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☞ Details: Medicaid and Health Care Reform. Hearing held in Madison, Wisconsin on August 28, 2006.

(FORM UPDATED: 08/11/2010)

WISCONSIN STATE LEGISLATURE ...
PUBLIC HEARING - COMMITTEE RECORDS

2005-06
(session year)

Senate
(Assembly, Senate or Joint)

Select Committee on Health Care Reform...

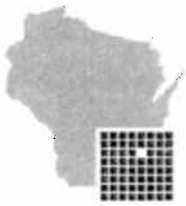
COMMITTEE NOTICES ...

- Committee Reports ... **CR**
- Executive Sessions ... **ES**
- Public Hearings ... **PH**

INFORMATION COLLECTED BY COMMITTEE FOR AND AGAINST PROPOSAL

- Appointments ... **Appt** (w/Record of Comm. Proceedings)
- Clearinghouse Rules ... **CRule** (w/Record of Comm. Proceedings)
- Hearing Records ... bills and resolutions (w/Record of Comm. Proceedings)
  (**ab** = Assembly Bill) (**ar** = Assembly Resolution) (**ajr** = Assembly Joint Resolution)
  (**sb** = Senate Bill) (**sr** = Senate Resolution) (**sjr** = Senate Joint Resolution)
- Miscellaneous ... **Misc**

* Contents organized for archiving by: Stefanie Rose (LRB) (August 2012)



Wisconsin Chapter
American College of
Emergency Physicians

Crisis in the Emergency Room

Select Committee on
Health Care Reform

August 28, 2006

Wisconsin Chapter
American College of Emergency Physicians

Attachments:

- Executive summary
- Committee hearing statement
- Institute of Medicine report talking points
- Articles from the *Annals of Emergency Medicine*
- Policy statement from the American College of Surgeons

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CRISIS IN THE EMERGENCY ROOM:
EXECUTIVE SUMMARY
AUGUST 28, 2006

The problems:

- Emergency departments provide an essential public service. We are legally required to see every patient who comes through the door, regardless of insurance status or ability to pay, and that's a good safety net. Problems from elsewhere in the health care system and society generally wind up in the emergency room – lack of access to primary care, inability to afford medicines, violence and abuse, natural and manmade disasters.
- Emergency department visits have increased **26 percent** in 10 years, but emergency departments are closing and waiting times are longer for all patients. The patchwork combination of funding for this essential public service is unraveling. While volume increases, revenues are decreasing.
- In particular, Medicaid's grossly inadequate payment rates threaten the emergency system's ability to continue providing care for all patients. For example: an emergency physician spends 3 ½ hours with a quadriplegic patient, on a ventilator, who arrived at the ER with a very serious condition requiring transfer to a tertiary care hospital for sophisticated surgery. Medicaid's payment for those 3 ½ hours is $26.99, or about $7.70 per hour.
- The problem doesn't just involve emergency physicians. We regularly call in specialists – plastic surgeons, orthopedists, and so on – to help provide optimal care to severely ill or injured patients in the ER. It's becoming harder and harder to find specialists to see patients in the ER. We may spend hours trying to locate specialists, sometimes without success; meanwhile, patients wait.

Immediate treatment:

- Set Medicaid rates for physicians' services in the emergency room at the Medi*care* level for "evaluation and management" (E/M) services – the services most closely correlated with the legal mandate of EMTALA[1] to screen and stabilize <u>all</u> patients regardless of their insurance coverage or ability to pay. By setting rates at these levels for specialists who see emergency patients as well as emergency physicians, we'll not only improve the financial viability of emergency departments, we'll alleviate the problem of finding specialists to see emergency patients.
- Make available to all emergency departments in the state an on-line information management system which allows emergency physicians to access basic medical record information about Medicaid patients' care –e.g., current medications and recent lab test results. This would speed diagnosis and treatment and reduce unnecessary duplication of expensive diagnostic tests.
- Create a referral database of specialty physicians we can use to find needed care in a timely manner.

First, do no harm: We are mindful that well-intentioned plans, such as proposals to curtail "inappropriate" emergency room visits, often have unintended consequences for patients' lives as well as for the health care system. Be careful about reducing access to this safety net in an effort to preserve it.

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[1] EMTALA = Emergency Medical Treatment and Active Labor Act, the federal law that requires emergency departments to screen and stabilize <u>all</u> patients.

Select Committee on Health Care Reform
Monday, August 28, 2006

"Crisis in the Emergency Room"

Wisconsin Chapter - American College of Emergency Physicians
Christine M. Duranceau, MD, *President*
Platteville

Howard J. Croft, MD, *Governmental Affairs Chair*
Milwaukee

Madame chair and members of the committee, my name is Dr. Christine Duranceau. I am a board certified emergency physician practicing in Platteville, and I also currently serve as the Wisconsin Chapter President of the American College of Emergency Physicians. Joining me today is Dr. Howard Croft, also board certified in emergency medicine. He practices at Columbia St. Mary's Hospital in downtown Milwaukee. On behalf of myself, Dr. Croft and all emergency physicians who take care of your constituents throughout the state, we want to thank you for inviting us to this hearing.

I want to congratulate you for taking the time and showing the interest in our state's health care system. To be sure, there are many challenges facing our citizens, especially those who need emergency medical care. In recent years, there has been an increasing focus in this aspect of the health care system, and we're hopeful that your leadership will point the State of Wisconsin on a path to success.

The Health Care Safety Net

We'd like to take just a minute to share with the committee who we are and why it has been rightly said that emergency medicine is in a state of crisis. The emergency department in your local hospital really is the first line of defense in the health care safety net.

We see it all – during a single shift an emergency physician may treat trauma victims from traffic accidents, gunshots or even a major catastrophe... patients fighting for their lives due to heart attack, diabetes or asthma... a drug overdose... alcoholics... and victims of domestic abuse, rape or other crimes. At the same time, we take care of people who accidentally cut themselves at home, who are sick with the flu, who are about to deliver a baby, or who just plain have nowhere else to turn for even the most routine health care.

You may not know it, but under federal law, those who provide trauma and emergency medical care are required to see every patient who comes through the door regardless of their insurance status or ability to pay. This is the "EMTALA" law, and we think this is a good policy. As a society, we all want to know the safety net will be there for everybody when it's needed.

An Essential Public Seri ve

But that law also puts emergency departments and the doctors who work there in a special category. Much like the fire department, we fill the role of an essential public service. Yet, unlike the fire department, we must function in a system financed through a combination of private sources, public dollars or no funding at all ... as in the case of the working poor who don't qualify for Medicaid, have no insurance and can't afford to pay for care out of pocket.

As an essential public service, we are there for everybody. Our patients are not just poor people on Medicaid, it's you, your family and your neighbors. We are open 24/7, and like

the canary in the coal mine, many of the problems in the health care system – and society itself – are first noticed in the emergency department. That includes community problems like drug and alcohol abuse. It includes the strain resulting from tight finances and insufficient staff to keep up with the demand. It includes people without insurance seeking routine care. And it even includes a big piece of homeland security through disaster preparedness and responding to bioterrorism. Emergency departments are likely the first to see victims of bioterrorism . . . they can show up anywhere as we saw with the anthrax scare a few years ago.

Challenges are Growing

The challenges facing the emergency medical system certainly are evident within the Medicaid program. But through "ripple effect," these problems ultimately affect everybody. In an overcrowded emergency department, even those with the best insurance have to wait to see a doctor. Meanwhile, cost shifting because of uncompensated, or under-compensated, care places a greater burden on those who are able to pay.

Did you know that there were nearly 114 million emergency department visits nationally in 2003? That's a 26 percent increase in 10 years. In 2002, Wisconsin reported more than 1.5 million visits. And while the volume continues to grow, emergency physician compensation is *declining* because of grossly inadequate payment rates under Medicaid, skyrocketing medical liability insurance premiums, rising overhead costs, and care that simply is never paid for. According to the American Medical Association, individual emergency physicians average $138,300 annually in lost revenue for providing EMTALA-mandated care. And we can't even deduct that as a charitable contribution!

Let me give you an example of how inadequate Medicaid fees are in this state. Recently, I had a Medicaid patient who is a quadriplegic and on a chronic ventilator who arrived with a severe headache and low blood pressure. This gentleman required a complete work-up, a CT scan, lab tests and a thorough physical. We found he had a very serious condition and needed immediate surgery. He was transferred to Madison for that treatment. I spent 3½ hours with this patient. My normal charge for this very high level of care was $281.25, but Medicaid paid the princely sum of $26.99 – or about $7.70 per hour, the same rate a junior high girl would charge for babysitting... if you're lucky. This is *not* an isolated example. You just can't keep the doors open when fees are discounted as much as 90% like this case.

"On-Call" Specialty Coverage Needs Improvement

(Dr. Croft)

Very often, a patient's medical needs are more appropriately handled by a specialist such as an orthopaedic surgeon, a cardiologist, or a plastic surgeon. In my personal experience, I've found it is becoming more difficult to get that critical "on-call" backup from specialists. While research shows there are complex reasons for this, one that stands out over and over is low Medicaid payment rates. It's very hard to overcome this reality when we're trying to call a doctor away from his home and family in the middle of the night, especially when they know their compensation will be very low, if any at all. So as a result, some doctors just don't take call period.

Here's a case I had about a year ago. A little girl had been bitten in the face by a dog. Her parents had insurance, so this was not even a Medicaid patient. She needed stitches and because of the severe injury to her face, a plastic surgeon was the best choice for her. I spent hours on the phone trying to find a surgeon that night to see this girl... with no luck. Eventually, I admitted her. She developed an infection and required much more intense treatment, not to mention the anxiety of being sick in the hospital. Plus she still needed the services of a plastic surgeon. The cost of this care was many times what it might otherwise have been if we had an adequate backup call schedule.

A couple of years ago, we were very gratified that Secretary Helene Nelson agreed to meet with

us to discuss some of these issues. The first thing she said was that she recognized emergency medical care – and Medicaid in general – is underfunded. This fact has real consequences, and you've just heard two examples. Wisconsin's emergency physicians have committed themselves to caring for our patients, and that includes working with public policy makers, like yourselves, to find solutions to these challenges.

Recommendation #1 - Medicare Rates in the ER

One recommendation we hope the committee will seriously consider is setting Medicaid rates at the Medicare level for EMTALA-services. This clearly is justified, and we believe it's essential to keep the health care safety net in your districts from unraveling. About one-third of the patients at my hospital (Columbia St. Mary's in Milwaukee) are covered by Medicaid. You just can't make up in volume what you're losing on every patient. Keeping this essential public service financially solvent is critical; letting it go will have a ripple effect throughout our communities. We already are beginning to observe symptoms from our failure to act with exceeding long waits to see a doctor, hospitals who have to divert patients elsewhere because all of their beds are filled, patients like the little girl with the dog bite who can't get proper treatment from a specialist, and even entire emergency departments being closed because of insurmountable financial pressures.

Recommendation #2 - Information Management

While adequate funding is very important, lack of access to information is a huge headache for emergency physicians. This involves both data about current and previous care received by the patient, as well as the ability to quickly find doctors for follow-up care.

I can't begin to tell you how much money simply is wasted because of tests that are repeated needlessly. Strange as it may seem, it's common for a patient to *not* reveal they just had an x-ray or a CT scan the previous week for the same complaint they have today. Who knows why... either they don't make the connection, they didn't like the answer they got from the other doctor, or they're just dysfunctional. But without that information and given certain symptoms or complaints, we are obligated to proceed with lab or imaging tests.

Lack of shared information also can affect the continuity of care when I have no idea what medications a patient might be on as a result of a previous visit to a different emergency department or doctor. And, we all have heard about the "drug shoppers" who go from ER to ER with back pain hoping to get some medicine. Believe me, they're out there.

(Dr. Duranceau)

Finally, emergency physicians are spending significant time away from patients while we call around trying to find a doctor who will provide needed follow-up care. Not long ago, I had a 32-year old man who fell off a ladder and broke his hip. I spent hours calling at least five orthopedists and five different hospitals, none of whom could or would accept the patient (who, by the way, had insurance). We ended up sending the patient to Rockford. I've also had to send patients as far as Iowa City. Now isn't that a sad state of affairs when we have to export patient to another state?

As sorry as it is to send patients far away for follow-up care, it's just as sorry that I have to spend a significant portion of my shift on the phone looking for doctors to take the patients.

These examples illustrate the urgent need for a good information management system available to all emergency departments. We already have the technology, we just need the will to make it happen. We think two steps would go a long way toward helping to ease the burden:

First, we should establish a database of doctors who will accept new patients – and especially Medicaid patients – or who will respond when called to the emergency department. At the very least, this will allow emergency physicians to direct more time to patient care. And by more effectively arranging for follow-up visits, the continuity of care will improve, as well.

Secondly, on-line medical information about Medicaid patients not only would result in better treatment, but it also would save a tremendous amount of money that's currently being wasted. We're not proposing a gold-plated electronic medical record system, which certainly would be nice but also is a huge undertaking. Something as straight-forward as a listing of previous doctor/hospital visits, recent tests, current medications and known allergies or chronic conditions would at least give us a basis upon which to make reasoned judgments about the care that's needed and justified today.

When you consider that the average cost of a CT scan is $900 to $1,400, you can see that the savings could add up very fast when these expensive tests don't need to be repeated.

The Ripple Effect - Avoid Unintended Consequences

(Dr. Croft)

As we are searching for solutions to some of these problems, it is vital to keep in mind that each action has the potential for unintended consequences. Over the past few years, there have been some studies concerning "frequent fliers" in the emergency department who appear to be over-utilizing the services there. Others are seeking routine health care in the ER when it would be more appropriately delivered in a primary care physician's office or a community health clinic. Some have suggested imposing a "co-payment" or some other financial penalty on these patients, or tightening eligibility requirements.

In the same month not long ago, I had two diabetic patients who came to me severely ill in life-threatening conditions. Neither had been taking their insulin for months because they didn't have the $35 application fee for their GAMP – general assistance – card. For lack of thirty-five bucks, both ended up needing tens of thousands of dollars in hospital care and have continuing medical problems costing the system even more money... not to mention the impact on these individuals' quality of life. This is what happens when we do things that ultimately discourage people from seeking care when they first need it. It's the ripple effect.

No Easy Solutions

As these hearings are sure to demonstrate, there are no easy solutions to the challenges facing Wisconsin citizens, and society in general. It's an incredibly complex issue. From the standpoint of emergency medicine, we sincerely hope you will keep in mind the fact that your local ER is a pillar in the health care safety net; it is an essential public service that must survive.

Addressing the issue of grossly low Medicaid rates by setting fees for EMTALA-related services to be on par with the federal Medicare system would do a lot to keep the doors open and encourage medical specialists to be there when needed. Creating an information management system would improve efficiency and save money by speeding up referrals for continuing care and eliminating unnecessary tests, not to mention improving the overall quality of care.

Wisconsin's emergency physicians are totally committed to working with you to address these challenges. Thank you for taking the time to listen to us and for considering our recommendations.

Institute of Medicine Report on Hospital-Based Emergency Care

Main Point 1: The IOM Reports are landmark studies that confirm our nation's emergency departments are fragmented and stretched to the breaking point, unable to respond to disasters.

- — Underneath the surface, a national crisis in emergency care has been brewing and is now beginning to come into full view.
- — Hospitals must end the practice of boarding patients in emergency departments and ambulance diversion, except in the most extreme cases, such as mass casualty events.
- — An ambulance is diverted every minute in America, threatening the lives of sick and injured patients by delaying medical treatment.
- — Emergency departments provide a health care safety net for everyone — the insured as well as the uninsured. The problem affects every single American.
- — Emergency physicians treat 5 million more patients every year — more than 300,000 a day. 113 million came in 2003. U.S. hospitals have lost more than 198,000 beds since 1993.
- — The nation's emergency physicians provide the most charity care of any medical provider — 95 percent in 2003, compared with 31 percent of all other physicians

Main Point 2: Congress must convene a hearing to address the problems facing emergency patients.

