



IOM Releases Report on the State of Emergency Care in the U.S.

At a June 14 press conference held in Washington, D.C., the Institute of Medicine (IOM) released its long anticipated three-part study on the state of emergency care in the United States. According to the report, the nation's emergency care system is "at its breaking point" – it is overburdened, underfunded, and highly fragmented. As a result, ambulances are turned away from EDs once every minute on average, and patients in many areas may wait hours or even days for a hospital bed. Moreover, the system is ill-prepared to handle surges from disasters such as hurricanes, bombings, or disease outbreaks.

The number of ED visits increased by 26% from 1993 to 2003 – 90.3 million to 113.9 million – while the U.S. population increased by only 12%. During the same period, 703 hospitals and 425 EDs closed, and the number of hospital beds decreased by 198,000. This situation is further compounded by the fact that the population coming to the ED is older, sicker, and requires "more complex and time-consuming workups and treatments."

The 40-member panel of health care experts were charged

with creating a vision for the future of emergency care. They responded by producing the three reports released at the press conference. *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 panel identified what it believes are the most important issues facing the nation's emergency care system and made a series of recommendations for how best to deal with those issues. The recommendations fall under four basic themes: improving hospital efficiency and patient flow; a coordinated, regionalized, accountable system; increased resources; and paying attention to children.

The study recommends that states and hospitals establish emergency health systems coordinated regionally to direct patients and help prevent crowded EDs and that Congress establish a new federal agency within two years to address the problems with the emergency care system. The reports also state that Congress should establish a pool of at least \$50 million to reimburse hospitals for uncompensated emergency and trauma care. In addition, the IOM panel believes Congress should allocate \$88 million to be disbursed as grants over five years for projects designed to test ways to promote greater coordination and regionalization of emergency care. And that it should appropriate \$37.5 million each year for the next five years to the Emergency Medical Services for Children Program, to address deficiencies in pediatric emergency care. Even though, according to one survey, children make up more than a quarter of all ED and trauma patients, only 6 percent of hospital EDs have all of the supplies deemed essential for managing pediatric emergencies.

In response to the report's release, **AAEM** is calling for additional funding for hospitals that care for the under- or uninsured along with increased congressional scrutiny over the practice of fee-splitting. "We can no longer breathe with such a tight financial (Cont'd page 3)

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Hearing Held on Alternatives to Current Medical Malpractice System

At a hearing on June 22, held by the Senate Health, Education, Labor, and Pensions Committee, witnesses urged the panel to consider legislation backing health courts as a solution to medical malpractice problems. Such courts would feature full-time judges specializing in medical malpractice cases. The court would choose impartial medical experts to testify, and winning plaintiffs would be reimbursed for their medical cost and lost income, plus a fixed amount that would be established via an awards schedule.

The proponents said the courts would insert more fairness and reliability into the system, while lowering healthcare costs and medical malpractice insurance premiums. Under such a system, the supporters said, cases would be resolved in months, not years, and legal fees would be reduced. They urged lawmakers to establish a pilot program for testing the idea, perhaps via Medicare.

Opponents, however, said the predetermined awards schedule used by health courts would be no better than caps on noneconomic damages currently in use in many states and the subject of federal legislative proposals. Also, they said that the courts could preclude patients from suing providers if they were dissatisfied with the outcome of their case. Several of the witnesses opposed to health courts acknowledged that the current medical malpractice system may not work perfectly, but they maintained that wholesale changes are not needed.

Over the past several years, the Senate has tried – but failed – to pass traditional medical malpractice legislation that caps noneconomic damages and makes other changes to the system. As a result, a movement is underway in Congress toward alternative dispute resolution proposals. Committee Chair Mike Enzi (R-WY) and Senator Max Baucus (D-MT) have introduced legislation S.1337, the *Fair and Reliable Medical Justice Act*, that includes funding for state demonstrations to implement alternatives, including health courts, to the current medical malpractice legal dispute system. Also, Senator John Cornyn (R-TX) told the committee that he would soon introduce legislation establishing a federal pilot program for health courts through the Department of Health and Human Services. The voluntary program would involve hospitals around the country, and patients electing this course of action would not be precluded from seeking redress through the legal system.

