. What you can do

CODE BLUE



Crisis in the ER



Turning away patients.
Long delays. A surefire
recipe for disaster

BY NANCY SHUTE AND MARY BROPHY MARCUS
PHOTOGRAPHY BY KENNETH JARECKE
CONTACT FOR USN&WR

It's a lazy August afternoon in Fairfax County, Va., and the usually congested roads are almost empty. Not so at Inova Fairfax Hospital, where the emergency department is gridlocked. The rooms are filled; the corridors are clogged with stretchers where patients wait, tethered to oxygen bottles for hours, their faces pinched with anxiety. Outside the suburban hospital, ambulances bearing more sick people are turned away. The hospital is on "reroute." That's a polite way of saying the emergency department is unable to tend to another soul. "The sicker they are, the harder it is to explain," sighs Andrew Snead, battalion chief for the county's paramedic service, as he views the scene. "If you think your mother's having a heart attack, it's hard for us to explain why you're going right by the hospital."

Across the nation, people who go to hospital emergency departments seeking treatment for sprains, chest pains, or a child's spiking fever are not met with the speedy service they expect but rather with delay and frustration. "It

TRAUMA. Staff monitor vital stats of a car accident victim at Inova Fairfax Hospital in Fairfax County, Va. The man died.

seemed to me like the end of the world," says Judith Díaz, a 77-year-old woman from Tysons Corner, Va. She spent five hours lying in the busy hall at Inova Fairfax with excruciating back pain, but without aspirin or even a drink of water, before she saw a doctor. "I was desperate."

The national ER crisis has doctors and nurses feeling desperate, dreading the day when the crush and chaos will create the conditions for a fatal mistake. Paramedics worry about the ambulance calls they're missing while they're forced to idle at the hospital because there's no place to unload patients. The delays may well be costing lives. The state of Massachusetts is investigating the case of a man in the city of Lawrence who died of an asthma attack after his ambulance was diverted. California is probing the deaths of three people in Los Angeles after emergency dialysis treatments were delayed. But perhaps even more frightening is the growing realization that the 24/7 emergency care we've come to count on in times of crisis may become a thing of the past.

"We get yelled at on a daily basis," says Inova Fairfax nurse Elizabeth Irland. She recently went to court because an 18-year-old traffic accident victim, angry that he had to wait, grabbed her by the throat and yanked her off her feet.

Maxed out. It used to be that ERs got swamped just during winter flu outbreaks, or just in inner-city neighborhoods on Saturday nights. But now emergency departments are overwhelmed year-round. They're maxed out in world-class institutions that consistently land on this magazine's honor roll of Best Hospitals—including Johns Hopkins Hospital, the University of California—San Francisco Medical Center, and the Cleveland Clinic, which last year turned away ambulance patients almost half the time. And they're struggling in wealthy suburbs like Fairfax County, a high-technology mecca with a median household income of more than \$90,000 and home to Colin Powell and ABC newscaster Sam Donaldson. "When there's not enough room," says Thom Mayer, chairman of the Inova Fairfax emergency department, "there's not enough room."

Even emergency doctors aren't immune. Earlier this year, Mayer's 81-year-old father suffered abdominal pain and was being taken from his assisted-living facility to the hospital when his ambulance was diverted from Inova Fairfax—where his doctor and medical records were—to

