

EMERGENCY CARE

HEARING
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
ONE HUNDRED NINTH CONGRESS
SECOND SESSION

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EMERGENCY CARE

THURSDAY, JULY 27, 2006

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10:10 a.m., in room 1100, Longworth House Office Building, Hon. Nancy L. Johnson (Chairman of the Subcommittee), presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
July 20, 2006
HL-18

CONTACT: (202) 225-3943

Johnson Announces Hearing on Emergency Care

Congresswoman Nancy L. Johnson (R-CT), Chairman, Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on emergency care. **The hearing will take place on July 27, 2006, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from the invited witnesses only. Witnesses will include representatives from the Institute of Medicine and the hospital and health care provider community. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

BACKGROUND:

A recent report issued by the Institute of Medicine suggests that demand for emergency room services has increased in recent years, capacity has been reduced, patients are often “boarded” until inpatient beds become available, and diversions to other hospitals frequently occur. Also, there are concerns regarding the availability of medical specialists to provide emergency and trauma care.

Hospitals are an important component of the nation’s health care system, particularly with respect to emergency care, and they operate under various federal requirements. For instance, hospitals with emergency departments are required to screen and stabilize all individuals who enter hospital emergency rooms, regardless of their income level, citizenship, or insurance status.

In announcing the hearing, Chairman Johnson said, “Recent information appears to indicate that emergency health care providers, including the Nation’s hospital systems, are experiencing increasing demands for their services. We need to better understand the demands placed on the health care provider community, and the reasons for these demands in order to fully assess any problems and explore potential solutions.”

FOCUS OF THE HEARING:

This hearing will focus on the status of emergency health care and administration of health care services within the jurisdiction of the Subcommittee.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, <http://waysandmeans.house.gov>, select “109th Congress” from the menu entitled, “Hearing Archives” (<http://waysandmeans.house.gov/Hearings.asp?congress=17>). Select the hearing for which you would like to submit, and click on the link entitled, “Click here to provide a submission for the record.” Once you have followed the on-line instructions, completing all informational forms and clicking “submit” on the

final page, an email will be sent to the address which you supply confirming your interest in providing a submission for the record. You **MUST REPLY** to the email and **ATTACH** your submission as a Word or WordPerfect document, in compliance with the formatting requirements listed below, by close of business Thursday, August 10, 2006. **Finally**, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225-1721.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be provided in Word or WordPerfect format and MUST NOT exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. All submissions must include a list of all clients, persons, and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, telephone and fax numbers of each witness.

Note: All Committee advisories and news releases are available on the World Wide Web at <http://waysandmeans.house.gov>.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202-225-1721 or 202-226-3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Chairman JOHNSON OF CONNECTICUT. Good morning. Mr. Stark will be here momentarily, and I'm going to start with my opening statement and hope that by the time I finish it, he'll be here. He has been unavoidably delayed, but we're going to start. I'm very pleased to chair a hearing to consider the recent Institute of Medicine (IOM) report, "Hospital-Based Emergency Care at the Breaking Point." We've all known this was coming. We've all known it as we've visited hospitals and circulated in our districts, so I welcome this report. I think it will be very helpful to this Committee and to the Administration, and I do consider addressing the issues it raises as very high on our agenda and indeed, an emergency.

Emergency departments play a critical role in our health care system. They're responsible for urgent care, lifesaving care, they act as a safety net for those with limited access to the health care system, and they're the first line of defense in a public health emergency and in a disaster. Yet today, emergency departments face unprecedented challenges, and without attention, I believe they will not be able to fulfill their responsibilities, and the institu-

tions on which they rely and which they serve will be at risk. Each year, there are approximately 114 million visits to emergency departments.

According to the Institute of Medicine's recent report in 2002, almost half of all hospital admissions occurred through the emergency department. In addition to the critical role emergency departments play in the health care system, they are also required to comply with unique legal requirements. In 1986, Congress enacted Emergency Medical Treatment and Active Labor Act (EMTALA) (P.L. 99-272) to ensure public access to emergency services, regardless of ability to pay. section 1867 of the Social Security Act (P.L. 108-173) imposes specific obligations on Medicare participating hospitals that offer emergency services to provide a medical screening exam when a request is made for examination or treatment for an emergency medical condition, including active labor, regardless of an individual's ability to pay.