“The constant threat of litigation also drives [the] inefficient, costly, and even dangerous practice of ‘defensive medicine,’ which occurs when a doctor departs from doing what is best for the patient because of fear of a lawsuit.”

– Senator Mike Enzi

Both witnesses and committee members disagreed about whether the current system is broken to the point that new approaches are needed. In his opening statement, Enzi said, “The medical litigation system urgently needs first aid.” Cornyn made a similar statement, asserting that the current malpractice system fosters widespread medical errors, raises insurance premiums, increases healthcare costs, and is causing physicians to leave practice.

But the committee’s ranking minority member, Senator Edward Kennedy (D-MA), said that many of the proposed reforms of the current system would deny patients “their basic right of justice against wealthy and powerful defendants.” Kennedy observed that only one in 10 malpractice cases goes to trial, that the scrutiny these trials produce helps produce fair settlements for other plaintiffs, and that most malpractice juries “are conscientious and render fair verdicts.” He did not specifically comment on the merit of health courts, but said any alternative dispute resolution mechanism must be voluntary.

The experts testifying at the hearing also reflected both sides of the argument. Harvard University associate professor of law and public health David Studdert said that, while the current system appears to be doing a “reasonable job” in correctly compensating injured patients, it is expensive and slow. He favored state demonstrations of alternative dispute mechanisms to determine if a health court would be better than the current system; and (Cont’d page 4)

AAEM Endorses Health Courts Concept

In a July 7 letter to Senators Michael B. Enzi (R-WY) and Max Baucus (D-MT), **AAEM** stated its support of the concept of special health care courts as contained in S.1337, the *Fair and Reliable Medical Justice Act*. **AAEM** President Tom Scaletta applauded the Senators' leadership for introducing this legislation which includes funding for state demonstration programs to implement alternatives, including health courts, to the current medical malpractice legal dispute system. Scaletta stated that "Litigation discourages the exchange of critical information that could be used to improve the quality and safety of patient care. The constant threat of litigation drives the inefficient, costly, and even dangerous practice of "defensive medicine." Some estimates suggest that Americans will pay \$70 billion for defensive medicine in 2006. **AAEM** believes that special health care courts would insert more fairness and reliability into the system while lowering medical malpractice insurance premiums.

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stranglehold. If fee-splitting were eliminated from the cycle of patient care in the emergency department, all resources could be focused on care delivery. That would lead to more resources to go toward additional physician staffing, at essentially no additional cost to the general public" stated **AAEM** President Tom Scaletta.

A series of IOM workshops will be held across the United States to:

- Disseminate findings from the study;
- Provide a forum for engaging the public and stakeholder groups in a national discussion of issues identified in the reports;
- Explore the implications of the recommendations at the federal, state, and local levels;
- Identify continuing research and data needs; and
- Consider implementation issues and strategies.

The workshops will be conducted as one-day public meetings with panels comprising experts and key stakeholders drawn from the region and nationally. They will feature invited presentations and structured discussions and there will be an opportunity for attendees to make comments or pose questions to panelists.

According to the IOM, the morning sessions of the three regional workshops will be organized to take a broad look at the findings from the three reports. The afternoon sessions will focus on specific topics. A fourth workshop – to be held in Washington, D.C. – will provide an opportunity to engage congressional and other federal policy leaders in a discussion of emergency care issues.

The workshops will be provided free of charge to all members of the public, but registration is required. The schedule is as follows:

Salt Lake City, Utah

Thursday, September 7, 2006

Focus on pediatrics and emergency care in rural areas
Primary Children's Medical Center

Chicago, Illinois

Friday, October 27, 2006

Focus on workforce and operations/IT
Northwestern Memorial Hospital

New Orleans, Louisiana

Thursday, November 2, 2006

Focus on EMS and disaster preparedness
Tulane University Medical Center

Washington, D.C.

Monday, December 11, 2006

National Academies of Sciences Building

Following completion of the four workshops, the IOM will publish a workshop summary report that describes the format of the workshops; summarizes the formal presentations including key sources of evidence; and synthesizes the discussion including various stakeholders' points of view.