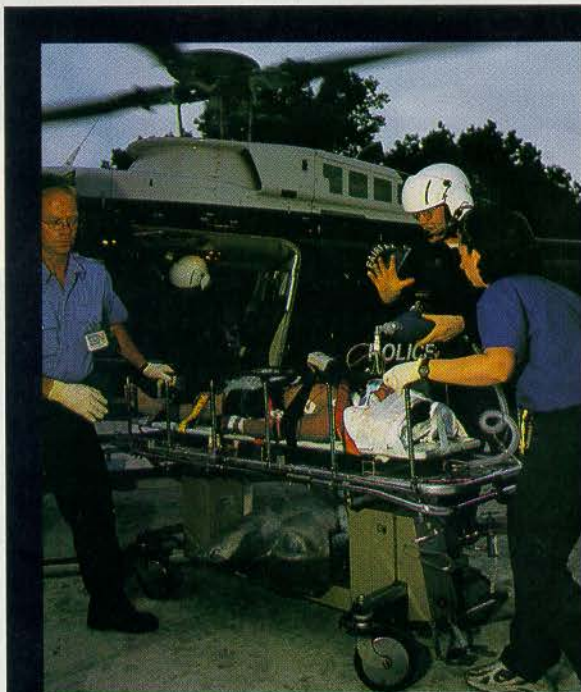
Inova Fair Oaks Hospital, 10 miles away. Mayer drove to Fair Oaks to explain that his father had a hernia and to make sure he got the right treatment. "If I hadn't been there," he says, "he would have gotten a number of unnecessary tests that would have further driven up costs—and delayed others' care."

Someone without a son who runs an emergency department would have had to wait for the diversion to end at his "home" hospital, then be transferred there for treatment. "You can be rich and insured, and there's no guarantee that you'll get timely care," says Wesley Fields, chairman of the American College of Emergency Physicians Safety Net Task Force. And the crisis goes far beyond the emergency room. The crunch there is just the most visible symptom of a much larger national malady. "What we're seeing is a very significant crack in the healthcare system," says Carmela Coyle, senior vice president for policy for the American Hospital Association. "One that involves everybody."

A remarkable number of people in America end up in the emergency department each year, and that number is rising—fast. From 1992 to 1999, emergency visits rose 14 percent, according to the Centers for Disease Control and Prevention, to 103 million a year. People show up at the emergency department with a dizzying array of complaints: asthma attacks, stomach aches, horse bites, psychotic breaks, earaches, the flu. They are people like Candace Kedde, who sat in an examining room at Desert Samaritan Medical Center in Mesa, Ariz., late one Saturday night last month, watching her 2½-year-old son, Markus, alternate between rolling his toy trucks on the bed and throwing up in a wastebasket. She worried that the reddish spots on his cheek might be chickenpox. "I just want this taken care of,"

Kedde, 25, said, caressing her son's silky, sandy brown head. "When your son's so sick and you can't do anything for him, it breaks your heart."

In some ways, emergency medicine is a victim of its own success. That success has been built by decades of public-health



ADMIT. Helicopter rushes in an unconscious car accident victim; Bryan Johnson after a motorcycle crash. Right: medical resident Fatima Khambati at work.





PAIN. Steve Engleberg, a physician assistant, gives a spinal anesthetic in the hospital's fast-track section, for less urgent cases.

campaigns urging people to call 911; the sophisticated care available in emergency departments, which are a far cry from the "accident rooms" of decades past; and the lure of the glamorous EMTs and nurses portrayed in *Third Watch* and *ER*. But a real emergency department is anything but glamorous. "Do you think people have fun sitting in our ED for six hours?" asks Tom Kirsch, an attending emergency physician at Maricopa Medical Center in downtown Phoenix. "It's horrible. It's awful. But people need healthcare, and our country has chosen to make EDs the providers."

Some of the people seeking care are like María DeJesus, a 54-year-old woman from Chihuahua, Mexico, who came to the county hospital to get attention for the vaginal bleeding afflicting her for 2½ weeks. "I know they

accept everyone here," she says in Spanish. Her treatment will become part of the \$5 million that the hospital loses each month treating the uninsured. "We need to educate people that we won't turn people away,

but it's not free," says Joe Hernandez, an emergency technician. "People are here eight or 10 hours, and they're not pleased. I tell 'em this is not a clinic. It's the last resort."

But many emergency customers are like Candace Kedde. They come to the emergency department only after they have tried—and failed—to get healthcare elsewhere. Some are too poor to pay; many others, who work in jobs that don't provide health insurance, make up the bulk of the nearly 43 million uninsured, a number that has risen by 10 million in the past decade.