Hospitals are then required to provide stabilizing treatment for patients with emergency medical conditions. If a hospital is unable to stabilize a patient within its capacity, or if a patient requests it, an appropriate transfer must be made. The IOM also found that, as the demand on emergency services has grown, the nature of how hospitals operate has also changed. Between 1993 and 2003, there was a net loss 198,000 hospital beds in the United States. This, in part, has given rise to boarding, which occurs when admitted patients are required to stay in emergency departments either because of lack of in-patient beds or because the in-patient beds available are being reserved for patients not entering the hospital through the emergency room.

These patients may be cared for in settings that are far less than optimal and for significant lengths of times. Emergency departments are not equipped to board such patients, and it's not in the best interests of the patient, and it places great strain on the department. Perhaps the most tragic example of this are adolescents with psychiatric problems. We should truly be ashamed of where we are with that particular group needing health care. Additionally, emergency departments are responsible for treating the whole spectrum of injuries and diseases and are therefore, required to be able to call a specialist at any time of day or night to ensure that patients receive optimal and appropriate care.

However, for a number of reasons, including increased malpractice premiums, the financial implications of caring for the uninsured, and the strain of being on call in addition to a full-time physician, means most emergency departments are finding it very difficult to have sufficient on-call physicians to care for their patients. As we will also hear, this situation has given rise to local and regional coordination efforts to raise the quality of care within the same resource base. Today, we'll first hear from Gail Warden, president emeritus of the Henry Ford Health System in Detroit, Michigan. I don't believe we will hear from her. Is she here? Oh, Mr. Warden. Sorry.

Mr. Warden will testify to the findings and recommendations of the Institute of Medicine's ongoing series of reports on emergency departments, pediatric care in emergency departments, and emergency medical services. Additionally, Alan Kelly, vice president and

general counsel of Scottsdale Healthcare in Arizona, will speak to the challenges of providing emergency care to a population with a significant number of undocumented immigrants and the unique challenges hospitals face in caring for these individuals. Alan Levine is president and CEO of the North Broward Hospital District in Florida, which is one of the largest nonprofit public health care systems in the nation. Mr. Levine will also speak to the stresses being placed upon emergency departments, the complexity of the causes, and the need for state and regional flexibility to meet these challenges.

Finally, Dr. Frederick Blum, associate professor of emergency medicine, pediatrics, and internal medicine at West Virginia University School of Medicine, and president of American College of Emergency Physicians, and Larry Bedard, an emergency department physician, will provide the physician perspective on emergency department care in the United States. I look forward to hearing from all of the witnesses and thank you for being here today, but I would like to yield at this time a moment to my colleague from Arizona for the purposes of an introduction.

Mr. HAYWORTH. Madam Chairman, thank you very much. As you mentioned, among the witnesses, and I would be remiss if I did not welcome all of our witnesses today to deal with the challenges confronting emergency care, but I am very pleased to have one of my constituents and friends, Alan Kelly, who serves as vice president and general counsel of Scottsdale Health Care in my hometown of Scottsdale, Arizona. As one who has not taken advantage well, no, strike that. Perhaps not personally, but with kids and athletic accidents, for purposes of full disclosure, we have availed ourselves of the emergency facilities at what we used to call Scottsdale North. We've since changed the nomenclature.

I've seen firsthand the emergency care, and look forward to hearing Alan document the challenges that we are encountering in Arizona, and challenges that don't simply come to hospitals in border states with emergency care to illegal immigrants. So Alan, we welcome you, as we welcome all of the witnesses, and Madam Chairman, I thank you very much for the generosity of your time, and for holding this hearing today. I yield back.

Chairman JOHNSON OF CONNECTICUT. Thank you very much. We are going to proceed, and Mr. Stark will make some comments when he arrives. He will be arriving momentarily. Mr. Warden.

**STATEMENT OF GAIL L. WARDEN, PRESIDENT EMERITUS,
HENRY FORD HEALTH SYSTEM, DETROIT, MICHIGAN**

Mr. WARDEN. Thank you, Madam Chair and Members of the Subcommittee. My name is Gail Warden. I'm the president emeritus of Henry Ford Health System in Detroit, Michigan, and was the chair of the Institute of Medicine's Committee on the Future of Emergency Care in the United States Health System. This Committee was formed in September of 2003 to examine the emergency care system, explore its strengths, limitations, and challenges to create a vision for the future of the system and to make recommendations to help the nation achieve that vision.