To receive information on upcoming meetings and other project-related news on the IOM report, go to http://www8.nationalacademies.org/mail_list/default.asp?list_id=561&action=subscribe.

Federal Malpractice Legislation: A Status Report

Having designated the first week in May “Health Care Week,” Senate Republican leaders tried to move three measures on their health care agenda. Two would have limited medical malpractice awards; the third was intended to provide small businesses with more affordable health insurance.

S.1955, the small-business health bill sponsored by Senator Michael Enzi (R-WY), was blocked from a floor vote after Republicans fell short of the 60 votes required to overcome a filibuster, 55-43. For legislation that never made it out of committee in previous Congresses, however, it was considered a small step forward. As for the medical malpractice bills, both met similar fates when motions to invoke cloture to limit debate on the issue were defeated – for the fourth and fifth times in the past three years.

S.22, sponsored by Senator John Ensign (R-NV), capped the amount of non-economic damages an injured person could collect from each defendant at \$250,000. If a doctor and more than one hospital or doctors’ group were involved, a patient could collect a maximum of \$750,000. The measure also guaranteed timely resolution of claims by requiring lawsuits to be

filed within three years of the date of injury, and it limited contingency payouts to plaintiffs’ attorneys. The other bill – S.23– sponsored by Senator Rick Santorum (R-PA) applied the same standards but only to cases involving actions against obstetricians and gynecologists. The cloture motion on S.22 was rejected 48-42, far short of the 60 votes needed. On the more limited S.23, the cloture motion was rejected 49-44.

In recent years, the House has passed medical malpractice legislation numerous times (the latest being its 230-194 vote in July 2005 passing H.R.5), but such legislation has been stalled in the Senate for several years now. In a sense, the votes on S.22 and S.23 had more to do with politics than policy. Senate Majority Leader Bill Frist (R-TN) knew going into debate that the measures were likely to be blocked, but wanted to put Democrats on record before the midterm elections in November. During floor debate, Democrats addressed such political purpose by criticizing not only the bills, but also the fact that they were brought to the Senate floor without committee consideration. In the end, both sides in the debate remained staunchly committed to their positions, and – given the political makeup of the Senate – the impasse on medical malpractice legislation is likely to continue, at least until 2007.

House Committee Approves Transfer of Disaster Duties to HHS

On May 24, the House Energy and Commerce Committee approved H.R.5438, a bill that puts HHS in charge of preparing for terrorist attacks and other major medical emergencies, including bioterrorism. Currently, Federal Emergency Management Agency (FEMA), which is now housed within the Department of Homeland Security (DHS), carries out those duties. According to the committee’s ranking Democrat, Representative John Dingell (MI), who is sponsoring H.R.5438 with committee chair Joe Barton (R-TX), over the years the Energy and Commerce Committee has had jurisdictional disagreements with the Homeland Security Committee. That committee, he said, has attempted “to raid this committee’s jurisdiction . . . by moving functions of various agencies to the Department of Homeland Security.”

Before being moved to DHS, FEMA operated independently. Under the current system, FEMA sends out medical teams, supplies, and equipment to disaster areas. FEMA also is to make sure that patients are moved from disaster zones to safe areas, and that medical care is provided in the unaffected areas. According to the provisions of H.R.5438, those functions and the staff who carry out the tasks would be transferred to HHS within nine months of the bill’s enactment. Contracts and funding for the National Medical Emergency System also would move to HHS.

H.R.5438 now goes to the full House. FEMA spokesperson Aaron Walker said, “FEMA is examining the newly introduced bill and is looking at what ramifications it has for the agency.”

Physician Shortage Points to Healthcare Crisis

Experts are warning that a looming doctor shortage is threatening to create a national healthcare crisis by further limiting access to physicians, jeopardizing quality, and accelerating cost increases. Across the country, patients are experiencing or soon will face shortages in at least a dozen specialties, including cardiology, radiology, and several pediatric and surgical subspecialties. Twelve states – California, Florida, and Texas among them – report some physician shortages now or expect them within a few years.