Still others have insur-

ance and can't get help. After Markus's pediatrician moved away, Kedde, who works as a hotel guest-services representative, called a half-dozen doctors on her insurer's list, but they weren't taking new patients. So when Markus gets sick, she takes him to the Desert Samaritan ED. "Better safe," she says, "than sorry."

Increasingly, emergency staff say that their busiest time is not Saturday night but Monday afternoon. "People come to the ED because their doctor can't give them an appointment for three days," says David Denekas, an emergency physician at Calvert Memorial Hospital in Prince Frederick, Md., an area with rapid population growth and a short supply of pediatricians and family practitioners. "For a kid with a fever, three days is too much."

All comers. But when patients like Markus Kedde arrive at the hospital, they have to compete for attention with patients who are far sicker than those seen at a doctor's office and even sicker than in the emergency rooms of days past. That's partly because of the aging of the American population and partly because of high-technology medicine that keeps sicker people alive longer. Caring for sicker peo-

NEWS YOU CAN USE

When to go

Do you need ER care? Millions of ER visits are unnecessary.

HEAD TO the ER for uncontrollable bleeding, poisoning (but call Poison Control first), severe allergic reactions, severe difficulty in breathing, or possible signs of a heart attack or stroke. (A more comprehensive list of symptoms is at www.usnews.com.)

MAKE a doctor's appointment for controlled bleeding, flu, minor burns and rashes, chronic conditions, or to get a second opinion.

ple takes more time and means that less sick people must wait.

Yet emergency departments are required to see all comers, even if the patients are seeking help with complaints, like sexually transmitted diseases, that could clearly be better treated elsewhere. In 1986, alarmed by persistent reports that hospitals were turning away poor or uninsured patients, Congress passed the Emergency Medical Treatment and Active Labor Act (EMTALA), which created overnight a guarantee of treatment for anyone who can make it to the hospital.

In the early 1990s, managed-care companies countered by refusing to foot the bill for patients who went to the emergency department but ended up being less than grievously ill and were sent home. Public outrage prompted many state legislatures to pass "prudent layperson" standards, which require insurers to pay emergency bills regardless of the eventual diagnosis (story, Page 66). The "patients' bill of rights" now before Congress also includes prudent layperson protections. But increased right of access is not what's flooding emergency departments. "The problem is not the uninsured, and it's not the prudent layperson," says Charlotte Yeh, an emergency physician in Boston. "It's because we can't get people into hospital beds."

The problem isn't that the demand for care has soared. The problem is that the supply of care has been choked back. Between 1994 and 1999, more than 370 emergency departments across the country were shuttered at hospitals that were closed down or financially ailing. About 4,200 remain. The number of emergency departments in rural areas dropped by 11 percent in the past decade. The remaining emergency departments end up serving a much larger volume of patients.

At the same time, the nation radically reduced its hospital capacity. Throughout the 1990s, state and federal governments and insurers pressured hospitals to jetti-