Over 40 national experts from fields including emergency care, trauma, pediatrics, health care administration, public health, and health services research participated as Members of the Committee or Subcommittee. The study was requested by Congress and funded through a congressional appropriation along with additional sponsorship from the Josiah Macy Foundation, the Department of Health and Human Services, and the Department of Transportation. In my brief time this morning, I'm going to basically focus on the findings and recommendations of the report as they relate to hospital-based emergency care. As far as the findings are concerned, I think it's fair to say that beneath the surface, there's a growing crisis in emergency care.

Many emergency departments today are severely overcrowded with patients, many of whom are being held in the emergency department because of no in-patient bed being available. When crowding reaches dangerous levels, hospital often divert ambulances to other facilities. In 2003 alone, U.S. hospitals diverted more than half a million ambulances, which is an average of one per minute. Each diversion adds minutes to the time before a patient can be seen by a doctor and these delays may mean the difference between life and death for some patients. A second finding, which is important, which, Madam Chair, you mentioned in your opening statement, is it is becoming increasingly difficult for hospitals to find specialists who will agree to be on call.

The rising cost of uncompensated care, the fear of legal liability for performing risky procedures, and the disruptions of daily medical practice and home lives have led more surgical specialists to opt out on taking emergency department (ED) calls. The resulting shortage of on-call specialists in emergency departments can have a tragic result. Thirdly, today's emergency care system is often highly fragmented and variable. Coordination of emergency care providers on the ground is often poor. Emergency medical services, hospitals, and public safety often lack common radio frequencies, much less interoperable communications systems, and these technological gaps are compounded by cultural gaps between public safety providers and emergency care personnel. The fourth important finding is that there's a lack of preparedness within the system to care for children.

We have recognized for decades that children require specialized care, and although children make up 27 percent of all visits to the emergency departments, a recent study found only 6 percent of the hospitals have all the supplies deemed essential for managing pediatric emergencies. We believe the country can do better. As far as recommendations are concerned to improve the nation's emergency care system and deal with the growing demands placed upon it, the Committee described a vision of the emergency system that we would like to see, in which we talked about coordination, regionalization, and accountability: Coordination of all the components of the system, such as EMS, hospital emergency departments, trauma centers, local dispatchers working together; Regionalization so patients are taken to facilities that are best able to address the needs of each patient based upon their particular illness or injury; Accountability in that an emergency care system should be trans-

parent and accountable to the public it serves and their preferences should be measured.

To achieve that vision, we recommended that Congress establish a demonstration program to promote that vision through an \$8 million appropriation over 5 years for demonstrations in 10 states in each phase, Phase 1 and Phase 2. We recommended the establishment of a lead agency in the Department of Health and Human Services for emergency and trauma care, and asked that that lead agency establish a working group to consolidate the funding and functions. We also recommended that the Federal agencies establish evidence-based categorization of systems' pre-hospital protocols and indicators of system performance.

A second recommendation related to the fact that we felt we must end the practice of emergency department boarding and diversion except in the most extreme circumstances, such as community mass casualty events, and recommended that the tools developed from engineering and operation research and information technology that are available be applied in institutions—

Chairman JOHNSON OF CONNECTICUT. Mr. Warden, could I ask you to just start back? You've just gone on to recommendation number one. So, if you would start back with your first recommendation, that would be useful.

Mr. WARDEN. Back to describing the vision, ma'am?

Chairman JOHNSON OF CONNECTICUT. You may proceed.

Mr. WARDEN. Okay. In the recommendations, there were four recommendations that I thought we should highlight today. The first was a vision that we establish, as it relates to what we thought the emergency system ought to be able to do in this country. We emphasized coordination among all components of the system; We emphasized regionalization, where patients are taken to facilities that are best able to address the needs for each patient based upon their particular illness or injury; Accountability, in that an emergency care system should be transparent and accountable to the public it serves, and their preferences should be measured.

To achieve that vision, we recommended that Congress establish a demonstration program to promote a regionalized, coordinated, and accountable emergency care system over five years. We also suggested that Congress should establish a lead agency in the Department of Health and Human Services for emergency and trauma care, and a working group should be brought together to consolidate functions of funding which are now in a multiple number of agencies. We also recommended that Federal agencies establish evidence-based categorization of systems' pre-hospital protocols and indicators of system performance.