Currently, one in five U.S. residents living in a rural or urban area is considered medically underserved by the federal government because of low availability of physicians. Moreover, difficulties in recruiting physicians have become common, and not just in rural communities. Practices, hospitals, and medical centers in places such as Los Angeles also report finding it difficult to recruit physicians – primary care doctors and specialists alike.

Wait times for appointments are another indicator of the shortage. According to a 2004 survey by physician staffing firm Merritt, Hawkins & Associates, the wait to see a dermatologist for a routine skin cancer examination in 15 large cities averaged 24 days. The survey also found that women faced an average wait of 23 days for a routine gynecological checkup. The wait to see a cardiologist for a heart checkup was 19 days, and to have an orthopedic surgeon check out a knee injury, the average wait was 17 days.

Furthermore, within the next 15 years, aging baby boomers are expected to increase the demand for urologists and geriatricians. One study found that the aging population will increase the demand for cataract surgery alone by 47%. Yet, as the boomer generation moves into its time of greatest medical need, much of the physician workforce is also aging and headed for retirement.

At the same time, younger male physicians and women – who constitute half of all medical students – are less inclined to work the long hours that have typified the profession. As a result, the next generation of physicians is expected to be 10% less productive, Edward Salsberg, director of the Association of American Medical Colleges' Center for Workforce Studies, told a congressional committee in May.

The shortages are putting pressure on medical schools to boost enrollment, and on lawmakers to lift a cap on funding for physician training and to ease limits on immigration of foreign physicians, who already constitute 25% of the doctor workforce. Yet, the experts say that, given the long lead time to train surgeons and other specialists, it may be too late to avert the crisis.

The number of medical school graduates has remained virtually flat for a quarter-century, because the schools limited enrollment out of concern that the nation was producing too many doctors. Many people and groups – including the AMA – had predicted a doctor glut. A year ago, however, the AMA changed its position on the physician workforce, acknowledging that a shortage was emerging, and momentum for change is building.

This month, the executive council of the Association of American Medical Colleges will consider calling for a 30% boost in enrollment, double the increase it called for last year. In addition, some states, such as California, Florida, and New Jersey, are proposing building new medical schools or expanding existing schools. More aggressive measures may still be needed, however, for – even with a 30% boost in enrollment – the ratio of physicians to patients would begin to decline by 2025.

At present, a third of the nation's 750,000 active post-residency physicians are older than 55 and, by 2020, physicians are expected to retire at a rate of 22,000 a year, up from 9,000 a year in 2000.

Study Disputes Conventional Wisdom on Causes of ED Crowding

A popular belief has held that high numbers of Hispanics, immigrants, and the uninsured are responsible for increases in the use of hospital EDs, resulting in crowding. In fact, according to a new study published July 18 on the web site of the journal *Health Affairs*, those three groups are actually among the lowest ED users because of fear of out-of-pocket expenses, high medical bills, and even deportation. The study, which also will be published in the July/August edition of *Health Affairs* magazine, was conducted by the Center for Studying Health System Change.

Based on a 2003 survey conducted by phone and in-person interviews of 46,000 individuals in 60 communities nationwide, the researchers found that use of EDs varied by region, with an average of 32 visits per 100 residents. Despite their high numbers of uninsured and immigrant residents, both Orange County, California and Phoenix, Arizona had low ED usage rates. Orange County's rate was 21 visits per 100 individuals. By contrast, Cleveland had the highest rate of ED usage with 40 visits per 100 residents; yet the city has among the lowest uninsured and immigrant rates.

The highest levels of ED use, the study found, are in areas with large elderly populations where the wait at the doctor's office can be unpredictable. Furthermore, the study cites varying wait times at the doctor's office as a constraint on health system capacity and a major factor in the increasing use of EDs by all, but especially the elderly, the insured, and the wealthy. Overall, about a third of all trips to the emergency room are not for problems that are considered true medical emergencies.

The findings are significant, study author Peter J. Cunningham said, because they demonstrate that ED crowding is more likely to affect areas that do not have large populations of immigrants and uninsured. He said that while a rapid influx of immigrants may contribute to crowding in some EDs, especially near the Mexican border, immigration is not a major contributing factor to ED crowding nationally, even in many communities that have large populations of Hispanic immigrants. Cunningham added that it is also a problem that cannot be alleviated with "simple solutions like expanding coverage or restricting access for illegal immigrants."