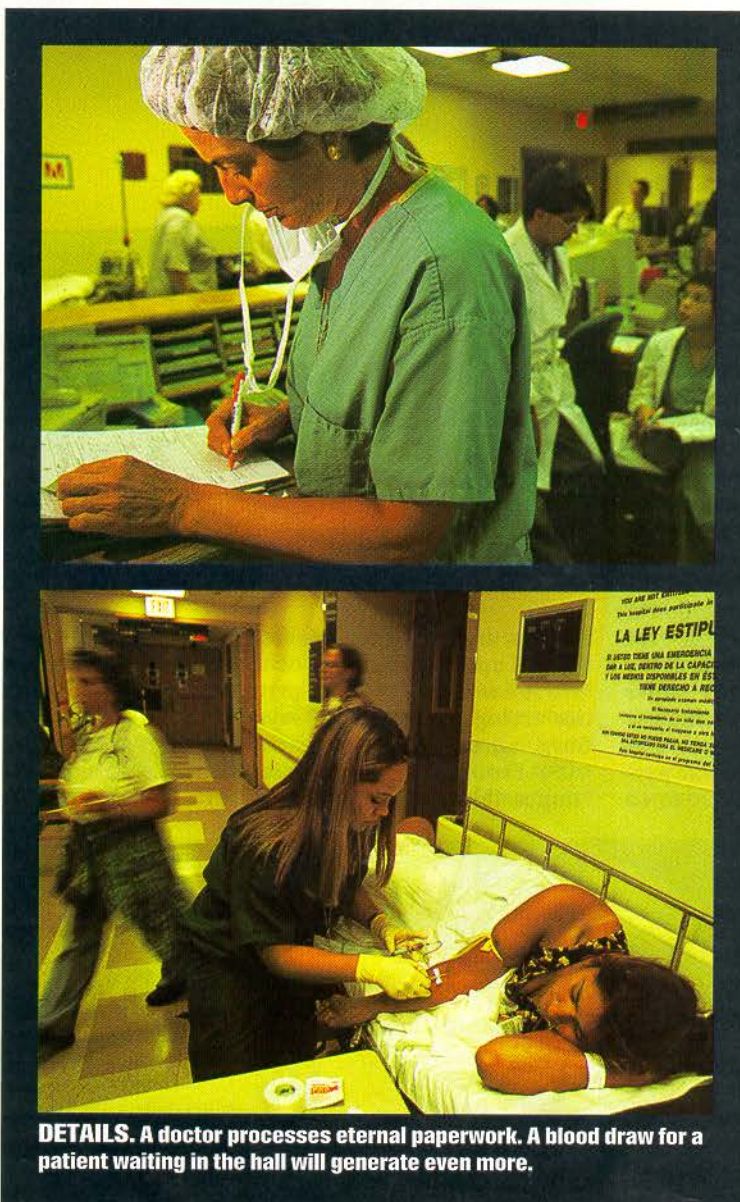
son excess capacity, even paying hospitals to close wards. The number of beds nationwide dropped 8 percent from 1994 to 1999, according to the American Hospital Association. Massachusetts has been particularly hard hit. Between 1988 and 1998, the state lost 24 percent of its hospitals, and the number of beds declined by nearly one third, from 23,224 to 16,498.

Indeed, most of the backups in emergency departments, the ones that leave patients stranded in the hall for hours, have nothing to do with the ED itself. Patients are stuck because there's no place in the regular hospital wards for them to be admitted. "We've had patients wait almost a week for an in-hospital bed," says Robert Fuller, chief of emergency medicine at the

University of Connecticut Health Center in Farmington. Lois Holland, a 76-year-old woman from Vienna, Va., waited 16 hours for a bed at Inova Fairfax this summer after a gallbladder attack. "I was shaking," Holland's daughter, Ellen Nicholson, says. "I didn't know if she was going to make it."

Saying no. Hospitals, seeing the emergency departments overwhelmed, have tried to deflect demand by shutting their doors. Under the EMTALA law, hospitals can turn away ambulances if they're full up, and they're increasingly saying no. In Phoenix, the hours in which hospitals were on diversion more than doubled in the first six months of this year, compared with 2000. In July, Boston's 27 hospitals were on diversion almost twice as often as in the previous July. From January to June of this year, Inova's four Northern Virginia hospitals were on diversion for 1,426 hours, compared with 640 hours for the same period last year.

Yet diversion is at best a holding action; hospitals can divert only ambulance traffic, not the 75 percent or so of patients who arrive on their own. And patients are starting to figure that out. When Fairfax County paramedic Gerald Pfeifer responded to a 911 call for a woman who was throwing up blood, Inova Mount Vernon, the hospital at which she'd been treated earlier that day, said: Sorry, we're on reroute. The patient and the paramedic spent long minutes debating, she saying he should just drop her off, he saying she wouldn't be safe on her own. "The hospital said, well, if she comes in her neighbor's car we can't refuse



DETAILS. A doctor processes eternal paperwork. A blood draw for a patient waiting in the hall will generate even more.

Medicare and Medicaid payments were trimmed to help balance the federal budget, shrinking a cushion that hospitals had used to help subsidize care. And hospitals manage their patient load much more closely; the Cleveland Clinic's cardiac intensive care unit averages greater than 95 percent full. "There is no more flex in the system," says Yeh.

her," Pfeifer says. "So that's what she did."