The second recommendation was that we must end the practice of emergency department boarding and diversion except in most extreme circumstances, such as a community mass casualty event. We outlined in much detail about the tools that are available from engineering and operations research and information technology that would help to accomplish that. We also suggested that, since there are few financial incentives for hospitals to reduce crowding, that the Joint Commission should develop strong standards about emergency department crowding, boarding, and diversion. The third important recommendation was really related to increasing

funding that could help improve the nation's emergency care system. Much research is needed.

We also felt Congress should provide greater reimbursement to the large safety net hospitals and trauma centers that bear a disproportionate amount of the cost of taking care of uninsured patients and that there should be greater funding for disaster preparedness. Finally, as the 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, because they have not gotten the attention that they should. In closing, the Committee believes that the nation's emergency care system is in serious peril. Strong measures must be taken by Congress, the state, hospitals, and others to achieve the level of response that Americans expect and deserve. Thank you for the opportunity to testify, and I'll be happy to answer any questions that the Subcommittee might have.

[The prepared statement of Ms. Warden follows:]

Statement of Gail L. Warden, President Emeritus, Henry Ford Health System, Detroit, Michigan

INTRODUCTION

Good morning Madame Chair and members of the Subcommittee. My name is Gail Warden and I am President Emeritus of Henry Ford Hospital in Detroit, Michigan. I served as chair of the Institute of Medicine's Committee on the Future of Emergency Care in the U.S. Health System.

THE IOM

The Institute of Medicine, or IOM as it is commonly called, was established in 1970 under the charter of the National Academy of Sciences to provide independent, objective, evidence-based advice to the government, health professionals, the private sector, and the public on matters relating to medicine and health care.

THE STUDY

The Institute of Medicine's Committee on the Future of Emergency Care was formed in September 2003 to examine the full scope of emergency care; explore its strengths, limitations and challenges; create a vision for the future of the system; and make recommendations to help the nation achieve that vision. Over 40 national experts from fields including emergency care, trauma, pediatrics, health care administration, public health, and health services research participated on the Committee or one of its subcommittees. The Committee produced three reports—one on prehospital emergency medical services (EMS), one on hospital-based emergency care, and one on pediatric emergency care. These reports provide complimentary perspectives on the emergency care system, while the series as a whole offers a common vision for the future of emergency care in the U.S.

This study was requested by Congress and funded through a Congressional appropriation, along with additional sponsorship from the Josiah Macy Jr. Foundation, the Agency for Healthcare Research and Quality, the Health Resources and Services Administration, the Centers for Disease Control and Prevention, and the National Highway Traffic Safety Administration.

I will briefly summarize the Committee's findings and recommendations, giving particular attention to those that relate to hospital-based emergency care.

GENERAL FINDINGS

Emergency and trauma care are critically important to the health and well being of Americans. In 2003, nearly 114 million visits were made to hospital emergency departments (EDs)—more than 1 for every 3 people in the U.S. While many Americans need emergency care only rarely, everyone counts on it to be available when needed.

Emergency care has made important strides over the past 40 years: emergency 9–1–1 service now links virtually all ill and injured Americans to an emergency medical response; EMS systems arrive to transport patients to advanced, life-saving care; and scientific advances in resuscitation, diagnostic testing, trauma and emergency medical care yield outcomes unheard of just two decades ago. Yet just beneath

the surface, a growing crisis in emergency care is brewing; one that could imperil everyone's access to care.

Emergency Department Crowding

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. 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 board 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, 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. Each diversion adds precious minutes to the time before a patient can be wheeled into an ED and be seen by a doctor, and these delays may mean the difference between life and death for some patients. Moreover, the delays increase the time that ambulances are unavailable for other patients.

Fragmentation

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 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. There are 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. There is no single agency in the federal government that oversees the emergency and trauma care system. Instead, responsibility for EMS and 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, there is very little accountability. In fact, it is often difficult even to determine where system breakdowns occur and 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. It has become increasingly difficult, however, for hospitals to find specialists willing to be on call for the ED. The resulting shortage of on-call specialists in EDs can have dire and sometimes tragic results.

There are many reasons why specialists are often unwilling to be on-call in EDs. Many specialists find that they have difficulty getting paid for services provided in the ED because many emergency and trauma patients are uninsured. Specialists are also deterred by the additional liability risk 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 higher than for those who do not. Finally, many specialists find the demands of providing on-call services too disruptive to their private practices and their family lives.