- — Congress must dedicate funding to the emergency system for disaster preparedness and to reimburse hospitals that provide significant amounts of uncompensated emergency and trauma care.
- — It's not enough to address the problem by asking people not to get sick.
- — These results are a wakeup call to the nation to recognize emergency care as an essential community service that must be funded.
- — The IOM reports confirm the results of ACEP's 2006 National Report Card on the State of Emergency Medicine — that 80 percent of states earned near-failing grades for their lack of support for emergency care systems., and the nation overall received a C-

Main Point 3: Congress must ensure that America is ready to respond to medical emergencies during a disaster and every day.

- — The reports confirm that only a tiny fraction of federal funding for emergency preparedness has been spent on medical preparedness. Although emergency service providers are a crucial part of the response to any disaster, they received only 4 percent of $3.38 billion distributed by the Homeland Security Department for emergency preparedness in 2002 and 2003.
- — Emergency departments are completely unsupported and unprepared for disasters, such as terrorist events, pandemic flu and hurricanes.
- — Congress must recognize the role of emergency physicians and nurses in responding to disasters, and allocate funds accordingly.
- — Emergency physicians are like the levies in the nation's health care system. They have a crucial role to play in disaster planning at the local, state and federal levels.

- **Main Point 4: Emergency physicians are asking the public to visit www.acep.org and send a message to Congress to convene a hearing and support of the Access to Emergency Medical Services Act** (H.R. 3875 and S. 2750).
  - — This issue affects everyone. It is a national problem that requires a national solution.
  - — The nation's emergency physicians are advocating for passage of the Access to Emergency Medical Services Act, which if passed, would:
    - o Address the growing lack of resources in emergency care by recognizing emergency medicine as an essential community service that must be funded.
    - o Address the growing physician shortage by extending limited liability. protection to physicians who care for patients in emergency departments
    - o Provide financial incentives to hospitals to end the practice of "boarding" patients in the emergency department.

Who is the IOM: The Institute of Medicine serves as adviser to the nation to improve health. Established in 1970 under the charter of the National Academy of Sciences, the Institute of Medicine provides independent, objective, evidence-based advice to policymakers, health professionals, the private sector, and the public.

American College of Emergency Physicians

Annals *of* Emergency Medicine

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The Future of Emergency Care in the United States Health System

Institute of Medicine

0196-0644/$-see front matter

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[Ann Emerg Med. 2006;48:115-120.]

If one were to judge solely from popular TV shows, the nation's emergency care system is in fine shape. Its doctors, nurses, and ambulance personnel are dedicated and competent professionals who save lives with their expertise and state-of-the-art equipment and can always be trusted to come through in a crunch. And, indeed, there is a great deal of truth to this picture: Our emergency and trauma care system has made tremendous strides over the past few decades, and today it manages to save many lives that just ten or twenty years ago would have been inevitably lost.

But underneath the surface, a national crisis in emergency care has been brewing and is now beginning to come into full view. Emergency departments (EDs) across the country are overcrowded. Ambulances are turned away, and patients, once they are admitted, may wait in hallways for hours or even days before inpatient beds open up for them. Often the specialists that patients need to see are not available. And the system that transports patients to the hospitals is fragmented and inconsistent in the level of quality it provides.

It was against this backdrop that the Institute of Medicine's Committee on the Future of Emergency Care in the United States Health System convened in September 2003 to examine the state of emergency care in this country. Charged with creating a vision for the future of emergency care, the committee has responded by publishing a series of three reports that look at hospital-based emergency and trauma care, at prehospital emergency medical services (EMS), and at the special challenge of providing emergency care for children. The Future of Emergency Care series includes: Hospital-Based Emergency Care: At the Breaking Point; Emergency Medical Services At the Crossroads; and Emergency Care for Children: Growing Pains. In these three volumes, the committee has identified what it believes are the most important issues facing the nation's emergency care system and has made a series of recommendations for how best to deal with those issues.

OVERCROWDING

The emergency care system in the United States is in many ways a victim of its own success. Not only has the hospital ED become the place that Americans turn to first when they have an illness or injury that demands immediate attention, but it has been given an increasing number of other responsibilities as well. EDs today provide much of the medical care for patients without medical insurance. Insured patients increasingly turn to the ED during times when their physician is unavailable, such as evenings and weekends, and they are often sent to the ED for tests and procedures that their physician can't easily perform in the office. In some rural communities, the hospital ED may be the main source of health care for a large percentage of residents. EDs also play a key role in public health surveillance and in disaster preparation and response.

The number of patients visiting EDs has been growing rapidly. There were 113.9 million ED visits in 2003, for example, up from 90.3 million a decade earlier. At the same time, the number of facilities available to deal with these visits has been declining.

Between 1993 and 2003, the total number of hospitals in the United States decreased by 703, the number of hospital beds dropped by 198,000, and the number of EDs fell by 425 (Figure 1).

The result has been serious overcrowding. If the beds in a hospital are filled, patients cannot be transferred from the ED to inpatient units. This can lead to the practice of "boarding" patients—holding them in the ED, often in beds in hallways, until an inpatient bed becomes available. It is not uncommon for patients in some busy EDs to be boarded for 48 hours or more. These patients have limited privacy, receive less timely services, and do not have the benefit of expertise and equipment specific to their condition that they would get within the inpatient department.

Another consequence of overcrowding has been a striking increase in the number of ambulance diversions. Once considered a safety valve to be used only in the most extreme circumstances, such diversions are now commonplace. Half a million times each year—an average of once every minute—an ambulance carrying an emergency patient is diverted from an ED that is full and sent to one that is farther away. In 2004, according to the American Hospital Association (AHA), nearly half of all hospitals—and close to 70 percent of urban hospitals—diverted patients at some point during the year. Each diversion adds precious minutes to the time before a

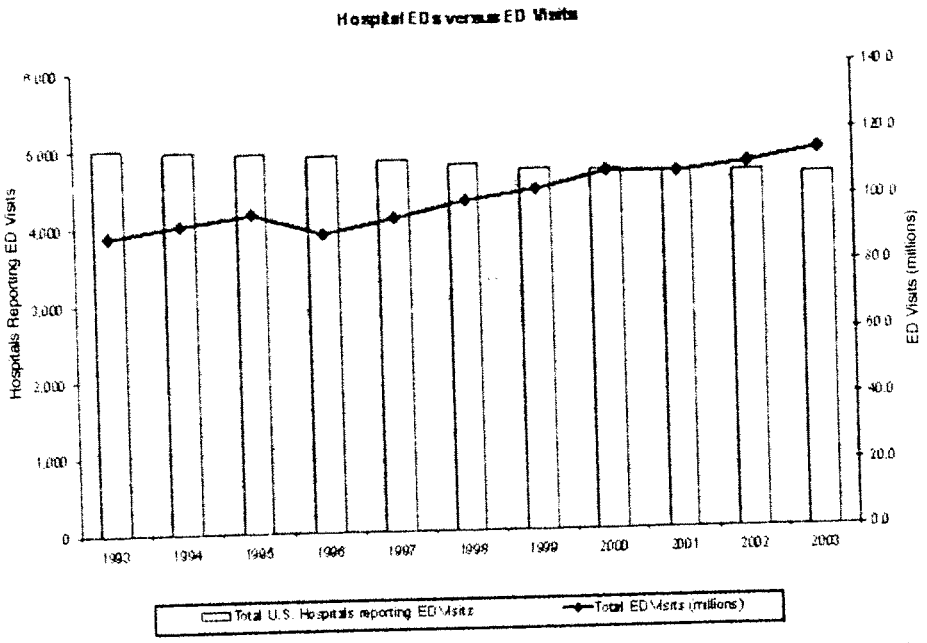

Figure 1. Hospital EDs versus ED visits. SOURCE: AHA Hospital Statistics and National Hospital Ambulatory Medical Care Survey (NHAMCS).

patient can be wheeled into an ED and be seen by a doctor, and these delays may in fact mean the difference between life and death for some patients. Moreover, the delays increase the time that ambulances are unavailable for other patients.

FRAGMENTATION

The modern emergency care system is a relatively new innovation. In the 1950s, for instance, emergency medicine was not a recognized specialty, and hospital emergency rooms were generally staffed by internists or primary care physicians, most of them young and inexperienced. There were no paramedics as such—EMS offered little more than first aid, and the local ambulance service often consisted of just a hearse and a mortician.

Since then the emergency care system has developed rapidly. The "emergency room" has become the "emergency department," and it is now frequently staffed with specialists trained in emergency medicine. Many ambulances employ specialized equipment and EMS personnel trained to stabilize patients and keep them alive until they reach the hospital. But the organization and delivery of these services has lagged behind their technical capabilities, limiting communication and cohesion among the various components of the system. As a result, today's emergency care system is highly fragmented and variable.

A single population center may have many different EMS agencies—some volunteer, some paid, some based in fire departments, others operated by hospitals or private companies—and these agencies do not always interact with one another effectively (Figure 2). EMS workers often cannot even communicate with police and fire departments because they lack

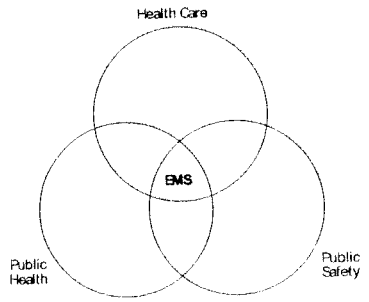

Figure 2. The overlapping roles and responsibilities of EMS.

compatible communications equipment or operate on different frequencies. Furthermore, EMS agencies in one jurisdiction are often unable to communicate with those in adjoining areas.

There is a similar lack of coordination between EDs and the EMS services that deliver their patients. Few systems around the country coordinate the regional flow of emergency patients to hospitals and trauma centers effectively, because most fail to take into account such things as the levels of crowding and the differing sets of medical expertise available at each hospital. Indeed, in most cases, the only time an ED passes along information concerning its status to EMS agencies is when it formally goes on diversion status and refuses to take further deliveries of patients. As a result, the regional flow of patients is managed poorly and individual patients may have to be taken to facilities that are not optimal given their medical needs.

Adding to the fragmentation is the fact that there is tremendous variability around the country in how emergency care is handled. Belying its apparent uniformity, there are

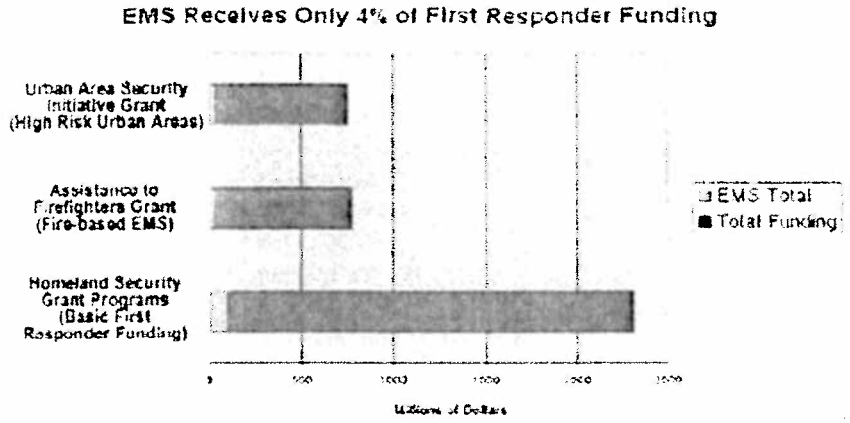

Figure 3. EMS receives only 4% of first responder funding. SOURCE: NYU Center for Catastrophe Preparedness and Response, 2005.

actually more than six thousand 9-1-1 call centers around the country and depending on their location, they may be operated by the police department, the fire department, the city or county government, or some other entity. Moreover, there are no nationwide standards for the training and certification of EMS personnel—or even any national accreditation of the institutions that train them. There is no single agency in the federal government that oversees the emergency and trauma care system. Instead, responsibility for EMS services and for hospital-based emergency and trauma care is scattered among many different agencies and federal departments, including Health and Human Services, Transportation, and Homeland Security. Because responsibility for the system is so fractured, it has very little accountability. In fact, it can be difficult even to determine where system breakdowns occur or why.

SHORTAGE OF ON-CALL SPECIALISTS

Emergency and trauma doctors can be called on to treat nearly any type of injury or illness, so it is important for them to be able to consult with specialists in various fields. Indeed, if a hospital offers specialist services to its inpatients—such as neurosurgery or vascular surgery—it must by law offer those services to ED patients as well. It has become increasingly difficult, however, for EDs to find specialists who will agree to be on call for the ED, and the resulting shortage of on-call specialists in EDs has had dire and sometimes tragic results.

There are a variety of reasons for the shortage of on-call specialists. Many specialists find that they have difficulty getting paid for their ED services because many emergency and trauma patients are uninsured. Specialists are also deterred by the additional liability risks of working in the ED. Many of the procedures performed in EDs are inherently risky and physicians rarely have an existing relationship with emergency patients. The result is that insurance premiums for doctors who serve as on-call specialists in the ED are much higher than for those who don't. Finally, many specialists find the demands of providing on-call services too disruptive to their private practices and their family life. After being in surgery all day, they have little desire to be called back into the hospital in the middle of the night, often without the assurance of payment for their services.

LACK OF DISASTER PREPAREDNESS

Any time a disaster strikes, whether it is a natural disaster, a disease outbreak, or a terrorist attack, EMS and hospital EDs are called on to take care of the ill and wounded. Unfortunately, the nation's emergency care system is very poorly prepared to handle such disasters.

The difficulties begin with the already-overcrowded nature of the system. With hospitals in many large cities operating at or near full capacity, even a multiple-car highway crash can create havoc in an ED. A major disaster with many casualties is something that many hospitals have limited capacity to handle.

Much of the problem, though, is due to a simple lack of funding. In 2002, for example, hospital grants from the Bioterrorism Hospital Preparedness Program were typically between $5,000 and $10,000—not enough to equip even one critical-care room. Emergency medical services are particularly underfunded. Although emergency service providers are a crucial part of the response to any disaster, they received only 4 percent of the $3.38 billion distributed by the Homeland Security Department for emergency preparedness in 2002 and 2003 and only 5 percent of the funding from the Bioterrorism Hospital Preparedness Program (Figure 3). In general, of the billions of federal dollars being spent on disaster preparedness, only a tiny fraction is spent on medical preparedness, and much of that is focused on one of the least likely threats—bioterrorism.

Due to this lack of funding, few hospital and EMS personnel have received even minimal training in how to prepare for and respond to a disaster. Furthermore, they lack the equipment and supplies necessary to deal with disasters. Few hospitals have negative pressure units, for instance, which are crucial in isolating victims of airborne diseases, such as avian flu. Nor do many hospitals have the appropriate personal protective equipment to keep their staffs safe when dealing with an epidemic or other disaster.

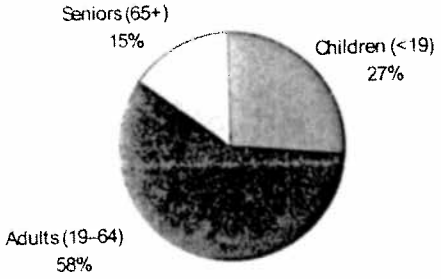

Figure 4. Emergency department visits by age. SOURCE: 2002 NHAMCS, Calculation by IOM staff.