Some hospitals are adding back capacity they pared in the 1990s; Massachusetts General Hospital restored 24 beds this year as part of its effort to reduce its ED crowding, and plans to add more. But simply adding beds isn't enough. A bed without a nurse isn't a hospital bed, and hospitals are falling far short in finding enough nurses, pharmacists, and technicians.

During the 1990s, enrollment in nursing schools slumped as people turned to more lucrative and less stressful careers (the average registered nurse's salary last year was \$46,782—a rate of remuneration that has barely risen in the past decade). The average age of registered nurses is 45. Many hospitals have 20 percent of their nursing slots empty, with the most vacancies in specialties like intensive care and emergency. For the nurses who remain, that can mean working mandatory 16-hour shifts or working weeks without a day off. "We want to help people in the most efficient, caring way we can, and we can't do it anymore," says Lynn Forgues, 53, who has been an emergency nurse in Concord, Mass., for 25 years. "It feels awful. There's nothing worse than having someone unhappy or uncomfortable or in pain because of what you can't do." She's quitting the emergency department this month to work at a clinic at MIT. Her former colleague Ellen Lambert, 54, quit to work at a medium-security prison. "It's much less stressful," Lambert says.

No takers. Hospitals also find it harder and harder to find specialists willing to come in and treat emergency cases. The specialists, for their part, say that payments have dropped so low—to 20 to 40

cents on the dollar—that it's hardly worth getting up in the middle of the night. "We've been trying to get a private-practice urologist to come in," says Michael Burg, an emergency physician at the UCSF-Fresno University Medical Center. "Impossible. Can't be done. We rely on

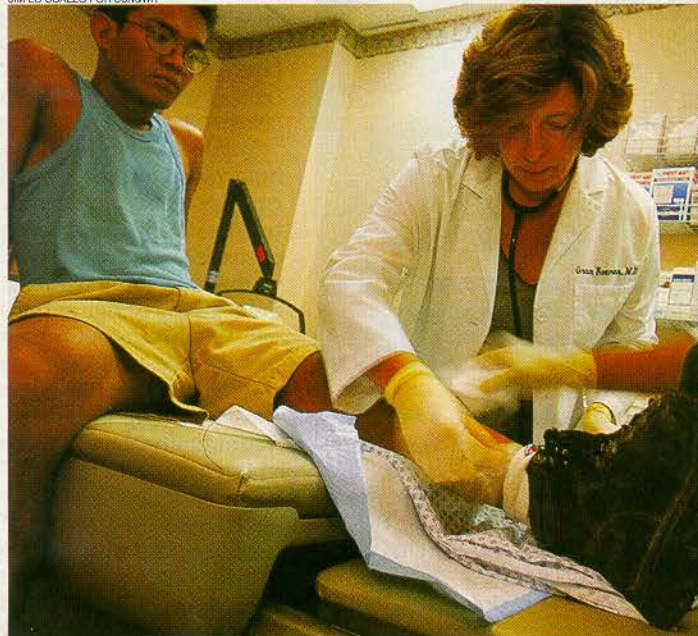
physician assistants trained in urology."

Nurses, doctors, and paramedics fear that this year's winter flu season will overwhelm a system close to the breaking point. "We're going to move from a crisis to a disaster," says Alan Woodward, director of the emergency department at



AFTERMATH. A weary nurse peels off gloves. The nationwide nursing shortage makes more

JIM LO SCALZO FOR USN&WR



FOR LIFE'S LITTLE EMERGENCIES

Urgent-care clinics take some pressure off the ER

When Marcia Mayo's 11-year-old daughter, Meredith, came down with "swimmer's ear" last month, Mayo whisked her to an urgent-care center she had visited two years ago on New Year's Day, when Mayo had broken her arm. A mom with a brood of five kids in Excelsior, Minn., Mayo says she chose the urgent-care center

deliberately over the local ER—for convenience. "I've never been in and out of the ER in less than four hours. I didn't want to sit and wait," she says.