With the demand for physicians continuing to rise as baby boomers reach retirement age, some researchers are projecting that the number of physicians will not meet this increased demand. If this is the case, the study's author – Peter J. Cunningham – predicts that fewer people will go to doctors' offices because of the constraint in capacity and instead will go to the ED, where it is "more convenient with round-the-clock and open access without an appointment."

Health policy analysts who had read advance copies of the study said they agreed with the findings. While some noted that patients at inner-city EDs do reflect the demographics of their communities, many described the idea that immigrants and the uninsured are the main cause of nationwide ED crowding as a "myth."

HHS Web Site Offers Guidance on HIPAA

The Department of Health and Human Services (HHS) has posted on its web site an interactive guidance document to help emergency planners properly obtain and use protected health information during an emergency. Cautioning that the tool "is for advance planning purposes," the document: shepherds readers through a series of questions and answers about who may obtain the data and how the information may be used during an emergency; directs readers to fact sheets and frequently asked questions for more discussions of the Health Insurance Portability and

Accountability Act's (HIPAA) privacy rule; and includes a flow chart containing questions that should be answered regarding disclosure of health information. The document also explains when the privacy rule applies and when disclosure is not permitted without prior written authorization.

To obtain the HIPAA guidance document, go to <http://www.hhs.gov/ocr/hipaa/emergencyPPR.html>.

Hearing Held on Alternatives to Medical Malpractice System (Cont'd from page 2)

William Sage, law professor at Columbia University, confirmed that a Medicare demonstration could be crafted to test alternative programs.

Positing that “The medical profession hasn’t paid attention to its own complicity” in producing medical malpractice lawsuits, Richard Boothman, chief risk officer for the University of Michigan Health System, told the committee that the current system does not need radical changes. It only needs, he said, willingness by providers to openly admit mistakes or to explain to patients why they believe a mistake was not made in their case. Boothman cited a substantial drop in the number of lawsuits and claims that followed the establishment of a program at his facility in which physicians openly discuss cases with patients.

In essence, the American Bar Association said it opposes health courts based on a lack of procedural protections of an injured patient’s constitutional and other rights. The AMA said it “remains committed” to legislation capping noneconomic damages at \$250,000 per case, but also supports “other approaches that hold potential for improving the current dispute resolution climate.” In regard to health courts, the group said more research is needed.

JCAHO Questioned on Possible Conflicts of Interest

Three members of Congress have sent a letter to JCAHO president Dennis O’Leary questioning JCAHO’s ability to independently accredit hospitals while its consulting subsidiary, Joint Commission Resources (JCR), profits from the sale of products and services that aid hospitals in meeting accreditation standards. In a May 19 statement accompanying the letter, Representative Pete Stark (D-CA), Senator Charles Grassley (R-IA), and Senator Max Baucus (D-MT) disputed JCAHO’s claims to be a not-for-profit organization, and said its relationship with JCR was especially troublesome since JCAHO determines the eligibility of hospitals to participate in the Medicare program.

Following the release of a July 2004 Government Accountability Office (GAO) investigation that found what Stark called “serious deficiencies” in JCAHO’s

accreditation process, the three legislators sponsored bills that would have brought JCAHO’s accreditation process under the authority of the Centers for Medicare & Medicaid Services. Congress did not act on those bills (H.R.4877 and S.2698), but the three said they intend to introduce revised legislation.

In a May 22 statement, JCAHO said it welcomes a congressional review of its accreditation process, and expects such a review to better inform public policymakers of the benefits JCAHO provides. “The Joint Commission has co-operated fully with the GAO’s evaluation and likewise will provide a comprehensive response to Messieurs Grassley, Baucus, and Stark in an expeditious manner,” JCAHO said in the statement. JCAHO did rebuke the 2004 GAO study as “seriously flawed,” and also refuted Stark’s statement that JCR is a for-profit entity.