Lack of Preparedness for Disasters

Unfortunately, the nation's emergency care system is very poorly prepared to handle 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 most hospitals have limited capacity to handle.

Much of the problem, though, is due to a simple lack of funding. Hospital grants from HRSA's National Bioterrorism Hospital Preparedness Program are small—not enough to equip even one critical-care room. 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. 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. Few hospitals have negative-pressure units, for instance, which are crucial for isolating victims of airborne diseases, such as the 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.

Shortcomings in Pediatric Emergency Care

Children who are injured or ill have different medical needs than adults with the same conditions. They have different heart rates, blood pressures, and respiratory rates, and these change as children 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. 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.

IOM RECOMMENDATIONS

To improve the nation's emergency care system and deal with the growing demands placed on it, the Committee recommends a broad strategy for reform, beginning with a new vision for the future of emergency care.

A Vision for the Future of Emergency Care

The Committee believes the challenges that exist in the system today can best be addressed by building a nationwide network of regionalized, coordinated, and accountable emergency care systems. They 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. A patient should be taken to the optimal facility within the region based on his or her 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 a way of determining the performance of the different components of the system and reporting that performance to the public. This will require the development of well-defined standards and methods to collect data and measure performance against those standards.

To promote the development of these systems, the Committee recommends two important roles for Congress. First, Congress should establish a federally funded demonstration program to develop and test various approaches to regionalize delivery of prehospital and hospital-based emergency care. Second, Congress should designate a lead agency for emergency care in the federal government to increase accountability, minimize duplication of efforts, and fill important gaps in federal support of the system.

The Committee recommends that states actively promote regionalized emergency care services. This will help insure that the right patient gets to the right hospital at the right time, and help hospitals retain sufficient on-call specialist coverage. Disaster planning at the local and regional level would take place within the context of these regionalized systems so that patients get the best care possible in the event of a disaster. Integrating communications systems would improve coordination of services across the region; not only during a major disaster but on a day-to-day basis.

Improving 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 from other providers. Such increased use of information technologies will not only lead to greater hospital efficiency but will increase safety and improve the quality of emergency 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 on 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.

Increasing Resources for Emergency Care

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 from the delivery of emergency and trauma services, Congress should provide additional funding to large safety-net hospitals and trauma centers that bear a disproportionate amount of the cost of taking care of uninsured patients.

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

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 ensure 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.

CLOSING

The Committee believes that the nation's emergency care system is in serious peril. If the system's ability to respond on a day-to-day basis is already compromised to a serious degree, how will it respond to a major medical or public health emergency? Strong measures must be taken by Congress, the states, hospitals, and other stakeholders to lead the emergency care system into the future. The Committee's recommendations provide concrete recommendations for action.

Thank you for the opportunity to testify. I would be happy to address any questions the Subcommittee might have.

Chairman JOHNSON OF CONNECTICUT. Thank you very much, Mr. Warden. Mr. Kelly. I should have mentioned to begin with, your entire testimony will be included in the record. You each have 5 minutes. Mr. Kelly.

STATEMENT OF ALAN B. KELLY, VICE PRESIDENT AND GENERAL COUNSEL, SCOTTSDALE HEALTHCARE, SCOTTSDALE, ARIZONA

Mr. KELLY. Good morning, Chairman, and Members of the Committee, and thank you for the kind introduction, Congressman Hayworth. Again, my name is Alan Kelly. I am vice president and general counsel for Scottsdale Healthcare. I'm greatly honored to be here today. Scottsdale Healthcare is a three-campus health care system located in Scottsdale, Arizona. A full description of our hospitals is in the submission given to the Committee, but I would like to emphasize a few things.

Our Osborn facility is the only Level 1 trauma center for the Greater Eastern Phoenix area serving over 2.5 million people. We provide over 51,000 emergency room visits with over 3,200 trauma cases. Our Shea facility provides over 50,000 ER visits, and our new Thompson Peak facility, which is expected to open in 2007, we expect around 20,000 ER visits. On the issue of overcrowding, this has existed many years in ERs, the origins I think being the increase in the number of uninsured and the EMTALA Act. Now, we have new pressures that I would like to focus this Committee's attention on, and if the Committee will indulge me, I am passionate about these two issues.