More families like Mayo's are opting for medical care at urgent-care centers (UCCs) for pressing, yet not life-threatening, health troubles—such things as strep throat or a cut that needs stitches. Increasingly, families are using them as alternatives to their primary-

Treating an injury at an urgent-care center in Sterling, Va.



work for fewer nurses.



HUGS. Dana Hartigan's son had choked on a stick.

Emerson Hospital in Concord, Mass. Hospitals there are working on a statewide disaster plan. But disasters are usually short term. If flu season is bad, Woodward says, "we're going to run in disaster mode all winter long."

Efforts are underway to shore up the sys-

tem. Many hospitals are adding separate fast-track emergency sections, which are designed to quickly evaluate and treat less serious cases, such as cuts and simple fractures. Mass General has added 30 new staffers and a second CT scanner to the emergency department and set up a sep-

arate lab there. Desert Samaritan has technicians draw blood from patients when they arrive, so that by the time they get into an examining room their lab results will be ready. Other hospitals are installing computerized patient-tracking systems in lieu of the paper-laden clipboards and dry-erase boards still commonly used.

But even the people who are working hard to make these changes are quick to say that they are band-aids; they'll make emergency departments work a little better, but they won't solve the underlying problems of too much demand for care and not enough care to be had. One step could be to expand doctors' office hours to meet the reality of today's working-parent families, or to build more urgent-care centers (box). Another could be to provide coverage to the 43 million uninsured people in America, who so often end up hurting at the ED. Still another could be to recognize emergency medical care as a basic public service, one that should be provided to every community, just like fire, police, and ambulance service.

Short of such solutions, parents like Candace Kedde will be waiting in the emergency department. The staff at Desert Samaritan said Markus didn't have chickenpox, but he was admitted to the hospital on Saturday night because he couldn't stop vomiting. They waited in the emergency department until 8:30 a.m. for a bed to open up in the pediatrics ward, then waited until 4:30 to be discharged. On Tuesday night, Markus was throwing up again. This is no way to get healthcare, Candace says. But right now it's the only way she has. ●

care physician's and pediatrician's offices when they can't get quick appointments.

Convenient care. UCCs first sprouted up in the mid-1970s, and they had a growth spurt about five years ago when managed-care companies began tightening their belts. In 1995, about 10,000 UCCs operated nationwide; by 2000, there were 16,000, according to a survey by the North American Association for Ambulatory Urgent Care (NAFAC). Patients like the centers for their convenience and affordable cost. "We usually never wait more than a few minutes," says Kathy Sig-

norelli, a former nurse and mother of four in Plymouth, Minn., who uses Now Care in nearby Minnetonka. The \$15 copayment is equal to what she would dish out at her pediatrician's office, with a bonus: A physician routinely sees them, rather than a nurse practitioner. Many will fill a full prescription, not just the first dose, so patients don't have to make a second stop at a pharmacy.

UCCs can take some pressure off the ER. "The doctors don't really feel it, but patients may experience shorter waits," says Raul Armengol, medical director of Inova

Emergency Care Center in Springfield, Va. Yet urgent-care clinics don't pretend to be ERs. They manage under strict guidelines, which don't allow handling of life-threatening conditions such as heart attacks. Such patients must be transferred to an ER.

In some communities, urgent-care centers aren't getting enough business. Matthew McGarvey, practice administrator at Family Healthcare Centers in Brunswick, N.Y., outside Albany, said reimbursements were so low that this spring the UCC was converted to a primary-care practice.

Yet in much of the country, insurers have warmed to the idea of reimbursing urgent-care visits. And because staff at these clinics are often less stressed, they can spot things a busy ER triage staff might miss. "We received a family here who had waited for hours in a local ED. Their young child had abdominal pain," says Steve Whitson, vice president of ambulatory services at Cook Children's Medical Center in Fort Worth. The family finally headed to Cook's UCC. The diagnosis? Acute appendicitis; the child was rushed into surgery, just in time to prevent a rupture. —M.B.M.