SHORTCOMINGS IN PEDIATRIC EMERGENCY CARE

Children who are injured or ill have different medical needs than adults with the same problems. They have different heart rates, blood pressures, and respiratory rates, and these change as they grow. They often need equipment that is smaller than what is used for adults, and they require medication in much more carefully calculated doses. They have special emotional needs as well, often reacting very differently to an injury or illness than adults do. Unfortunately, although children make up 27 percent of all visits to the ED, many hospitals and EMS agencies are not well equipped to handle these patients (Figure 4).

One survey finds, for instance, that only 6 percent of U.S. EDs have all the supplies necessary for handling pediatric emergencies and only about half of the departments had even 85 percent of the essential supplies. Training is also an issue. Many EDs, particularly those in rural areas, rely on doctors and nurses without specialized pediatric training to handle pediatric patients. Many EMS agencies require little pediatric training of their personnel.

A number of large cities do have children's hospitals or hospitals with pediatric EDs that offer state-of-the-art treatment for children. However, the vast majority of ED visits by children are made instead to general hospitals, which are less likely to have pediatric expertise, equipment, and policies in place for the care of children.

RECOMMENDATIONS

To improve the nation's emergency care system and deal with the growing demands placed on it, the committee recommends a multi-pronged strategy. Together the three reports contain a number of recommendations, but the main thrusts of the recommendations can be summarized by four basic themes:

Improving hospital efficiency and patient flow

Tools developed from engineering and operations research have been successfully applied to a variety of businesses, from banking and airlines to manufacturing companies. These same tools have been shown to improve the flow of patients through hospitals, increasing the number of patients that can be treated while minimizing delays in their treatment and improving the quality of their care. For example, smoothing the peaks and valleys of patient admissions has the potential to eliminate bottlenecks, reduce crowding, improve patient care, and reduce cost. Another promising tool is the clinical decision unit, or 23-hour observation unit, which helps ED staff determine whether certain ED patients require admission. Hospitals should use these tools as a way of improving hospital efficiency and, in particular, reducing ED crowding.

At the same time hospitals should increase their use of information technologies with such things as dashboard systems that track and coordinate patient flow and communications systems that enable ED physicians to link to patients' records or providers. Such increased use of information technologies will not only lead to greater hospital efficiency but will increase safety and improve the quality of ED care.

Since there are few financial incentives for hospitals to reduce crowding, the Joint Commission on the Accreditation of Healthcare Organizations should put into place strong standards about ED crowding, boarding, and diversion. In particular, the practices of boarding and ambulance diversion should be eliminated except in the most extreme circumstances, such as a community mass-casualty event.

A coordinated, regionalized, accountable system

Many of the problems of today's emergency care system can be traced to its fragmented nature. The emergency care system of the future should be by contrast highly coordinated, regionalized, and accountable.

It should be coordinated in the sense that, from the patient's point of view, delivery of emergency services should be seamless. To achieve this, the various components of the system—9-1-1 and dispatch, ambulances and EMS workers, hospital EDs and trauma centers, and the specialists supporting them—must be able to communicate continuously and coordinate their activities. When an ambulance picks up a patient, for example, the EMS personnel gather information on the patient, and the information is automatically passed on to the ED before the ambulance even arrives.

The system should be regionalized in the sense that neighboring hospitals, EMS, and other agencies work together as a unit to provide emergency care to everyone in that region. Patients should be taken to the optimal facility within the region based on their condition and the distances involved. In case of a stroke, for example, a patient might be better served by going to a hospital that is slightly farther away but that specializes in treatment of strokes.

Finally, the system should be accountable, which means that there must be ways of determining the performance of the different components of the systems and reporting that performance to the public. This will demand the development of well-defined standards and of ways to measure performance against those standards.

The reports call for a series of ten demonstration sites to put these ideas into practice and test them to determine which strategies work best under various conditions.

Once under way, this coordinated, regionalized, and accountable system not only should address the problem of fragmentation of the nation's emergency care system, but it should also help the shortage of on-call specialists by routing patients to those hospitals with the appropriate specialists. To further increase the availability of specialists in EDs, the report also calls on Congress to find a way to mitigate the effect of medical malpractice suits on services provided to patients in the EDs.

Furthermore, the development of a coordinated, regionalized, accountable emergency and trauma care system is hindered by the way that responsibility for emergency care programs is spread out across different agencies of the federal government. The scattered nature of federal responsibility for emergency care makes it difficult for the public to identify a clear point of contact, limits the visibility necessary to secure and maintain funding, creates overlaps and gaps in program funding, and engenders confusion on key policy issues. The report calls for the creation of a lead federal agency that would consolidate many of the government programs that deal with emergency and trauma care.

Increased resources

Increased funding could help improve the nation's emergency care system in a number of ways. More research is needed, for instance, to determine the best ways to organize the delivery of emergency care services, particularly prehospital EMS. And, given that many closings of hospitals and EDs can be attributed to financial losses caused by the cost of emergency and trauma care, Congress should consider providing greater reimbursements to the large, safety-net hospitals and trauma centers that bear a disproportionate amount of the cost of taking care of uninsured patients.

An area in which greater funding is needed is disaster preparedness. To date, despite their importance in any response to disaster, the various parts of the emergency care system have received very little of the funds that Congress has dispensed for disaster preparedness. In part this is because the money tends to be funneled through public safety agencies that consider medical care to be a low priority. Congress should therefore make significantly more disaster-preparation funds available to the emergency system through dedicated funding.

Paying attention to children

Finally, as these various improvements are made to the nation's emergency care system, it will be important to keep pediatric patients in mind in all aspects of emergency care. The needs of pediatric patients should be taken into account in developing standards and protocols for triage and transport of patients; in developing disaster plans; in training emergency care workers, to assure that they are competent and comfortable providing emergency care to children; and in conducting research to determine which treatments and strategies are most effective with children in various emergency situations.

ACHIEVING THE VISION

There is no "one size fits all" solution to building the best possible emergency care systems from state to state and region to region. In order to explore different approaches and see what works best in different situations, the committee recommends that Congress establish a 5-year demonstration program to provide funding for individual states to develop coordinated, regionalized, and accountable emergency-care systems in various parts of the country. Over time these projects will help identify "best practices" that can address the problems facing today's emergency systems and point the way toward a future emergency care system that ensures high-quality, efficient and reliable care of all Americans.

FOR MORE INFORMATION . . .

Copies of the Future of Emergency Care in the United States Health System reports are available from the National Academies Press, 500 Fifth Street, N.W., Lockbox 285, Washington, DC 20055; (800) 624-6242 or (202) 334-3313 (in the Washington metropolitan area); Internet, http://www.nap.edu. The full text of this report is available at http://www.nap.edu.

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Hospital-Based Emergency Care: A Future Without Boarding?

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SEE RELATED ARTICLE, P. 115.

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On June 14, 2006, the much-anticipated Institute of Medicine (IOM) reports on the future of emergency care in the US health system were released. By now, many readers have formed their initial reactions. Without a doubt, the committee waded into a few controversial areas with recommendations that will divide experts within and without the fields of emergency care. But whether readers agree or disagree with the committee's individual recommendations, the real question is relatively simple: What's next? The Committee on the Future of Emergency Care in the US Health System has deliberated for more than 2 years to determine its vision for hospital-based emergency care in the 21st century. But without the combined efforts of many individuals, organizations, and public institutions, the vision of the reports will simply collect dust like books on a shelf. Now the real work must begin.

The committee has outlined a bold vision for a coordinated, regionalized, and accountable emergency and trauma care system. As the title of the report suggests, today's reality paints a much different picture. Despite dramatic improvements in care during the past 4 decades, hospital-based emergency care truly is at the breaking point in many areas of the United States in 2006.[1] The combined pressures of rapidly increasing emergency department (ED) volumes, countless hours of boarding hospital inpatients in ED hallways, the shortage of on-call specialty services, regional examples of skyrocketing malpractice premiums, and the global access problems created by a health care financing system that leaves tens of millions of Americans without health insurance have taken their toll on the US emergency and trauma care system.[2-6] Although it is quite unlikely that any Americans will wake up tomorrow to find that they no longer have access to emergency care, it is equally unlikely that they will find an emergency and trauma care system that is consistently poised to deliver on the IOM's quality goals—care that is safe, effective, patient-centered, timely, efficient, and equitable.[7]

The IOM subcommittee on hospital-based emergency care made no fewer than 25 recommendations for improving our emergency and trauma care system (see Table).[1] Despite the report's broad scope, the committee's vision for hospital-based emergency care can be condensed into 4 major themes: financing an inclusive emergency and trauma care system, creating a new era of operations management in US hospitals, building the 21st-century emergency care workforce, and expanding the scientific knowledge base for emergency and trauma care.

FINANCING AN INCLUSIVE EMERGENCY AND TRAUMA CARE SYSTEM

The IOM's Committee on the Consequences of Uninsurance eloquently described the tremendous burdens that lack of insurance places on individuals, families, communities, and the US economy.[8-12] Nowhere are these burdens more evident than in our nation's emergency and trauma care system. The Emergency Medical Treatment and Active Labor Act (EMTALA) mandates that any individual who presents to a hospital ED must receive a medical screening examination and, if an emergency medical condition is identified, be offered treatment to stabilize that condition or offered safe transfer to an appropriate facility. The health care goals of EMTALA are laudable; unfortunately, there has never been a commitment to finance the care that it mandates. To address this gap, the Committee on the Future of Emergency Care recommends that Congress establish dedicated funding to reimburse hospitals that provide significant amounts of unreimbursed emergency and trauma care. The goal of this funding is to stabilize the hospitals and providers that are at greatest risk because of uncompensated care.

In addition to addressing financial shortfalls, the committee envisions a reorganized emergency and trauma care system that is built around the themes of coordination, regionalization, and accountability. Because the ideal structure of these systems likely will vary according to local factors, the committee thought that a demonstration program would be a logical first step. The demonstration projects may identify several successful approaches for coordinating emergency care across a region. An important part of achieving these goals is to categorize the emergency and trauma care resources in each region according to adult and pediatric service capabilities. The committee envisions this process as one that includes all of a region's resources—much like trauma systems in many states today—not one that excludes facilities or providers because of limited capabilities.

A NEW ERA OF OPERATIONS MANAGEMENT IN US HOSPITALS

The title of this editorial was followed by a question mark. The committee didn't use a question mark. Rather, it called on US hospitals, the Joint Commission for the Accreditation of Hospital Organizations (JCAHO), and the Centers for Medicare and Medicaid Services to eliminate inpatient boarding in the ED by adopting proven operations management strategies, enforcing strong regulatory standards, and providing payment incentives that promote patient flow in hospitals.

Although there is no question that financial incentives and regulatory enforcement may assist hospitals in accomplishing this goal, what the committee is really calling for is a new era of operations management in US hospitals. Beginning with the chief executive officer, hospitals must adopt facility-wide approaches for enhancing the reliability, consistency, and efficiency of operations. This is the only approach that will successfully reduce bottlenecks in patient flow. The use of information technology will greatly enhance the ability of hospitals to transition to a new era of operations. Implementing systems that enable real-time availability of both clinical and operational data (eg, key performance indicators for patient flow) is essential.

The committee recognizes the unique role that our emergency and trauma care system plays in the response to disasters. In addition to specific recommendations about funding and educational needs for disaster preparedness, the committee strongly believes that the first step in preparing for a mass casualty incident is to maximize the day-to-day operational efficiency and reliability of the system. We cannot expect emergency medical services (EMS) systems and hospital EDs to have adequate surge capacity if they continue to be burdened by the daily bottlenecks caused by ambulance diversion and boarding.

BUILDING THE 21ST CENTURY EMERGENCY CARE WORKFORCE

One of the most acute problems facing today's emergency care system is the declining availability of on-call specialists to support EDs. The combination of costly medical malpractice insurance, inadequate reimbursement for services, lifestyle considerations, and other factors has severely eroded on-call specialty panels in many areas of the country. To address this concern, the committee recommends that hospitals collaborate to regionalize critical on-call specialty services. The committee also calls on Congress to appoint a commission to examine the factors that are responsible for declining on-call specialty availability, with a special emphasis on the role that medical malpractice liability is playing. The emergency and trauma care community must come together to ensure that Congress follows through on this recommendation. The longer policymakers delay, the more likely we will see further deterioration in on-call specialty services.

The future vision of a regionalized, coordinated, and accountable emergency and trauma care system can only be achieved with a highly competent workforce. The growth in residency training programs in emergency medicine during the past 3 decades has been a tremendous achievement. Building on this success, the committee envisions competency standards that enhance the consistency of training at each level of the emergency care continuum, from rural EMS personnel to highly specialized staff at tertiary referral centers. Two specific recommendations are worth noting in this area. The first recognizes the important role that telemedicine could play to support emergency care providers in rural areas. The second recognizes the long-overdue need to extend eligibility for board certification in critical care medicine to all acute and primary care physicians who complete an accredited critical care fellowship program.

EXPANDING THE EMERGENCY AND TRAUMA CARE KNOWLEDGE BASE

Perhaps more than in any other section of the report, the committee's recommendations for promoting research in emergency and trauma care represent an investment in a brighter future. These recommendations begin with a focus on building research capacity in emergency and trauma care. Important investments should be made to promote research training for new investigators, provide adequate research time and facilities, and establish autonomous academic departments of emergency medicine. In addition to these capacity-building steps, the committee calls on the secretary of the Department of Health and Human Services to identify the gaps and opportunities for emergency and trauma care research and then recommend an approach for funding the necessary research efforts. With a relatively modest investment and no overall coordinated federal effort to promote emergency and trauma care research during the past 3 decades, we have seen important improvements in the scientific knowledge base for emergency care. Through these reports, the IOM is calling for a dramatic acceleration in the scientific advancement of emergency and trauma care, with potential for worldwide benefits. It is our responsibility to create a sense of urgency among policymakers to follow through with these recommendations.

The committee has delivered. Now the real work begins. With the publication of these reports, there is now an opportunity for a different kind of conversation about emergency care in the United States. In May 1961, President Kennedy challenged Congress and the American public to put a man on the moon by the end of the decade.[13] Undoubtedly, many Americans at the time thought this was at best a pipe dream and at worst an unachievable vision that would only lead to disappointment. In most EDs around the United States today, the committee's vision of hospital-based emergency and trauma care may seem like a comparably remote possibility (Eliminate boarding? Good luck!). But if we cannot envision a future without boarding, there is no hope of creating one.

The committee has developed a vision for a hospital-based emergency and trauma care system that is much stronger than the one we have today. Because we all have a stake in the quality

Table. Recommendations: Hospital-Based Emergency Care: At the Breaking Point.

