



The Dire Straits of Emergency Care in the United States

by Kathleen Ream, Director of Government Affairs

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 IOM panel of healthcare experts was charged with creating a vision for the future of emergency care. They responded by producing three reports that were 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. Congress should also 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 six 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 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 going 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 of 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:

Chicago, Illinois

Friday, October 27, 2006

Afternoon sessions will focus on workforce and operations/IT
Northwestern Memorial Hospital

New Orleans, Louisiana

Thursday, November 2, 2006

Afternoon sessions will focus on EMS and disaster preparedness
Tulane University Medical Center

Washington, D.C.

Monday, December 11, 2006

National Academies of Sciences Building, Constitution Avenue NW

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 via e-mail on upcoming meetings and other project related news on the IOM report, go to <http://www.iom.edu/?id=35808>

Study Disputes Conventional Wisdom on Patient Populations and 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 website 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.

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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." And, 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, 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 overcrowding as a "myth."

Witnesses Discuss Health Courts vis à vis 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.

Oponents, 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.

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 when a doctor departs from doing what is best for the patient because of fear of a lawsuit." Cornyn made a similar statement, asserting that the current malpractice system fosters widespread medical errors, raises insurance premiums, increases healthcare costs in some cases and causes 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 ten 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 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 he followed the establishment of a program at his facility in which physicians openly discussed 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.

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AAEM Endorses Health Courts Concept

In a July 7 letter to Senators Michael B. Enzi (R-WY) and Max Baucus (D-MT), the American Academy of Emergency Medicine 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, MD, 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, "Litigation discourages the exchange

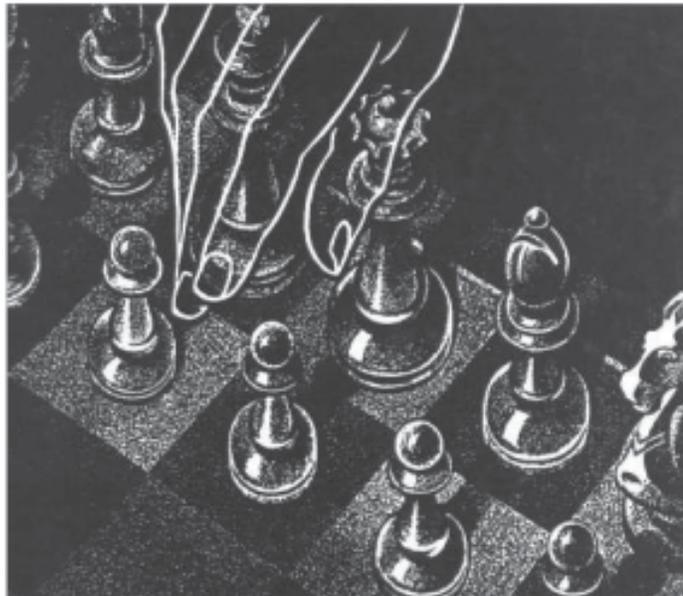
of critical information that could be used to improve the quality and safety of patient care. The constant threat of litigation drives the inefficient, costly and even dangerous practice of 'defensive medicine'."

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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