Providers Reminded of Funding for Services to Undocumented Aliens

In a recent issue of *MLN Matters*, the Center for Medicare and Medicaid Services (CMS) said that many physicians, hospitals, and ambulance service providers may not be receiving the funds available to them. Section 1011 of the *Medicare Prescription Drug, Improvement, and Modernization Act of 2003* provides \$250 million each year – for FY 2005 through 2008 – for payments to eligible providers for emergency health services given to undocumented and other specified aliens. Two-thirds of the funding is divided equally among the 50 states and the District of Columbia, based on each state’s relative percentage of undocumented aliens. The remaining one-third is divided among the six states with the largest number of undocumented alien apprehensions: Arizona, California, Florida, New Mexico, New York, and Texas. Payments are made directly to enrolled hospitals, physicians, and ambulance providers. (Cont’d page 8)

The States . . .

✓ AZ House Passes Frivolous ED Lawsuits Bill

In April, the **Arizona** House of Representatives unanimously passed a bill, SB 1351, aimed at curbing frivolous lawsuits against ED workers. Despite the unanimous vote, the measure remains controversial. As passed by the Senate on a close (16-13) vote, SB 1351 raised the standard of proof needed to win a lawsuit against ED personnel to “clear and convincing” from the current standard of “preponderance of evidence.” But, prior to its vote, the House passed – then struck – then passed again an amendment removing the “clear and convincing clause.” Supporters of tort reform claim the amendment strips the measure of any significant impact. As finally passed, the House version of SB 1351 does not raise the burden of proof but instructs judges and juries to consider the unique situations in ED care, such as the lack of patient records, when making their determinations in malpractice cases.

Supporters of the Senate version say that raising the burden of proof is needed to address the shortage of doctors willing to work in EDs. Opponents counter that requiring patients to show “clear and convincing” evidence would make it next to impossible for patients to win legitimate lawsuits and hold doctors and hospitals accountable.

SB 1351 must now go to a conference committee to see if the House version can be reconciled with the original Senate bill. Depending on what happens in conference, the measure will have to go back to one of the chambers for final approval before going to the governor. Representative Kyrsten Sinema (D), sponsor of the House amendment, maintains that the bill with the amendment “will protect medical personnel in emergency-room situations adequately” while not letting “bad actors” off the hook for their mistakes. But supporters of the original bill vow to strip off the amendment again when the measure goes to conference.

✓ GA Addresses Need for Aid to Trauma Centers

Legislators in **Georgia** are considering several strategies to bring more attention and funding to the state’s trauma centers that care for about 10,000 seriously injured people a year, but are struggling financially. A number of trauma-related bills have passed their chambers, while both the House and Senate have proposed \$4 million in funding to begin partially reimbursing trauma centers for the uncompensated care they provide to the poor and uninsured.

Senator Cecil Stanton (R-Macon) has proposed creating a commission that would be responsible for establishing and maintaining a statewide trauma network to coordinate care and direct patients to the most appropriate trauma center. With the cost to create a statewide network as much as \$25 million to \$30 million, legislators are considering such funding options as additional fines on moving violations or DUI offenses.

In addition to Stanton’s proposal, another resolution to create a trust fund to help pay for trauma care passed the House with bipartisan support. Also, Senate President Eric Johnson (R-Savannah) has proposed creating a study committee on the issue with the intention of drafting legislation to address the problem in the 2007 session.

The flurry of activity comes at a time when **Georgia**’s hospitals are struggling to provide increasingly expensive care, while coping with a growing number of uninsured patients, and the number of trauma centers has dropped from more than 20 to 14 – out of 185 hospitals. Furthermore, the state has only four level I trauma centers and could lose one of those. The Medical Center of Central Georgia – a level I trauma center – is considering dropping its trauma care entirely because it faces rising costs and the challenge of almost 20% of trauma cases going unpaid because patients lack insurance. The closure, health experts say, would have dangerous consequences for the entire state.

Providers Reminded of Funding for Services (Cont’d from page 7)

Providers wanting to request Section 1011 payments must enroll with TrailBlazer Health Enterprises LLC, the national contractor for the program. To enroll in the program, go to the TrailBlazer web site at www.trailblazerhealth.com/section1011, or contact TrailBlazer at (866) 860-1011.