	Congress	DHHS	DOT	DHS	DOD	States	Hospitals	EMS Agencies	Private Industry	Professional Organizations	Other
Chapter 2: The Evolving Role of Hospital-Based Emergency Care											
2.1. Congress should establish dedicated funding, separate from DSH payments, to reimburse hospitals that provide significant amounts of uncompensated emergency and trauma care for the financial losses incurred by providing those services.											
• Congress should initially appropriate $50 million for the purpose, to be administered by the Centers for Medicare and Medicaid Services.	X	X									
• Centers for Medicare and Medicaid Services should establish a working group to determine the allocation of these funds, which should be targeted to providers and localities at greatest risk; the working group should then determine the funding needs for subsequent years.											
Chapter 3: Building a 21st Century Emergency Care System											
3.1. The Department of Health and Human Services and the National Highway Traffic Safety Administration, in partnership with professional organizations, should convene a panel of individuals with multidisciplinary expertise to develop an evidence-based categorization system for EMS, EDs, and trauma centers according to adult and pediatric service capabilities.		X	X							X	
3.2. The National Highway Traffic Safety Administration, in partnership with professional organizations, should convene a panel of individuals with multidisciplinary expertise to develop evidence-based model out-of-hospital care protocols for the treatment, triage, and transport of patients.			X							X	
3.3. The Department of Health and Human Services should convene a panel of individuals with emergency and trauma care expertise to develop evidence-based indicators of emergency care system performance.		X									
3.4. The Department of Health and Human Services should adopt regulatory changes to the EMTALA and the Health Insurance Portability and Accountability Act (HIPAA) so that the original goals of the laws are preserved but integrated systems may further develop.		X									
3.5. Congress should establish a demonstration program, administered by the Health Resources and Services Administration, to promote regionalized, coordinated, and accountable emergency care systems throughout the country and appropriate $88 million during 5 years for this program.	X	X									
3.6. Congress should establish a lead agency for emergency and trauma care within 2 years of the publication of this report. The lead agency should be housed in the Department of Health and Human Services and should have primary programmatic responsibility for the full continuum of EMS and emergency and trauma care for adults and children, including medical 911 and emergency medical dispatch, out-of-hospital EMS (both ground and air), hospital-based emergency and trauma care, and medical-related disaster preparedness. Congress should establish a working group to make recommendations about the structure, funding, and responsibilities of the new agency and develop and monitor the transition. The working group should have representation from federal and state agencies and professional disciplines involved in emergency and trauma care.	X	X									
Chapter 4: Improving the Efficiency of Hospital-Based Emergency Care											
4.1. Hospital chief executive officers should adopt enterprise-wide operations management and related strategies to improve the quality and efficiency of emergency care.						X					
4.2. The Centers for Medicare and Medicaid Services should remove the current restrictions on the medical conditions that are eligible for separate clinical decision unit (CDU) payment.		X									
4.3. Training in operations management and related approaches should be promoted by professional associations; accrediting organizations, such as the JCAHO and the National Committee for Quality Assurance (NCQA); and educational institutions that provide training in clinical, health care management, and public health disciplines.									X	X	

Table. Continued

	Congress	DHHS	DOT	DHS	DOD	States	Hospitals	EMS Agencies	Private Industry	Professional Organizations	Other
4.4. The JCAHO should reinstate strong standards that sharply reduce and ultimately eliminate ED crowding, boarding, and diversion.		X					X				X
4.5. Hospitals should end the practices of boarding patients in the ED and ambulance diversion, except in the most extreme cases, such as a community mass casualty event. The Centers for Medicare and Medicaid Services should convene a working group that includes experts in emergency care, inpatient critical care, hospital operations management, nursing, and other relevant disciplines to develop boarding and diversion standards, as well as guidelines, measures, and incentives for implementation, monitoring, and enforcement of these standards.											
Chapter 5: Technology and Communication											
5.1. Hospitals should adopt robust information and communications systems to improve the safety and quality of emergency care and enhance hospital efficiency.							X			X	X
Chapter 6: The Emergency Care Workforce											
6.1. Hospitals, physician organizations, and public health agencies should collaborate to regionalize critical specialty care on-call services.	X										
6.2. Congress should appoint a commission to examine the factors responsible for the declining availability of providers in high-risk emergency and trauma care specialties, including the role played by medical malpractice liability specifically, and to recommend targeted state and federal actions to mitigate the adverse impact of the responsible factors and ensure quality of care.										X	X
6.3. The American Board of Medical Specialties and its constituent boards should extend eligibility for certification in critical care medicine to all acute care and primary care physicians who complete an accredited critical care fellowship program.		X	X	X							
6.4. The Department of Health and Human Services, the Department of Transportation, and the Department of Homeland Security should jointly undertake a detailed assessment of emergency and trauma workforce capacity, trends, and future needs and develop strategies to meet these needs in the future.		X								X	
6.5. The Department of Health and Human Services, in partnership with professional organizations, should develop national standards for core competencies applicable to physicians, nurses, and other key emergency and trauma professionals, using a national, evidence-based, multidisciplinary process.						X	X				
6.6. States should link rural hospitals with academic health centers to enhance opportunities for professional consultation, telemedicine, patient referral and transport, and continuing professional education.											X
Chapter 7: Disaster Preparedness											
7.1. The Department of Homeland Security, the Department of Health and Human Services, the Department of Transportation, and the states should collaborate with the VHA to integrate the VHA into civilian disaster planning and management.		X	X								
7.2. All institutions responsible for the training, continuing education, and credentialing and certification of professionals involved in emergency care (including medicine, nursing, EMS, allied health, public health, and hospital administration) should incorporate disaster preparedness training into their curricula and competency criteria.							X			X	X
7.3. Congress should significantly increase total disaster preparedness funding in fiscal year 2007 for hospital emergency preparedness in the following areas:	X										
• strengthening and sustaining trauma care systems											
• enhancing ED, trauma center, and inpatient surge capacity											
• improving EMS response to explosives											
• designing evidence-based training programs											
• enhancing the availability of decontamination showers, standby ICU capacity, negative-pressure rooms, and appropriate personal protective equipment											
• conducting international collaborative research on the civilian consequences of conventional weapons terrorism											

Table. Continued

	Congress	DHHS	DOT	DHS	DOD	States	Hospitals	EMS Agencies	Private Industry	Professional Organizations	Other
Chapter 8: Enhancing the Emergency and Trauma Care Research Base											
8.1. Academic medical centers should support emergency and trauma care research by providing research time and adequate facilities for promising emergency care and trauma investigators and by strongly considering the establishment of autonomous departments of emergency medicine.							X				
8.2. The secretary of the Department of Health and Human Services should conduct a study to examine the gaps and opportunities in emergency and trauma care research and recommend a strategy for the optimal organization and funding of the research effort. This study should include consideration of training of new investigators, development of multicenter research networks, funding of general clinical research centers that specifically include an emergency and trauma care component, involvement of emergency and trauma care researchers in the grant review and research advisory processes, and improved research coordination through a dedicated center or institute. Congress and federal agencies involved in emergency care research (including DOT, DHHS, DHS, and DOD) should implement the study's recommendations.	X	X	X	X	X						
8.3. Congress should modify FWA regulations to allow the acquisition of limited, linked, patient outcome data without the existence of an FWA.	X										

DHS, Department of Homeland Security; *DHHS*, Department of Health and Human Services; *DOD*, Department of Defense; *DOT*, Department of Transportation; *FWA*, Federalwide Assurance Program; *VHA*, Veterans Health Administration.

of emergency care in the United States, only 1 question remains: What will you start doing tomorrow to help make this vision a reality?

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Introduction

Annals News and Perspective explores topics relevant to emergency medicine, in particular those in which our specialty interacts with the political, ethical, sociologic, legal and business spheres of our society. Discussion of specific clinical problems and their management will be rare. By design, it will not be a "breaking news" section with the latest (and undigested) developments, but instead a reflective investigation of recent and emerging trends. If you have any feedback about this section, please forward it to us at feedback@acep.org.

0196-0644/$-see front matter

DEBATE RAGES OVER THE "FUTURE OF EMERGENCY CARE"

Maryn McKenna
Special Contributor to Annals News and Perspective

The US emergency care system is overwhelmed, underfunded, understaffed and "at the breaking point," the Institute of Medicine (IOM) announced on June 14 in releasing a three-part report on problems in emergency care.

Once a minute every day—501,000 times per year—an ambulance carrying a sick patient is turned away from an emergency department (ED). Treated patients wait hours or days on gurneys for admission elsewhere in the hospital. And nowhere in the country is an ED adequately equipped—with staff, technology or spare beds—to handle a mass-casualty terrorist attack or the introduction of pandemic flu.

"The Future of Emergency Care in the United States Health System," which was prepared over 2 years by a committee of more than 40 physicians and nurses from around the country, makes a number of urgent recommendations to ease the bottlenecks. But its authors said they hope more than anything to draw the attention of the public and Congress to a situation accelerating out of control.

"In most communities there is a crisis under the surface," Dr. Gail Warden, president emeritus of the Henry Ford Health System in Detroit and the chair of the report committee, said at a lengthy briefing at IOM headquarters in Washington.

"We have overcrowded emergency departments and hospitals with long waits for beds. We have ambulance diversions because the emergency room is overcrowded and not able to handle the volume coming to it. We have a lack of specialists available to care for emergencies. . . The transport of patients is often fragmented and disorganized."

The crux of the problem is a mismatch between supply and demand, the report authors said. Use of EDs is rising: There were 114 million visits in 2003, up 26% from 10 years before. But the number of EDs is shrinking: Over that same decade, 425 EDs and 703 hospitals closed, and the number of hospital beds contracted by 198,000.

The remaining departments are providing more care—despite a shrinking pool of on-call specialists, a nursing shortage of more than 110,000 open positions, and cuts in federal reimbursements—because they feel a moral obligation, said Dr. A. Brent Eastman, a report co-author and the chief medical officer of ScrippsHealth in San Diego, CA.

SAFETY NET FOR SHOWING THE STRAIN

"The safety net is currently being kept afloat by incredibly dedicated professionals," he said at the IOM briefing.

But, the experts pointed out, overloaded departments are also providing care because they are legally compelled—by EMTALA, the Emergency Medical Treatment and Active Labor Act—to treat anyone who comes through their doors.

"We value emergency care so much that it is the only medical care to which Americans have a legal right," said Dr. Arthur Kellermann, a report co-author and professor and chair of emergency medicine at Emory University School of Medicine in Atlanta. "But we value it so little we are not willing to pay for that care. It is in Congressional parlance an unfunded mandate."

An instant infusion of funds for emergency medical care tops the reports' list of urgent recommendations: a one-time appropriation of $50 million to reimburse hospitals whose EDs are used as primary care providers by the under- and uninsured; $88 million to fund demonstration projects uniting fragmented EMS-hospital communication systems; and increases in budgets for the Emergency Medical Services for Children Program.

Those dollars will provide a short-term fix not a long-term solution, said Warden, who called the $50 million request "a down-payment to get Congress's attention."

The report calls as well for an immediate increase in the proportion of funds for bioterrorism and pandemic-influenza preparedness that are being sent hospitals' way. Since 2002, the

report committee said, emergency medical services nationwide have received only 4% of first-responder funds paid out by the Department of Homeland Security. Hospitals have received an average of $10,000 each from the Health Resources and Services Administration's post-anthrax Bioterrorism Hospital Preparedness Program —and, to date, none of the money granted states by the Department of Health and Human Services (HHS) to prepare for pandemic flu.

"We are definitely not prepared for the onslaught of patients we would receive today in a disaster, whether it is a hurricane Katrina, whether it is a terrorist attack which conventional wisdom would suggest may well be explosive, or a pandemic," Eastman said.

Along with funds, the committee recommended Congress create a new federal agency, preferably within HHS, that would unite under one roof programs now scattered among several departments.

"If we are calling for real integration of a very fragmented system of emergency care, regionally and locally, that has to flow all the way up to the federal level also," said Robert Giffin, PhD, an IOM senior program officer and the study's co-director. Currently, "there are some redundancies and lots of gaps," he said. "The system does not have good representation at budget time. Every organization is an orphan."

But the committee called on EDs, EMS and hospitals to make changes as well, on initiatives that range from cooperating with local and regional rivals, to gathering data to make evidence-based decisions, to implementing operational and technological improvements.

THE MARRIOTT MODEL OF BED CONTROL

"Marriott knows a lot more about the status of the rooms in their hotels than the vast majority of hospitals have any clue about in this country today," said Dr. Brent Asplin, associate professor of emergency medicine at the University of Minneapolis and a report co-author. "Even though most hospitals have electronic bed-capacity monitoring systems, we all know the real information in many hospitals is on a paper clipboard, and only the house supervisor knows where the patients are and where they are not."

Crucially, the committee said, hospitals must abandon the chokehold on inpatient bed space that forces EDs to board patients, and turn ambulances away.

"I didn't say, 'Work on it'–we said they must end it," Kellermann said at the IOM. "They need the resources and support to do that, but this is simply unacceptable. We cannot let the most time-critical form of entry into the health care system be gridlocked."

The 3 report sections released Wednesday focus on critical aspects of the emergency medical care system: in-hospital care, prehospital services and pediatric emergency care. Their titles give a flavor of the committee's sense of urgency: "Hospital-Based Emergency Care: At the Breaking Point"; "Emergency Medical Services: At the Crossroads"; and "Emergency Care for Children: Growing Pains."

Immediately after their release, the constituencies whom the reports touched responded—mostly positively—to their urgent calls for change.

"The IOM report. . . is a much needed wake-up call for all Americans," said Dr. Thomas R. Russell, executive director of the American College of Surgeons.

"The Emergency Nurses Association agrees with the general recommendations put forth today by the IOM," said Nancy Bonalumi, ENA president and director of emergency nursing at Children's Hospital of Philadelphia.

A CALL FOR CONGRESSIONAL ACTION

The American College of Emergency Physicians (ACEP) called for immediate Congressional hearings.

"Hospitals must be reimbursed for the significant amounts of uncompensated emergency care they provide," said Dr. Frederick Blum, ACEP president. "To do otherwise threatens to destroy the critical emergency care infrastructure that all Americans depend on."

Senator Richard Burr (R-NC), chairman of the Subcommittee on Bioterrorism and Public Health Preparedness, backed the call for action. Burr is leading a bipartisan effort to reauthorize the Public Health Security and Bioterrorism Preparedness and Response Act, first passed after the 2001 anthrax-letter attacks.

The IOM report "shows that across the nation our emergency care system has difficulty meeting the current pressures it must contend with," Burr said. "If our emergency rooms are strapped now, how will they provide emergency care in the event of a medical disaster? We must restructure the federal programs that affect emergency medical response and make sure there is one person in charge at HHS."

HHS itself—envisioned by the IOM committee as the home of the new federal agency for emergency medicine—responded conservatively.

"HHS will be reviewing the findings and recommendations in the Institute of Medicine reports on 'The Future of Emergency Care in the United States,' "the agency said in a prepared statement. "By and large, it is consistent with our understanding of the problems that currently exist, and it notes some of the actions we are currently taking to ensure that our emergency health care system provides safe and high quality healthcare."

The possibility that HHS could become the federal home of all emergency care oversight —rather than the Department of Transportation, which oversees the National Highway Traffic Safety Administration, federal home of EMS—was not universally applauded. During the IOM briefing, the National Association of Emergency Medical Technicians (NAEMT) released poll results showing that, while 93% of 3,000 NAEMT members agreed they are health care workers, 85% also see themselves as public safety responders.

Outside Washington, emergency medical professionals supported the IOM report.

"The committee got it right, pretty much across the board," said Dr. Brent King, chairman of the department of emergency medicine at The University of Texas Medical School at Houston. "There's no question in my mind that we absolutely must address the issue of the unfunded mandate."

Dr. Jeff Kalina, medical director of Houston's Methodist Hospital's ED and chair of the Texas Medical Center's disaster preparedness committee, added: "Despite the fact that over and over it has been discussed that emergency preparedness is key, a lot of the money goes to fire, police. Those are the squeaky wheels, and they have the political clout to get the funding." The committee focused some of its deepest concern on the participation of those outside the emergency medical community: the physicians whom EDs and hospitals rely on to provide on-call subspecialty care, but who have withdrawn in droves due to the cost of uncompensated care and the increased risk of medical liability.

PITFALLS IN PEDIATRIC CARE

In addition to all the above, the experts concluded, there are also problems with the emergency care of children. Very few of the nation's emergency departments have all the specialized equipment, technology or staff to care for the child patients who make up one-fourth of their patient load. Although pediatric skills deteriorate quickly without practice, continuing education in pediatric care is not required or is extremely limited for many prehospital emergency medical technicians (EMTs).