Opening the curtain

Hospitals are changing rules to allow relatives in the ER. The early signs show benefits to patients



Nurse Theresa Meyers has supported giving families access to loved ones in the ER.

BY BEN HARDER

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Theresa Meyers simply couldn't refuse when the parents of 14-year-old Donnie Hott asked to be with their son, who lay dying in intensive care at Parkland Health & Hospital System in Dallas, after falling from a tree. Days earlier, the ER nurse had followed hospital protocol by not letting in an elderly woman whose husband was in a car accident. He died suddenly, and Meyers still remembers his anguished widow saying, "We were married 47 years, and I never got to tell him goodbye." So Meyers felt compelled to bend the rules when approached by the parents of the dying boy. She ushered the couple to their son's side, and let them say their goodbyes. Donnie Hott's mother, Susie, remains grateful for the opportunity to "say the things I needed to say to our son, [and] that has helped my grief."

Yet by bringing the Hotts behind the curtain that tragic night in 1994, Meyers touched a nerve in her profession. The standard practice in emergency care has been to keep family members at a distance. Some hospitals explicitly forbid ac-

cess. But driven by empathy and by studies suggesting emotional if not medical benefits, many nurses are advocating change, and they're starting to make progress. In the aftermath of the Hott case, Parkland in 1998 reversed its policy and began allowing families to be with patients in the emergency department. Other hospitals have recently followed.

Having the family in the ER may benefit both the patient and relatives, proponents say. The Emergency Nurses Association has contended since 1993 that it is a right of families and patients. A study in the May issue of the *American Journal of Nursing* found that patients in the ER generally want and are soothed by having kin at their side. Earlier studies, some limited in scope, concluded that family members allowed in the room suffer less anxiety about the patient's outcome, feel they have better supported the pa-

tient, and, in the unfortunate cases, are more prepared to handle their relative's death. Also, family members who witness emergency treatment tend to better appreciate what the medical team has done, potentially heading off malpractice suits.

The movement for family presence in emergency departments has plenty of critics, however, particularly among physicians who work there. "My biggest concern is that distressed relatives will distract the trauma team," says R. Stephen Smith, a surgeon and trauma director at Via Christi Regional Medical Center in Wichita, Kan. Screening relatives properly also poses a challenge, he says, recalling incidents of domestic violence in which family members turned out to have caused the injury. Others worry that watching surgeons perform gruesome invasive procedures will be too upsetting for the patient's family or that relatives will misinterpret what they see and could unnecessarily sue for malpractice.

Bending the rules. Even advocates acknowledge that if relatives are to be allowed in the ER, staff must be on hand to support them and keep them out of the way. Without an escort "to help the family member understand what's happening," says Justine Medina, practice director of the American Association of Critical-Care Nurses, "it will detract from the caregivers' ability to do their jobs." Not all emergency departments have sufficient resources, and those that do must train staff to manage relatives in a chaotic environment. Meyers, who has dealt with this issue at two hospitals, says, "I ask the staff to think about it as if it were their loved one."

Sharon Dimitrijevic needs no imagination to put herself in the families' shoes. She was an ER manager 15 years ago when her own nursing staff, following procedure, kept her from her father's bedside while an emergency team tried futilely to resuscitate him after a heart attack. "I still resent that to this day," she says. Last month, bad news again brought Dimitrijevic rushing to the hospital in Zion, Ill., when her teenage daughter was hurled into a windshield in a car crash. This time, Dimitrijevic was at the bedside, and when the surgeons treating the girl's broken ankle and lacerated face asked her to step out, she politely refused. They then yielded to the patient's mother. ●

EMOTIONAL CHECK

Take your pulse

Could you handle being in the ER with a relative?

IF YOU can't stand blood, wait outside. A procedure like cracking open the chest is tough to watch.

SEDATED patients likely won't recall the pain, but you may. The crunch of bone against bone, says one nurse, "could send a parent into a faint."

Turned-away blues?