Many medications given to children have not been reviewed or approved for that use by the FDA. Disaster preparedness plans often overlook the needs of children, even though their needs differ from those of adults. Even a bus crash that badly injures a dozen children could overtax a department, they said.

"When you look at surge capacity, the checklists say, do you have a 3-0 tube, not do you have 15 of them," said Kathi Huddleston, a Virginia transport nurse in the IOM briefing's audience. "In this area of 6 million, we have less than 40 pediatric ICU beds."

REPORTS AS A SECOND LANDMARK

By accident or design, the IOM report comes on the 40th anniversary of another National Academy of Sciences publication —the report "Accidental Death and Disability: The Neglected Diseases of Modern Society," which triggered the passage of federal legislation, the creation of NHTSA and the Office of EMS and the rapid growth of US trauma care.

There was a palpable sense at the IOM briefing that committee members hungered for a similar second surge of public and political will.

"We transformed EMS and trauma care in the United States in less than a decade, and then we kind of ran out of momentum," Kellermann said. "We substituted, for some sense of strategy and direction, a lot of goodwill and talent and individual effort. We have run on that for 30 years—but that is a terrible way to make public policy.

"Imagine what we could do if we could harness good thinking, careful planning and the talent we have in the emergency care system, today . . . We could have a system that deserves the confidence of the American people that they still give us, and certainly that they deserve."

Maryn McKenna is an Atlanta journalist and author and a Kaiser Family Foundation Media Fellow studying emergency department stress.

Eric Berger contributed to this article.

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A Growing Crisis in Patient Access to Emergency Surgical Care

Introduction

Many changes have occurred in the surgical practice environment in the past two decades, but policy experts have given little scrutiny to the potential for unintended and undesirable effects. Even the rare policy research paper that notes how stresses in the system affect surgical patients tends to gloss over the implications of the situation. Surgeons in practice, however, have begun to take notice. While intermittent access and availability issues are becoming evident in many service areas and settings, one area raising deep concern universally is emergency care.

In March 2005 and March 2006, the American College of Surgeons hosted meetings with leaders of the surgical specialty societies to examine reports of a growing shortage of surgeons available to cover emergency departments (EDs) and trauma centers. In some specialties, the insufficient number of participants in emergency call panels has reached crisis proportions, and patients throughout the nation are feeling the impact. Furthermore, surgeons who remain in the emergency care system are experiencing professional and personal burdens that are simply unsustainable. The American Medical Association reached the same conclusions at meetings last fall and again in March of this year.

The situation is of such concern that several specialty organizations[1] independently surveyed their members on this issue. Despite the different survey populations, the findings were remarkably similar:

- A majority of surgeons take ED call five to 10 days a month; some surgical specialists take call far more often.
- Many surgeons provide on-call services simultaneously at two or more hospitals, and a significant number say they have difficulty negotiating their on-call schedules.
- Hospital bylaws typically require surgeons to participate in on-call panels, although older individuals are often allowed to "opt out," and they are more frequently taking advantage of this option.
- A significant number of surgeons have been sued by patients first seen in the ED, and some physicians are offered discounts on their liability coverage if they limit or eliminate ED call.

Despite earlier predictions, the number of surgeons trained through the nation's graduate medical education system has not expanded for more than two decades. A growing patient population and a stable supply of practicing surgeons are combining with other forces to produce surgical workforce shortages, particularly in specialties with total workforce numbers in the hundreds or low thousands. Our nation's trauma centers and EDs are feeling the most pervasive effects right now, although spot shortages are occurring in other settings and specialties as well.

The reasons for concern are clear. Patients need prompt access to definitive care when confronting a surgical emergency. But even more is at stake. Our nation's EDs provide the one point of universal access to our health care system. They are the nation's final safety net. Indeed, the public fully expects such access, and it is doubtful that patients realize it is eroding. Yet, policy experts and decision makers seem to be unaware of the trend, and certainly no focused efforts are under way to resolve the problem.

Equally important, our emergency care system (including the EDs, hospitals, trauma centers, and the health care professionals who comprise it) forms the foundation of our nation's response to future terrorist attacks and natural disasters. Emergency care capability has never been more important than it is in the post-9/11 world, and the need to strengthen it has never been more urgent.

The following information is an effort to document, based on the limited sources available, some of the underlying causes of this imminent crisis. Also included are proposed actions that should be explored immediately to begin addressing them. Clearly, much work remains to be done.

Overview of Surgical Care in the Emergency Department

According to the National Center for Health Statistics,[2] approximately 114 million ED visits (39 per 100 people) took place in 2003, representing a 26-percent increase since 1993. In addition, nearly half of all hospital EDs reported that they were at or beyond capacity in 2005 and, as a result, were forced to divert ambulances to other facilities. The problem is particularly acute for teaching hospitals, which reported that 79 percent of their EDs were at or over capacity. Overcrowding is attributed to many factors—inpatient capacity and patient flow management among them—but frequently cited issues are the federal mandate to screen and stabilize all patients and a scarcity of on-call physicians and surgeons to provide specialty care.[3]

A variety of patient emergencies may require surgical care. Common reasons for surgical admissions involve gallbladder disease, gastrointestinal bleeding, appendicitis, heart disease, aneurysm, stroke, and complications associated with procedures, devices, implants, or grafts. Patients suffering injuries from external forces, or trauma, most often require emergency surgical intervention. Trauma accounts for approximately 11.4 percent of nonpediatric and nonmaternity hospital admissions originating in the ED, according to the Agency for Healthcare Research and Quality.[4]

Formally designated trauma centers that function as part of a state or regional trauma care system are known to provide the highest quality care to severely injured patients.[5] Perhaps contrary to general assumptions, relatively few trauma center patients are victims of violence. According to the College's own National Trauma Data Bank® (NTDB),[6] victims of motor vehicle traffic accidents represent the largest segment of patients treated in our nation's trauma centers. Falls are the second most common cause of severe injury and are the most prevalent source of trauma in the elderly.

A March 2005 Harris interactive public opinion poll commissioned by the College's Committee on Trauma and the Coalition for American Trauma Care revealed that Americans appreciate the importance of prompt access to specialized trauma care services. Nearly all respondents recognized that it is extremely (63 percent) or very (31 percent) important to receive treatment at a trauma center in the event of a life-threatening injury. In fact, most respondents (eight out of 10) believed that having a trauma center nearby is of equal or greater value than a fire or police department.[7] Additionally, a significant majority indicated they would be extremely or very concerned to discover that their state's trauma system fell short of recognized standards of care. Unfortunately, a survey conducted by the Health Resources and Services Administration in 2002 found that only eight states met all the recognized criteria for a fully developed trauma care system, although 26 states met most criteria.[8]

Trauma systems provide an important means of ensuring access to emergency surgical care for the most severely injured patients. The trauma system model of regionalized care also holds promise for ensuring that patients receive treatment for other surgical emergencies, including those resulting from disasters. State or regional trauma systems are the bedrock for responding to disasters, whether natural or man-made, and policymakers have failed to support them with the vigor they show for other disaster preparedness and response programs.

The Underlying Problem: An Emerging Workforce Crisis

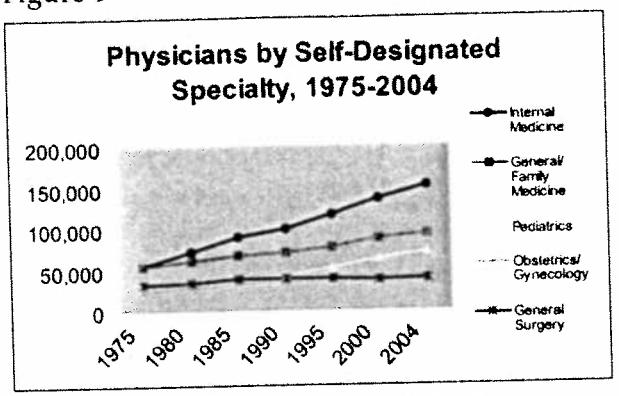
A growing shortage of surgical specialists available to cover our nation's EDs is threatening access to prompt acute care services. While the science of forecasting physician supply and demand continues to evolve, it is apparent that previous predictions of an oversupply of specialists missed the mark. Conventional wisdom has shifted with the introduction of new peer-reviewed studies, and physician workforce analysts now project potential shortfalls in specialties that are crucial to community-based emergency care response.

Contrary to earlier assumptions, the number of surgeons trained in our nation's graduate medical education system has remained stable for more than 20 years (*Figure 1*). As a result, U.S. population growth has outpaced the supply of surgeons. Furthermore, because the elderly comprise a disproportionate share of the surgical patient population, the "graying of America" is placing even greater demand on the supply of specialists.

An analysis conducted by the Lewin Group of the American Hospital Association's "ED and Hospital Capacity Survey of 2002" showed that neurosurgeons, orthopaedic surgeons, general surgeons, and plastic surgeons were among the specialists in short supply for ED on-call panels.[9] A similar survey conducted by the American College of Emergency Physicians in 2005 showed that nearly three-quarters of ED medical directors believe they have inadequate on-call specialist coverage, compared with two-thirds in 2004. In that survey, orthopaedic, plastic, and neurological surgeons, as well as otolaryngologists and hand surgeons, were reported as most often being in short supply.[10] Using conservative estimates of U.S. population growth, it is apparent that the ratio of surgeons in these specialties available to provide emergency services that Americans will need is on the decline (*Figure 2*).

The problem is compounded by an aging surgical workforce, which makes fewer surgeons available for ED coverage due to decreased workload capacity and retirements. In many

Figure 1



Source: American Medical Association (AMA): Physician Characteristics and Distribution in the US, 2006 edition

specialties that are key to ensuring adequate emergency call coverage, approximately one-third of the practicing surgeons are age 55 or older (*Figure 3*). Contributing to this shortage are provisions in many hospital bylaws that allow older physicians to opt out of ED on-call responsibilities.

Workforce shortages exist across a range of medical disciplines, but generally are far more significant for surgery. The workforce in nonsurgical specialties has grown steadily over time, while the number of individuals entering surgery each year has been relatively stable for more than two decades. In general surgery, for example, the rate of growth is not only slower than the growth in the general population, but it is significantly below the rate for nonsurgical specialties, including primary care specialties. (This statement is not intended to deny the genuine issues in other areas, but to clarify that the problem in general surgery is far more acute and generally overlooked.)

Other professional trends add to the problem, including the growing movement toward specialization. Program directors, professors of surgery, and other individuals who are familiar with residency matches report that about half of all general surgery residents go on to pursue fellowships and subspecialization. As their scope of service becomes narrower, a new and alarming trend has emerged—many surgeons no longer feel qualified to manage the broad range of problems they are likely to encounter in an ED.[12] We can anticipate that, as hospital credentialing policies and state

licensing requirements become more restrictive in coming years, this issue will be of increasing concern. Furthermore, if additional research confirms suspicions that younger surgeons are inclined to narrow the focus of their practice, the implications are even more troubling as older surgeons begin to retire.

Another important but overlooked factor is the small number of specialists produced by training programs each year. As an example, approximately 130 neurosurgery residency training positions are offered each year, far fewer than the largest medical specialty, internal medicine, which offers more than 4,700 positions.[13] In addition, recent studies have found that the number of operative cases has generally and significantly decreased for all neurosurgery residents because of compliance with the 80-hour workweek restrictions.[14] Considering the small number of neurosurgeons practicing in the U.S. today (approximately 3,200), the large portion of whom are older than age 55 (34 percent), and the time it takes to train a neurosurgeon (about seven years), it will be difficult to safely and adequately replace a shrinking pool of neurosurgeons participating in on-call panels.

The inadequate number of specialists providing emergency call services is taking its toll on quality of care. In a recent survey of ED administrators, 42 percent said that lack of specialty coverage in the ED poses a significant risk to patients. And, of those who indicated they would not choose their own ED as a source of care if they were seriously hurt (12 percent), an overwhelming majority (74 percent) listed the lack of specialty reinforcement as the reason.[15]

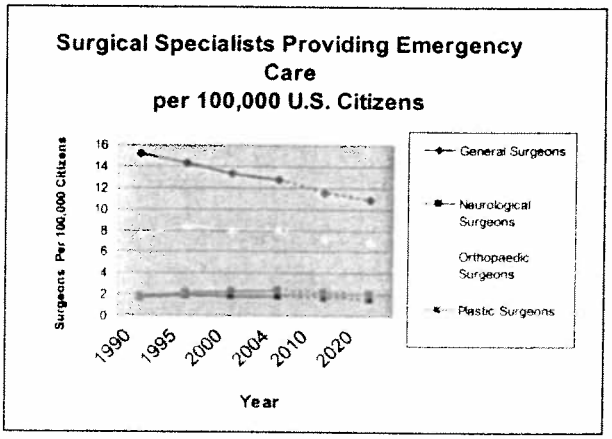
These workforce trends must be viewed within the context of rising demand for emergency services. Sharply accelerating need is chasing declining capacity, and the result is an emerging crisis in prompt access to emergency surgical care. In the short term, we need to develop new ways to manage our surgical resources in order to meet current needs. In the long term, we need to better understand and address the underlying causes of these problems.

Short-Term Solutions

We must develop the means to make our current emergency care system work well, despite the pressing workforce shortage. The American College of Surgeons has a long history of originating programs to improve emergency care, and we are now applying these models to new efforts to make effective use of scarce health care system resources.

- For example, the College's publication ***Resources for Optimal Care of the Injured Patient*** outlines the resources hospitals must have in order to fulfill their commitment to trauma patient care at various levels. State and local authorities throughout the U.S. have used this guidebook as the foundation for trauma center designation. In addition, the College's Committee on Trauma provides hospital consultation visits at the request of hospitals, communities, or state authorities to assess trauma care and to verify trauma center compliance with these criteria. Similar programs are conducted in collaboration with the American Burn Association to define and assess the resources required for burn treatment centers.

Figure 2

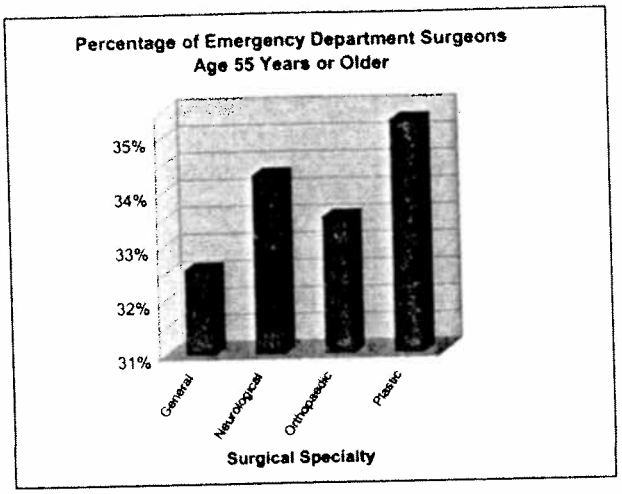


These data are for active surgeons, and the historical data were derived using figures from the AMA report titled, "Physician Characteristics and Distribution in the US," 2006 edition, Tables 5.2 and 5.16. The projected data beyond 2004 assume a flat supply of surgeons from 2004 through 2020 and steady increases in the U.S. population to 325 million by 2010 and 345 million by 2020. These projected population figures are similar to those used by the Centers for Medicare & Medicaid Services, according to Richard A. Cooper, et al.[11]

- The College's ***Trauma System Verification Program*** provides a comprehensive, on-site trauma system review to help states and regions assess their organizational strengths and weaknesses in providing optimal care for injured patients beyond the walls of individual trauma centers. Following the "Model Trauma Care System Plan" that the Health Resources and Services Administration introduced in 1992, these reviews may be conducted at a multistate, single-state, regional, county, or local level, depending on a particular system's scope and needs.
- The ***Advanced Trauma Life Support® Program*** (ATLS) is a series of courses offered throughout the U.S. and abroad to provide an organized approach for the evaluation and management of seriously injured patients. Now in its 25th year, this program exposes both physicians and physician extenders to proven methods of appropriately assessing and initially managing severely injured patients. ATLS is the widely accepted "gold standard" educational program for inculcating all members of the trauma team in the common principles of emergency care and is applicable in both large urban centers and small rural EDs.
- More recently, the College initiated the ***Rural Trauma Team Development Course*** to help all members of the health care team provide the initial assessment and stabilization of severely injured patients. It is designed to integrate the trauma care team of a small rural hospital or clinic into a larger state or regional trauma care system, both to improve the efficiency of resource use and to ensure that injured patients receive the appropriate level of care.

The American College of Surgeons and other surgical specialty societies remain committed to developing new strategies for expanding access to urgent services. For example, we are achieving some consensus on how to apply the trauma system model so that a blueprint can be developed for better regionalizing specialty care services that may be required in an emergency situation. We believe this new structure would relieve EDs of the burden of being expected to cope with the broad range of potential surgical problems at all hours of the day and night. This strategy would be particularly appropriate for

Figure 3



These data are derived from the AMA report titled, "Physician Characteristics and Distribution in the US," 2006 edition, Table 1.2.

services provided by specialties with workforce numbers in the few hundreds or thousands, such as neurological and hand surgery.

In addition, the ATLS and Rural Trauma Team Development Course models could be applied to develop and implement protocols that allow physicians and surgeons in the ED to better assess whether conditions and injuries would best benefit from immediate, definitive specialty care or stabilization and treatment the following day, thereby lessening the demands on specialists on call.

Of course, the profession cannot address all of the contributing causes on its own; the federal government will need to intervene as well. Together, we can strengthen our nation's emergency care system. In the short term, we will work with Congress to reauthorize and appropriate funds for the Trauma Care Systems Planning and Development Act, a program administered by the Health Resources and Services Administration that aims to ensure that state and regional systems of care are operating throughout the nation to provide prompt access to surgical care that severely injured patients need. We also will work with policymakers to help ensure that an emergency surgical workforce is identified and prepared to assist in the event of a national terrorist attack or natural disaster.

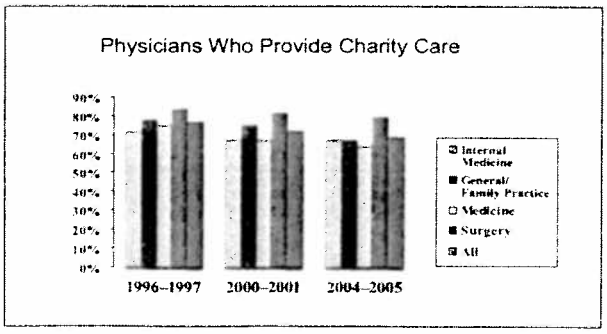
Forces Shaping the Workforce Crisis

The single most important factor shaping the surgical workforce issue today is declining reimbursement. Physician concerns center not only on reimbursement for the emergency services themselves, which frequently are uncompensated, but also on insurance payments for procedures that comprise a major component of elective practice. These payments have been declining steadily over the past two decades. Related issues, such as the disruption that late-night emergency care causes to a surgeon's routine practice schedule and the lifestyle impact of frequent on-call service, undermine surgeons' willingness to take call.

As a recent report from the Center for Studying Health System Change noted, surgical specialists are more likely than other specialists or primary care physicians to provide charity care, probably because of their emergency on-call responsibilities *(Figure 4)*.[16] Yet, the number of both surgeons and other physicians who are providing charity care is decreasing, a trend the center attributes to declining practice incomes, which make it more difficult for physicians to subsidize unpaid care.

NTDB data confirm that surgeons bear the significant brunt of providing uncompensated care provided to severely injured patients.[6] According to data compiled from more than 1.5 million patient records at 565 U.S. trauma centers, "self-pay" is the largest single payment category for trauma center patients (21%), followed by Medicare (17%), with Medicaid not far behind (11%) *(Figure 5)*. And, while hospitals may draw upon special federal and state financing streams to offset the costs of providing care to patients with little or no health insurance coverage, physicians and surgeons may not.

Figure 4



Source: Center for Studying Health System Change

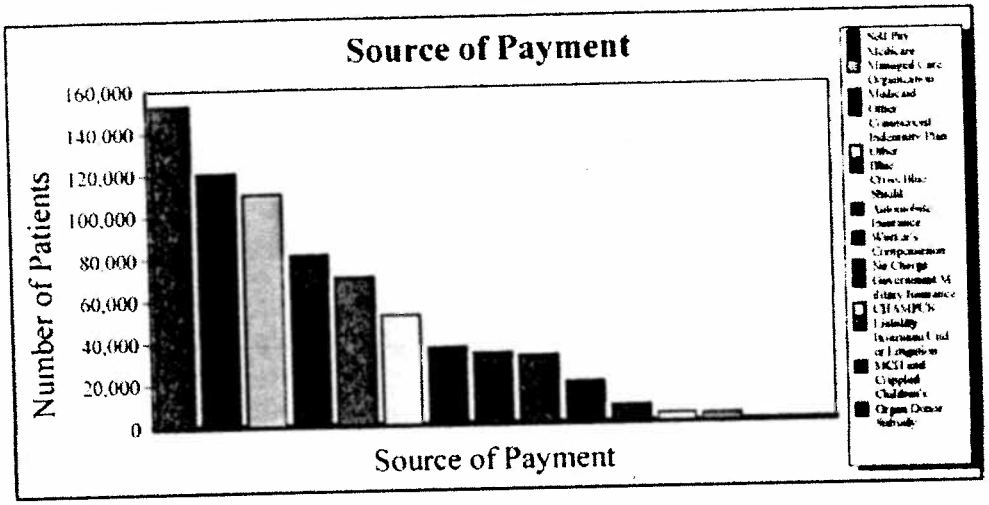
Further, as Table 1 illustrates, Medicare payments for many operations that elderly patients most often require are considerably lower than they were in the 1980s. These are actual, national average payment amounts, with no adjustment for inflation between 1989 and 2006. Payment levels for services frequently provided to injured patients in the ED have not fared much better, as shown in Table 2. Because many private insurance plans and Medicaid programs use the Medicare physician fee schedule as the basis for their own payment arrangements, these trends are reflected throughout the health care system. Again, the overall decline in practice income makes it difficult for surgeons, most of whom are in solo and small group practices, to shoulder the burden of caring for patients who are unable to pay. According to information that the Centers for Medicare & Medicaid Services recently released, the Medicare reimbursement situation will only worsen as the sustainable growth rate system produces further across-the-board payment reductions, amounting to an additional 39 percent in the next nine years.[17]

All specialties have concerns about the Medicare payment system, but its flaws are especially problematic for surgical specialists. As Medicare data show, medical services generally are growing at a rate that allows many specialists to offset per-service payment reductions by increasing service volume. However, the volume rates for surgical procedures are not growing—in fact, for many surgical services, volume is actually shrinking. So, not only are the overall payment cuts not offset, but, under the sustainable growth rate system, the increasing number of services provided by other physicians is actually *causing* the reductions.

Some surgeons are exhibiting market responses to these pressures, some of which affect access to emergency services. Certain surgeons have been forced to minimize financial disruptions to their practices by subspecializing in narrow fields dominated by elective services. In some cases, those surgeons who narrow their scope of services are able to omit hospital-based care

from their practices, making them unavailable for emergency on-call panels. According to a survey conducted by the American College of Emergency Physicians, 51 percent of ED directors in 2005 reported deficiencies in on-call coverage because specialists left their hospitals to practice elsewhere.[10] Hospital ED administrators report these specialists frequently relocate to ambulatory surgery centers (31 percent).[15]

Figure 5



In other cases, surgeons may eliminate risky or less profitable services from their practices. For example, a recent survey of neurosurgeons revealed that 38 percent now limit the types of procedures they perform. Of those, 57 percent have eliminated pediatrics, 13 percent no longer provide services related to trauma, and 11 percent no longer perform cranial procedures.[18] For other surgical specialties with elective patients requiring hospital resources, one option has been to form their own specialty facilities equipped to provide only a limited range of nonemergency procedures.

Table 1. Medicare Payments for Key Operations (1989–2006)

Remove cataract	$1,573	$684	-57%
Total knee replacement	$2,301	$1,511	-34%
Carotid endarterectomy	$1,677	$1,129	-33%
Prostatectomy (TURP)	$1,139	$695	-39%
Partial colectomy	$1,256	$1,226	-2%
Laminectomy	$2,078	$1,051	-49%
Hernia repair	$560	$469	-16%
Coronary arteries bypass	$3,957	$2,049	-48%
Mastectomy	$1,051	$997	-5%

Also affecting the availability of surgical care in EDs are liability issues unique to emergency care. Part of the growing reluctance to take call is because of a genuine concern that ED patients will sue. Surveys by the American College of Surgeons and the American Association of Neurological Surgeons/Congress of Neurological Surgeons revealed that more than one-third of respondents had been sued by a patient who was first seen in the hospital ED.[19] A 2005 hospital ED administration survey also lists "malpractice concerns" as the principal factor discouraging specialists from providing ED coverage.[15] Furthermore, because liability premiums have outpaced payments for their services, some surgeons have concluded that they simply cannot afford the added liability risk for a largely uninsured patient population.

In addition, younger surgeons, who often take the on-call shifts at trauma centers, are leaving states with the most severe liability problems. For example, according to the Project on Medical Liability in Pennsylvania, funded by the Pew Charitable Trust, "Resident physicians in high-risk fields such as general surgery and emergency medicine named malpractice costs as the reason for leaving the state three times more often than any other factor."[20] Further, an American Hospital Association study found that more than 50 percent of hospitals in medical liability crisis states now have trouble recruiting physicians, and 40 percent say the liability situation has resulted in less physician coverage for their EDs.[21] The crisis has even forced the

Table 2. Medicare Payments for Key Emergency Procedures (1990–2006)

Open treatment nose fracture	$1,044	$720	-31%
Open treatment eye socket fracture	$888	$714	-20%
Open treatment humerus fracture	$833	$751	-10%
Repair heart wound	$1,203	$1,129	-6%
Repair ruptured abdominal aneurysm	$2,535	$2,243	-12%
Burr hole for hematoma	$1,526	$1,087	-29%
Craniotomy for hematoma	$2,245	$1,749	-22%
Repair retinal detachment	$2,760	$1,375	-50%

closure of trauma centers in Florida, Mississippi, Nevada, Pennsylvania, and West Virginia at various times in recent years.[22]

Specialties that have experienced particularly high premium increases—including neurosurgery, orthopaedics, and general surgery—are also among those that provide services emergency patients most frequently require. According to a report from the General Accounting Office, soaring medical liability premiums have led specialists to reduce or stop on-call services to hospital EDs, seriously inhibiting patient access to emergency surgical services.[22]

Declining payments from all sources, a large burden of uncompensated care being provided in EDs, escalating practice overhead and medical liability premium costs, and new practice patterns that are causing some surgeons to narrow their breadth and limit in-hospital care are combining to produce an unfortunate result: the pool of surgical specialists from which to draft an emergency call schedule is being drained.

Long-Term Solutions

Many of the solutions the surgical profession has identified for these problems are enormous in scope and envelop the structure of our health care system and the interests of many stakeholders. Certainly, it is time for policy researchers and policymakers to begin addressing these difficult issues, bearing in mind that no stakeholder has more to lose than the surgical patient. Hence, it is time that surgeons and policymakers initiate changes that are currently feasible to address the underlying causes.

Federal and state laws do little to encourage surgical specialist participation in emergency on-call panels. The Emergency Medical Treatment and Labor Act (EMTALA), for example, was signed into law in 1986 as an effort to address the problem of patient-dumping by hospital EDs. The law grew both in scope and complexity for a number of years and was often interpreted in such a restrictive sense that it imposed untenable burdens on specialists providing emergency coverage. Although the federal government has taken steps to address some of the law's most serious weaknesses, specialists tend to view EMTALA as a mandate to provide uncompensated care around-the-clock, and the law is widely believed to be a primary factor behind practice behavior changes that are taking surgeons away from hospitals and EDs. In addition, the American College of Emergency Physicians noted in a recent report that EMTALA may actually encourage uninsured patients to seek ED care in increasing numbers because they are aware of the federal mandate to provide screening and stabilizing care.[23]

The College pledges to work with regulators to continue refining laws such as EMTALA to remove disincentives for specialists to provide emergency care.

State insurance laws also unintentionally contribute to the problem of uncompensated trauma and emergency care. One such statute, known as the Uniform Accident and Sickness Policy Provision Law (UPPL), permits health insurers to deny coverage for trauma care for alcohol- or drug-related injury. The original intent of UPPL was to free sober drivers from paying the medical bills of those who drive while intoxicated. However, the result is that surgeons receive no compensation for services provided to insured patients, who often require care in the middle of the night. Although a few states have repealed their UPPL laws in recent years, most still have them on the books.

Indeed, it is important to remember that there are few mechanisms that can be used to provide compensation to surgeons and other specialists who care for the uninsured or patients who are covered by programs like Medicaid, which traditionally provide low reimbursements. Unlike hospitals, surgeons do not have access to Medicare's "disproportionate share" payment program, and most states that collect funds for trauma and ED care through special driver's license fees, traffic violation fines, and so forth, funnel the money to institutions rather than to physicians.

A variety of mechanisms for improving the reimbursement issues that underlie the problem must be pursued. Of course, the federal government needs to take on the formidable task of comprehensively addressing the ever-growing number of Americans without health insurance. Moreover, the current Medicare payment system that is producing negative annual updates for all physician services, regardless of their unique value or spending trends, must be reformed.

The College will continue to work at the state level to eliminate UPPL laws that deny reimbursement for care provided to insured patients, as well as develop new strategies to provide physicians with access to the financing mechanisms available to facilities that provide uncompensated care.

At the federal level, we believe the government should support EMTALA's mandate that physicians provide care for the uninsured of emergency department patients by providing some tax relief for these services. Such a tax credit or deduction could be based on overhead costs as determined in the Medicare physician fee schedule. Alternatively, the government could adjust the practice expense "pools" it develops for each specialty in determining overhead costs in the Medicare fee schedule by taking into account the impact of uncompensated care on those costs, as it has for emergency medicine. Finally, we believe Medicare should support those hospitals that have resorted to paying stipends to ensure on-call coverage by recognizing these costs when determining changes in hospital market basket or updates under the prospective payment system, as it does for critical access hospitals.

To improve access in rural areas, where the surgical workforce problem is most acute, Medicare provides 5-percent bonus payments to physicians who practice in physician scarcity areas. Unfortunately, the program appears to work better for primary care physicians than for specialists, largely because bonus payments are based on the location where services are rendered. Surgeons who care for sparse populations tend to provide their services either in regional hospitals or office buildings near those institutions. As a result, the actual site of service may be outside a physician scarcity area, even though the vast majority of the population being served resides in such an area. Another program provides 10-percent bonuses to physicians who render services in health professional shortage areas, but that program applies only to primary care and mental health providers.