Your health plan could make it tough to get into the ER. This checklist may help you open the door

BY JOSH FISCHMAN

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Emergency rooms should be open to everyone, says Charles Cutler. And Cutler, chief medical officer of the American Association of Health Plans, insists that no insurance company will stand in the way: "It's been part of our code of conduct that if you think you have an emergency, then your plan should cover you. Virtually all our members subscribe to this."

But apparently not all health plans abide by it. A hard look at what your plan does—and does not—provide for ER access

can save you a lot of trouble.

For instance, last year, the insurance commissioner in Washington State took Regence BlueShield, a regional plan, to court over many ER claim denials and for misleading consumers about reimbursement. Regence agreed to change the way it processes claims and pay a fine. This July the New York state attorney general insisted that Blue Cross and Blue Shield of Rochester review more than 25,000 denied ER claims. Some of the denials stated that a physician had not directly referred the

patient to the ER. Yet New York law doesn't require such referrals.

Finding out about these policies isn't so easy, says Richard O'Brien, an emergency physician at Moses Taylor Hospital in Scranton, Pa. The dense language in health plan brochures makes coverage hard to figure out. "Even doctors have trouble picking out health plan features," O'Brien says. "And we work for hospitals." One plan he examined charged \$25 for going directly to the ER but had no charge if you waited and went to a clinic—a disincentive to call 911.

Cutler agrees such obstacles are dangerous and adds that others may lie with your physician, not just your plan. A 24-hour phone contact, for example, is hard for any insurer to ensure. But you can: Use this checklist (box) to help choose a doctor and a plan that won't get in your way when you think you have an emergency—and one that won't make paying for it seem like yet another crisis. ●

RATING YOUR ER ACCESS

Not all plans are equal

In a typical family of four, chances are that one member will be hustled into an ER this year. If you have a choice among health plans, use this list to compare their ER access. Developed by the American College of Emergency Physicians, the list highlights possible obstacles to ER care. If a plan rates two or more "No's," it's time to consider an alternative. If it racks up several "Don't Know's," get matters clarified in writing.

1. The health plan has given you written material that clearly explains what to do if you need emergency care. This material includes:

a. When to call for an ambulance or 911

Yes ☐ No ☐ Don't Know ☐

b. How to call for an ambulance or 911

Yes ☐ No ☐ Don't Know ☐

c. When to seek emergency care

Yes ☐ No ☐ Don't Know ☐

d. Where to go for emergency care

Yes ☐ No ☐ Don't Know ☐

2. The health plan clearly en-

courages you to call an ambulance or go directly to the ER if you think you have an emergency medical condition.

Yes ☐ No ☐ Don't Know ☐

3. The plan explains in writing that it will pay for the visit if you have symptoms that most reasonable people would consider an emergency. (This is called the "prudent layperson" standard.) The plan will pay even if the condition turns out to be less than a true emergency.

Yes ☐ No ☐ Don't Know ☐

4. The plan has given you a telephone number that you can call after regular busi-

ness hours, when your doctor's office is closed.

Yes ☐ No ☐ Don't Know ☐

5. At this number, you can speak with a qualified nurse or a doctor who can give advice about your condition and tell you whether you should go to the ER.

Yes ☐ No ☐ Don't Know ☐

6. The plan does not require that you call for authorization

before you go to the ER. It will pay for ER services even if you don't call first.

Yes ☐ No ☐ Don't Know ☐

7. The plan does not require the hospital staff to call about your insurance coverage before an emergency physician or nurse has examined you. (Federal law requires that a medical examination must be performed on every emergency patient regardless of ability to pay.)

Yes ☐ No ☐ Don't Know ☐

8. After emergency staffers have evaluated you, the health plan has qualified medical professionals available to make arrangements for further treatment.

Yes ☐ No ☐ Don't Know ☐

9. Payments you make out of your own pocket (known as copayments) are not expensive enough to discourage you from going to the ER.

Yes ☐ No ☐ Don't Know ☐

10. Hospitals approved by the plan are convenient to you.

Yes ☐ No ☐ Don't Know ☐