Similarly, federal programs geared toward recruiting more physicians to provide care in underserved areas tend to favor primary care and certain nonphysician providers. The National Health Service Corps, for example, provides scholarships and medical school loan repayments to health professions students in return for a period of service in an urban or rural health professional shortage area. Again, no such program is available to surgeons and other specialists.

We will work with Congress to create a health professions support program to cover medical school debt for young surgeons providing surgical care in community or rural hospitals/trauma centers. We also will work with policymakers to refine current laws pertaining to physician scarcity areas so they may more effectively encourage surgical specialists to provide care in areas where demand is greatest.

Even federal programs providing limited medical liability protections for volunteer physicians tend to favor office-based care rather than treatment for the uninsured in the nation's EDs. The Volunteer Protection Act, for example, applies only to individuals serving in not-for-

profit organizations. In addition, Public Health Service Act section 224 provides Federal Tort Claims Act protection for services provided to patients of community health centers. However, because the focus is on community health centers, these protections only apply to primary care and office-based services. Surgeons who provide care to patients referred by community health centers receive no protections under the statute.

All medical and surgical specialty organizations support enactment of comprehensive, common sense, medical liability reforms. Until a comprehensive and nationwide solution emerges, however, interim steps addressing the most immediate concerns should be considered. For example, policymakers can limit exposure to medical litigation and provide qualified immunity for EMTALA care by bringing these mandated services under the Federal Tort Claims Act. Similar strategies may be pursued on the state level.

One federal program intended to ensure prompt access to surgical care for severely injured patients was established in the Trauma Care Systems Planning and Development Act of 1990 mentioned previously. Administered through the Health Resources and Services Administration, in the past several years this program has distributed $31.4 million in funds to all 50 states and five territories for the purpose of developing state and regional trauma care systems. But today, even with this influx of federal funds, the nation's trauma systems remain incomplete, and, unfortunately, only one-fourth of the U.S. population lives in an area served by a trauma care system.[24] Furthermore, efforts to reauthorize the program failed in 2005, no funds were appropriated for 2006, and the President's fiscal year 2007 budget proposes its elimination—all despite the fact that in 1999 the Institute of Medicine called on Congress to "support a greater national commitment to, and support of, trauma care systems at the federal, state, and local levels."[25]

In addition to advocating the reauthorization of the Trauma Care Systems Planning and Development Act, we will work with policymakers in the future to expand this concept to other surgical emergencies, including those resulting from natural or man-made disasters. We also will explore improvements in telemedicine to facilitate specialist consultations across state lines.

Finally, it is vitally important that policy researchers and policymakers gain a greater understanding of the forces that are undermining our nation's emergency care system. Studies of the growing uninsured population, for example, must expand their focus beyond the important but narrow issue of chronic disease management and begin considering the implications for access to high-quality acute care services for all Americans. The American College of Surgeons is committed to initiating this dialogue and will continue its collaboration with representatives of all surgical specialties to improve our understanding of the problems confronting surgical practice today and to develop innovative solutions to resolve them.

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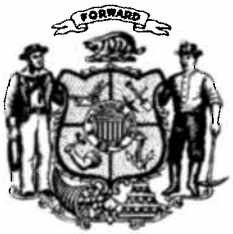
FORWARD

Department of Health and Family Services
Specialized Medical Vehicle Broker System Proposal Testimony
Before the Senate Select Committee on Health Care Reform
August 28, 2006

Good afternoon Senators Roessler, Darling and committee members. My name is Ron Hermes and I am the Legislative Liaison for the Department of Health and Family Services. With me today is, Eileen McRae, Medicaid budget and planning policy analyst.

I want to thank you for the opportunity to provide testimony to the Senate Select Committee on Health Care Reform on the Department's proposal to create a non-emergency transportation broker system for Medicaid recipients.

Under Federal law state Medicaid programs are required to ensure that recipients have transportation to and from Medicaid covered services. Wisconsin Medicaid meets this requirement by covering specialized medical vehicle (SMV) transportation services, tribal and county agency approved transportation, and transportation by ambulance.

The Medicaid program spends about $42 million (AF), annually, on non-emergency transportation services. Approximately half of these funds are spent on transportation services approved and paid for through tribal and county agencies. Transportation by SMV accounts for the other half of these expenditures.

In addition to Medicaid, transportation services are covered by several publicly funded programs. Over the last few years, the federal government has attempted to encourage better coordination of the various transportation programs in order to eliminate duplication and improve access. With funding from a federal grant, the Department of Transportation is currently working with DHFS and other agencies to improve coordination for human services transportation through an Inter-Agency Council on Transportation.

A recent change in federal Medicaid law included in the federal Deficit Reduction Act of 2005, allows states to more easily operate a transportation management program for Medicaid-funded transportation services. Prior to the enactment of the law, states were required to obtain a federal 1915(b) waiver of the freedom of choice provisions. Although a federal waiver is no longer required, states must ensure that the transportation management program is cost effective and that vendors are selected through a competitive procurement process. States must also submit a state plan amendment describing their program.

As you know, the Governor's 2005-07 biennial budget included a proposal to establish a transportation management system with an expected savings of close to $7 million (AF) in FY '07. Unfortunately, the Joint Committee on Finance (JCF) eliminated the statutory mandate for the broker, while requiring the Department to still meet the projected $7 million in savings.

In his veto message of the '05-'07 biennial budget, the Governor directed the Department to develop and implement a transportation management system for non-emergency transportation services. However, without the statutory mandate, the Department had to rely on voluntary participation of tribes and counties to operate a Medicaid transportation management system.

As the Department proceeded in the implementation of a voluntary broker system, meetings were held with tribes and county agencies to explain the proposed system and to seek their participation. The Department also established an advisory committee to provide feedback on program design and implementation. Additionally, the Department met separately with various provider and consumer groups to explain the proposal, hear their concerns and to seek their input.

The intent of the Department's proposal was to implement a program that improved access to covered non-emergency transportation services, simplified and improved customer service, increased accountability and fiscal savings for both the state and providers. The broker would have been selected through a competitive procurement process. Depending on the results of the procurement process either one statewide contract or regional contracts would have been awarded.

As noted earlier, the Department did not receive the statutory mandate in the budget so, the Department had to ask each county to voluntarily designate the transportation responsibility over to the Department. However, only twenty-seven counties indicated a willingness to give up this responsibility. Another fifteen indicated that they were undecided and ten chose not to delegate. Several counties did not respond.

Because there was minimal participation from counties, the decision was made in May 2006 to not move forward with the initiative. Operating a fragmented system would defeat the purpose of a single point of contact and improved coordination. With so few counties participating, it would have been difficult for a transportation manager to achieve improved coordination and savings.

The Department still believes that establishing a transportation management system is the right idea that will save the state money and improve access to transportation and access to Medicaid services in general. Based on feedback the Department has received, many counties, consumers and their representatives, and some transportation providers are disappointed that the Department did not continue its pursuit of the transportation management initiative. However, it became very clear throughout this process, that without the appropriate legislative mandate, the broker system can not work.

Again, I want to thank for the opportunity to discuss this proposal.


FORWARD
E PLURIBUS UNUM

Public Hearing
Select Senate Committee on Healthcare Reform
August 28, 2006

HIRSP Authority Status Update
Presented by: Amie Goldman

Transition Update:
Effective July 1, 2006, administration of the Health Insurance Risk-Sharing Plan (HIRSP) was successfully transferred from the Wisconsin Department of Health and Family Services (DHFS) to the newly created HIRSP Authority.

The contract DHFS held with the plan's administrator, WPS Health Insurance, was also transferred to the Authority. New contracts have been established for legal services (Dewitt, Ross and Stevens) and banking services (US Bank). Options for securing benefits for Authority staff are also under consideration.

It is expected that the Authority will have 4.0 FTE: Chief Executive Officer, Operations Manager, Accounting and Finance Manager and an Executive Assistant.

Governance Structure:
The Authority is governed by a 13 member Board of Directors. The Commissioner of Insurance or his or her designee also serves as a non-voting member of the Board. Dennis Conta serves as the Board Chair and Joe Kachelski is the Vice-Chair of the Board.

Board Composition	Current Members
Wisconsin Medical Society Representative	Dr. Michele Bachhuber Marshfield Clinic
Public Member	Mr. Dennis Conta
Insurer Representative	Mr. Jay Fulkerson United Healthcare of Wisconsin, Inc
Health Care Plan Representative	Mr. Michael Gifford AIDS Resource Center of Wisconsin
Consumer Advocate	Ms. Diane Greenley Disability Rights of Wisconsin
Insurer Representative	Ms. Patricia Jerominski Independent Health Care Plan
Wisconsin Hospital Association Representative	Mr. Joe Kachelski Wisconsin Hospital Association, Inc.
Pharmacy Society of Wisconsin Representative	Mr. Wayne MacArdy Phillips Pharmacies
The Commissioner of Insurance, or his/her Designee	Ms. Eileen Mallow Office of the Commissioner OF Insurance
Insurer Representative	Ms. Carol Peirick Wisconsin Education Association (WEA) Insurance Corporation
Small Business Representative	Ms Deborah Severson Realityworks, Inc.
Policyholder Representative	Ms Luann Simpson
Policyholder Representative	Ms. Annette Stebbins
Insurer Representative	Mr. Larry Zanomi Group Health Cooperative-South Central Wisconsin

At it's June meeting, the Board adopted a set of by-laws, which outline the responsibilities, duties and powers of the Authority as well as the Board of Directors. Six standing committees were created in the by-laws:

Executive Committee: The Executive Committee is authorized to act on behalf of the entire board between its meetings and also services as the Board's personnel committee.

This committee is chaired by Dennis Conta.

Strategic Planning Committee: The Strategic Planning Committee is charged with developing long-range strategic plans for the Authority and conducting short-term priority planning as directed by the Board Chair.

This committee is chaired by Dennis Conta and Jay Fulkerson serves as Vice Chair.

Finance and Audit Committee: The Finance and Audit committee oversees the preparation of the annual budget and financial statements. The committee is also responsible for guiding the development of internal controls and for overseeing the annual independent audit process.

Joe Kachelski chairs this committee.

Grievance Committee: The purpose of the Grievance Committee is to establish, maintain, supervise and apply procedures for responding to grievances regarding the denial of benefit claims of HIRSP policyholders, resolve benefit claim issues and to adjudicate other grievances.

Annette Stebbins chairs this committee.

Consumer Affairs Committee: The Consumer Committee is responsible for establishing procedures and media for providing general information about HIRSP to policyholders and to the public.

Diane Greenley chairs this committee.

Legislative Committee: The Legislative Committee will monitor state and federal legislation affecting the Plan and the Authority and will supervise the preparation of the annual legislative report required by statute.

Mike Gifford chairs this committee.

Priorities:
The Authority has begun to establish a number of priorities for itself.

Infrastructure
The initial priority of the Authority's was to develop its infrastructure. Considerable progress has been made toward this goal:

- CEO hired as of July 10, 2007
- Executive Assistant hired as of July 20, 2006
- Board orientation conducted.
- By-laws drafted and adopted.
- Staffing plan approved August 21, 2006 and recruitment initiated.
- Temporary offices established and permanent office space identified.
- Secured general liability and workers compensation insurance.
- Proposal obtained for provision of benefits (health, retirement, disability) for Authority staff
- Contract signed for payroll services.
- Contract signed for website development.
- Obtained proposals for phone and voice mail system, copier/printer and office furniture.
- Executive, Grievance, and Finance and Audit committees held. Consumer and Strategic planning committees scheduled.
- Consideration of Authority investment options.
- Plan changes effective July 1, 2006 successfully implemented (residency requirement and notices of declination).
- Fiscal year 2006-07 insurer assessment process completed.
- Development and adoption of operating procedures (accounting and expense reimbursement).
- Began assessment of mental health and AODA services in preparation of December 1st report to the Joint Committee on Finance.
- Completed assessment of current disease management services under the Plan.
- Establishment of "Data Dashboard" a web-based executive information system.

Cost-Effectiveness
Improving the cost-effectiveness is also a top priority of the Authority. The Board and Authority staff have begun to lay the groundwork for this priority. The following initiatives are completed or in progress:

- *Collections.* Since the inception of the WPS contract (4/1/05), there have been 500 instances where a policyholder owed HIRSP for unpaid premiums of health care claims. Of this total, approximately one-third were eventually paid as a result of multiple mailings to the policyholder. A decision was made to send the remaining 330 to a third party collection agency.

- *Mail-Order Pharmacy.* Navitus is the pharmacy benefit manger for HIRSP. In April 2006, an initiative to utilize a mail-order pharmacy for specialty drugs was launched. Moving the purchase of these specialty drugs from a retail pharmacy to a mail-order pharmacy generally lowers the drug cost by 3% for drugs that typically cost $1,000 to $10,000 per prescription. The benefits to the policyholder are one-on-one pharmacy consultation, free home delivery and refill reminders. In order to encourage more participation in this voluntary benefit, a second

mailing was developed and will be sent to 330 policyholders using the targeted drugs and to the 120 physicians prescribing the medication.

- *Other Pharmacy Savings*. Navitus has been asked to develop and present additional pharmacy cost-saving proposals. These will be presented to the Authority September 7, 2006.

- *Market Comparison.* WPS is currently undertaking a detailed comparison of the HIRSP policy to a standard WPS individual insurance policy to identify potential changes that could improve the cost-effectiveness of HIRSP. The results of this comparison will be presented to the Board at its October meeting.

- *Disease Management.* The Authority has inventoried the current disease management services provided through the WPS contract and has concluded that the current services are a good value to HIRSP, but are typically more like traditional care management services. The opportunity to develop and implement population based disease management programs will be considered by the strategic planning committee at its October 31, 2006 meeting.

Legislative Priorities

2005 Wisconsin Act 74 established two requirements for the Authority. The first was an assessment of the historical utilization of mental health and AODA services under HIRSP and consideration of whether the state mandated benefits for the treatment of mental health and AODA disorders would allow for evidence-based treatment of the HIRSP population. This assessment is underway and some preliminary utilization data will be presented to the Consumer Affairs Committee on August 31, 2006.

The second requirement was the development of a plan that would meet the federal definition of a health care tax credit plan. This requirement will be considered by the Strategic Planning Committee.

Other priorities

The Board is currently in the process of defining other priorities and initiatives to be considered by the Strategic Planning Committee. Two items that have been suggested to the Board by HIRSP stakeholders include development of a higher-deductible plan option and utilization of health savings accounts.

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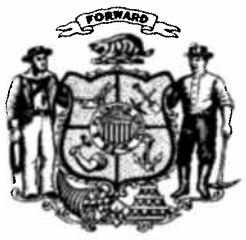

FORWARD

Testimony to the Senate Select Committee on Health Care Costs

Chronic Care Management

Theodore A. Praxel, MD, MMM, FACP
Medical Director Quality Improvement and Care Management
Marshfield Clinic
August 28, 2006

Objectives

- Review the current realities.
- Definitions
- Review the Physician Group Practice (PGP) demonstration project
- Value driven interventions
  - Anticoagulation services
  - Diabetes mellitus
- Care coordination objectives

Marshfield Clinic

- Founded 1916
- > 700 physician providers
- 41 Regional Centers
- >350,000 unique patients in 2004
- ~ 1.8 million patient encounters in 2004
- Security Health Plan (Clinic's HMO)
- Marshfield Clinic Research Foundation
- Education programs – Internal Medicine, Surgery, Pediatrics, Med/peds, Transitional, Dermatology

Fundamental Truth

Every system is designed perfectly for the results it achieves.

- Paul Bataldan, IHI

Current System Characteristics

- Fee-for-service
- Regardless of service value
- Disproportionately pays for the wrong things.
- Geographically adjusted

Current Situation

- > 100 million Americans have more than one chronic illness.
- > 50% of patients don't get appropriate evidence based care – Rand Corporation.
- Best practices could avoid 41million sick days and >$11 billion in lost productivity.
- Patients and family are increasingly recognizing defects in their care.

2004 Wagner

Medicare Beneficiaries

- Chronically ill consume > 95% of Medicare dollars.
- > 25% have 4+ chronic illnesses.
- The group with 4+ chronic illnesses consumes ~ 2/3rds of Medicare dollars.
- Can no longer think in individual disease state management strategies given increasing numbers of patients with multiple chronic illnesses.
- >70% of Medicaid dollars in Wisconsin are used by Seniors and people with disabilities.

Quality Measures

- Process measures – tell a team whether a specific process change has been accomplished and whether it is having the intended effect – e.g.- are the appropriate labs for a given condition being obtained (Taking a blood pressure).
- Outcomes/management measures -tell a team whether the changes it is making are actually leading to improvement – e.g.- is the therapy leading to the desired clinical outcome (Getting the blood pressure to goal < 140/90).

EFFECTIVE CARE

Medically necessary care on the basis of clinical outcome evidence, preferably from randomized clinical trials.

- ACEI/R in heart failure patients
- Warfarin in patients in qualified patients with atrial fibrillation
- Screening colonoscopy every 10 years after age 50

http://www.dartmouthatlas.org/

PREFERENCE-SENSITIVE CARE

Treatments that involve significant tradeoffs affecting the patient's quality and/or length life – should reflect patient's personal values because clinical outcomes are similar.

- Lumpectomy v. mastectomy in breast cancer

http://www.dartmouthatlas.org/

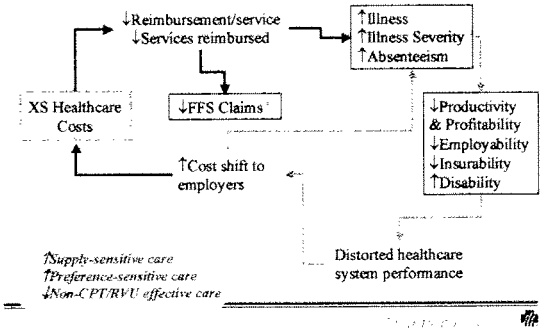
SUPPLY-SENSITIVE CARE

- 50% of all medical spending
- Chronic disease
- No evidence available
- Includes: **Office Visits, Consults, Diagnostics, Hospitalizations, ICU care**
- Determined by provider supply

http://www.dartmouthatlas.org/

Current Reality

Frequently starting with mental health and preventive services.



Health care purchasers are not getting what they want, but they ***are*** getting what they pay for.

Institute of Medicine Report

- Current care systems cannot do the job.
- Trying harder will not work.
- Changing care systems is the answer.

Centers for Medicare & Medicaid Services (CMS)

Physician Group Practice (PGP) Demonstration

The first 'value-based purchasing' demonstration applied to providers.

One of Ten in the Nation

- **Dartmouth-Hitchcock Clinic– Hanover, NH**
- **Deaconess Billings Clinic- Billings, MT**
- **Forsyth Medical Group– Winston-Salem, NC**
- **Geisinger Clinic– Danville, PA**
- **Integrated Resources for Middlesex Area– Middletown, CT**
- **Marshfield Clinic– Marshfield, WI**
- **Park Nicollet Health Services– St. Louis, MN**
- **St. John's Health System– Springfield, MO**
- **The Everett Clinic– Everett, WA**
- **University of Michigan Faculty Group Practice– Ann Arbor, MI**

PGP Objectives

- Align reimbursement with quality.
- Promotes using utilization and clinical data for improving quality.
- Encourage coordination of Part A (hospital) and B (outpatient) services.
- Promote efficiency in administrative structures and care processes.
- Reward for improving health outcomes.

PGP Year 1 'Q' (10 measures)

- DM-1: % DM patients (DMP) with ≥ one A1c measurement
- DM-2: % DMP A1c > 9.0
- DM-3: % DMP BP < 140/90
- DM-4: % DMP LDL Lipid Measurement
- DM-5: % DMP LDL Level < 130 mg/dl
- DM-6: % DMP ≥ 1 urine microalbumin test
- DM-7: % DMP ≥ 1 retina exam in reporting or prior year
- DM-8: % DMP ≥ 1 foot exam
- PC-7: % DMP Influenza Vaccination
- PC-8: % DMP Pneumonia Vaccination ever

PGP Year 2 'Q' (25 measures)

- HF-1: % Heart Failure Patients (HFP) LV Assess
- HF-2: % HFP hospitalized LV Ejection Fraction Testing
- HF-3: % HFP Office Visit Weight Measurement
- HF-4: % HFP Blood Pressure Measured
- HF-5: % HFP provided education on disease management
- HF-6: % HFP w/ LVSD prescribed β-blocker therapy
- HF-7: % HFP w/ LVSD prescribed ACE-I therapy
- HF-8: % HFP w/ Atrial Fibrillation prescribed Warfarin
- PC-7: % HFP Influenza Vaccination
- PC-8: % HFP Pneumonia Vaccination ever

PGP Year 2 'Q' (25 measures)

- CAD-1: % Coronary Artery Disease Patients (CADP) prescribed antiplatelet therapy
- CAD-2: % CADP prescribed lipid lowering therapy based on ATP III Guidelines
- CAD-3: % CADP w/ prior MI prescribed β-blocker therapy
- CAD-4: % CADP BP measured during last office visit
- CAD-5: % CADP ≥ 1 lipid profile during reporting year
- CAD-6: % CADP most recent LDL < 130 mg/dl
- CAD-7: % CADP and DM and/or LVSD prescribed ACE-I therapy

PGP Year 3 'Q' (33 measures)

- HTN-1: % Patient visits w/ BP recorded
- HTN-2: % Patients with last BP < 140/90
- HTN-3: % Patients w/ SBP ≥ 140 mm HG or DBP ≥ 90 mm w/ documented care plan for HTN
- PC-5: % Women, 50-69 years, mammogram in reporting or preceding year
- PC-6: % Patients screened for colorectal CA at appropriate interval
- PC-7: % Medicare patients Influenza Vaccination
- PC-8: % Medicare patients Pneumonia Vaccination ever

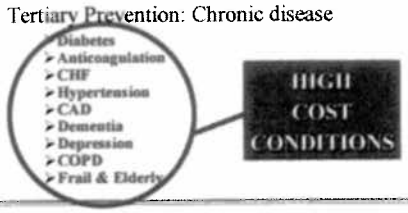
Process & Outcome Measures

Diabetes Mellitus	Congestive Heart Failure	Coronary Artery Disease	Hypertension & Cancer Screening
[illegible]	[illegible]	Antiplatelet Therapy	Blood Pressure Screening
HbA1c Control	[illegible]	Drug Therapy for Lowering LDL Cholesterol	Blood Pressure Control
Blood Pressure Management	[illegible]	Blood Pressure	Blood Pressure Plan of Care
[illegible]	[illegible]	[illegible]	[illegible]
LDL Cholesterol Level	Patient Education	LDL Cholesterol Level	[illegible]
[illegible]	Beta-Blocker Therapy	Ace Inhibitor Therapy	
[illegible]	Ace Inhibitor Therapy		
[illegible]	Warfarin Therapy		
Influenza Vaccination	Influenza Vaccination		
Pneumonia Vaccination	Pneumonia Vaccination		

Blue = process measures

Starting Points

- Primary Prevention: Avoid disease
- Secondary Prevention: Early detection
- Tertiary Prevention: Chronic disease



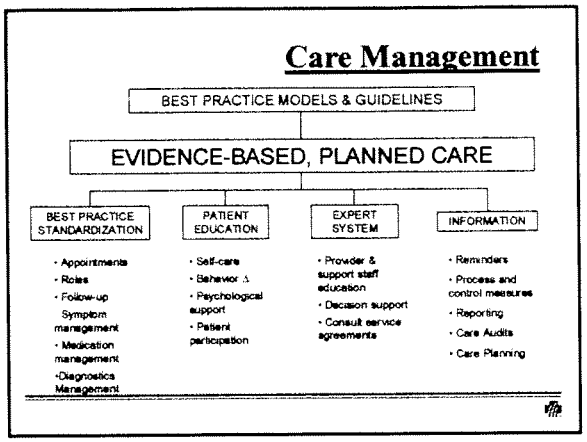
Work directly w/ each Department to …

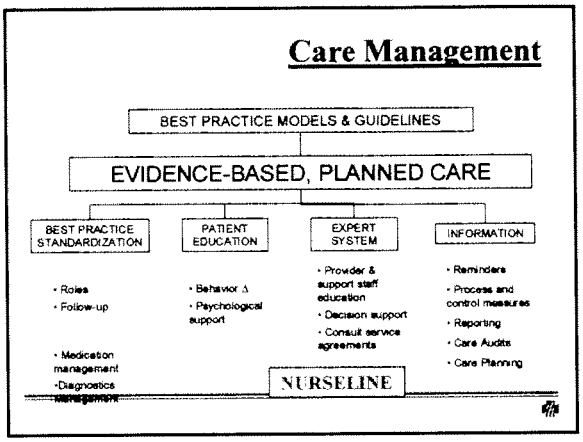
Achieve care in accordance with the Six Aims

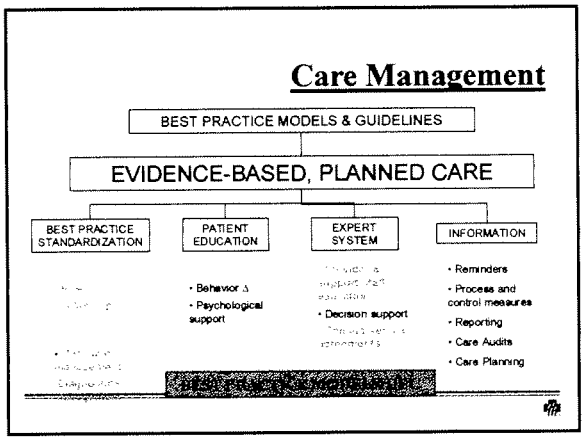
IOM Aims -

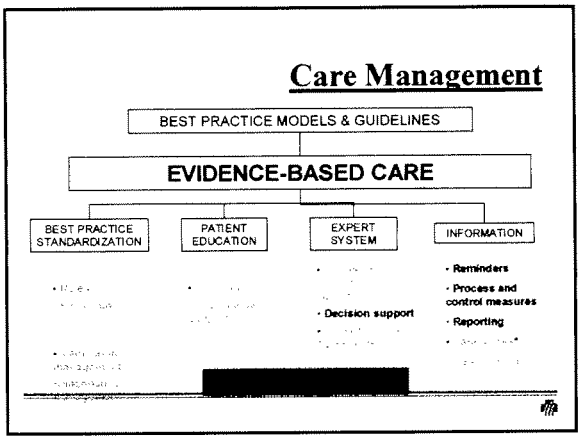
1. Safe
2. Effective
3. Patient-centered
4. Timely
5. Efficient
6. Equitable

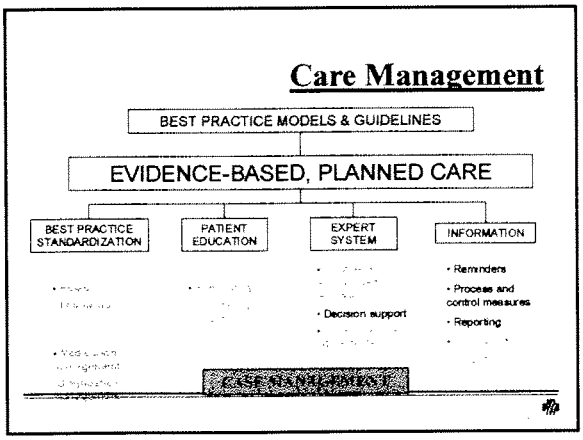
- Quality Improvement & Care Management
- Systems & Processes
- Clinic Operations











Chronic Care Management

- Anticoagulation Clinic
- Diabetes management

Anticoagulation: An Example of Better, Less Expensive Care Made Cost-Prohibitive by Current Reimbursement Policy

	Major Adverse Events	Annual Incidence of All-Cause Hospitalizations	% Time INR Values are within Therapeutic Range
National	15%		
Clinic Control Group	6.7%	0.70	60.4%
ACS Group	2.98%	0.41	73.7%

Anticoagulation: An Example of Better, Less Expensive Care Made Cost-Prohibitive by Current Reimbursement Policy

5,000 patients/year on warfarin

- **Medicare Savings: $11.67 million**
- **Patient Savings: $2.5 million**
- **Marshfield Clinic Costs: (~$1.4 million)**
- **Reimbursement: $0.00**

Diabetes Mellitus

- Reaching Epidemic Proportions
- Services typically covered –
  - Amputations –
  - Dialysis -
- Services not typically covered –
  - Diabetes protective footwear
  - Nutrition education
- New York Times Series early 2006

Direct Medical Costs

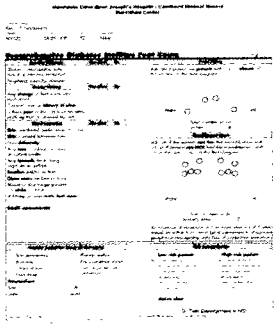
Stroke	84%	15,400 – 44,900
Acute MI	84%	15,500 – 50,000
Amputation (up to 15% of diabetic patients)	47%	23,300 – 62,200

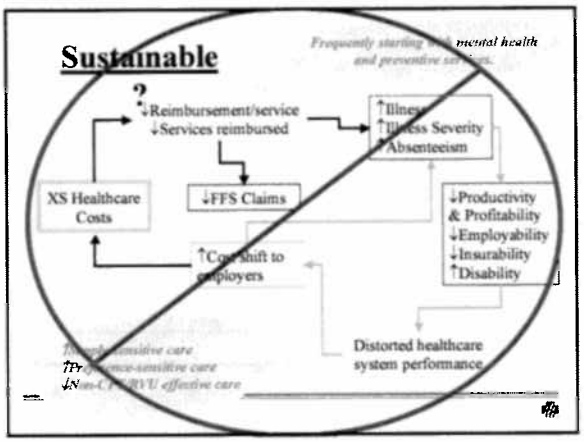
Diabetes Care 26(8), August 2003

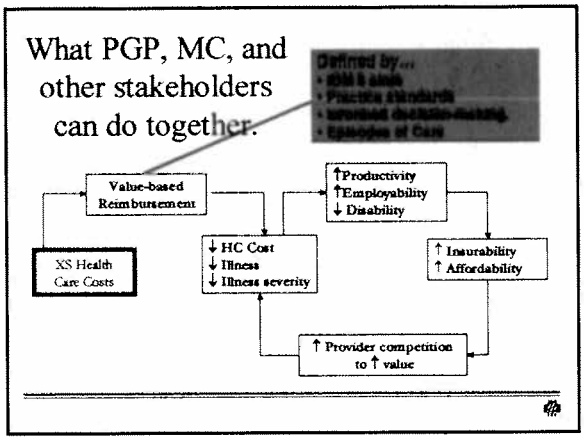
Preventing amputations

- 85% of all amputations are preceded by foot ulcers.
- Foot ulcers are preceded by loss of neuroprotective sensation.
- Early detection of loss of sensation with early intervention prevents amputations.

Diabetic Foot Exam forms







Challenges

- For patients, purchasers, and providers in the future -

$$Value = \frac{Quality}{Cost}$$

There will be a need to measure quality to prove it is high while working to continually improve quality and work to control costs to maximize value in the marketplace.

IOM vision for health care reform…

is an **economic**, as well as, **moral** imperative.

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