The first is the inflow and the influx of illegal immigrants which section 1011 tries to address but really does not. An example can best be illustrated by telling you about a man with many names, and this is a story that recently actually transpired in our facility. This is a 63-year-old Hispanic male who came into our trauma center via ambulance on January 18th of this year. He had sustained a laceration on the neck from a branch after falling from a tree, obviously picking fruit. He also suffered a stroke. After being treated in our trauma unit, the patient was transferred from the ER into our intensive care unit.

As a result of the stroke, he had difficulty swallowing and the patient required a feeding tube. On January 31st, the patient was considered stabilized and ready for transfer to a skilled nursing facility, but as all of the Members of this Committee know, no facility would accept him due to a lack of a payer source or place of origin. He was turned down from coverage from the Arizona Medicaid program, and the Social Security number found on his personal belongings was determined to be completely invalid. His employer's name was also found in his personal belongings. When contacted, however, the employer denied knowledge of his name. The next day when we called, the phone number was disconnected.

The Mexican Consulate in Phoenix was contacted, but office staff requested information which is impossible for even us to get. The Mexican Consulate is extremely difficult and little help in these matters. On January 24, 2006, the patient was transferred to a medical unit within our facility, and sitter care had to be maintained 24 hours, 7 days per week, because the patient attempted to get out of bed multiple times. Our case management department continued to explore skilled nursing care facilities, but was able to make a transfer because of the payer issue.

The Scottsdale Police Department fingerprinted the patient for identification purposes, and I authorized the hiring of a private in-

investigator to determine the patient's identification. The private investigator uncovered several police reports indicating that this patient had used at least 10 different names, had used at least 10 different date of birth, and at least six different Social Security numbers. The private investigator's final report also indicated that the patient had been arrested 10 times over three decades, released, and deported. The arrests included three felony convictions in this country, one for aggravated assault, and one for distribution of drugs.

The total investigator's report was finally faxed to the Mexican Consulate in Phoenix on April 17, 2006 of this year, and I think, Committee Members, they were basically shamed into finally giving us the necessary transport papers in order for us to get this patient back to Sonora, Mexico, at Scottsdale Healthcare's cost, of course. Scottsdale Healthcare incurred costs of over \$260,000 for this patient's 93-day length of stay and \$4,000 for ambulance transport to Mexico. Our system additionally incurred expenses for the numerous hours and clinical staff, including case managers, legal. A 93-day stay speaks for itself.

Unfortunately, this is only one example of the massive challenge to treat and care for the undocumented crisis patients in this country, just not in border states. The second other biggest problem that I face on a weekly basis is the shortage of on-call physicians, that my colleague has talked about. Scottsdale Healthcare spent over 13 million on stipends for surgical specialists to ensure their on-call attention in 2005. Whatever the Committee's position is on specialty care providers, whatever it is, the fact is that physicians have many other alternatives to practice, the ER being the least, since this cohort of patients are typically high in uninsured and under-insured.

We must, however, provide the coverage, as EMTALA requires, and therefore, have to pay handsomely for it. Now, I ask the Committee Members, what physician, given the practice choices now available, want to cover at difficult hours with little or no chance of getting collected for insurance, and with the exposure of being sued, what physician would like to take that type of coverage? In conclusion, more than 46 percent of the patients who are admitted in Arizona hospitals are emergency department patients. The cascading impact of ever tightening regulations, the flood of undocumented immigrants, and the spiraling costs of providing specialty physician coverage is foreboding. It is stressing a system that is already under considerable pressure.

Section 1011 is a blunt instrument. Although well-intended to help finance illegal alien health services, what we are really talking about is the distribution of expensive talent and existing resources to provide to our own citizens. Filling out the forms section 11 requires, it is almost impossible. Committee Members, look at the form yourself. Moreover, it turns our registration clerks into immigration officials. Members of this Subcommittee, 93-day stays in an in-patient setting is becoming more common, more common for illegal immigrants because of the special problems I have identified today, and therefore profoundly affects overcrowding throughout hospitals. section 1011 does not solve our shared constitutional

obligations to protect our borders. It only seeks to help finance it, but it's not the answer to this problem.

Prompt action is necessary to avoid a health care catastrophe that will shut the doors of emergency departments nationwide and further stress scarce in-patient resources. Again, Chairman, it has been a pleasure to be here today, and I look forward to your questions. Thank you.

[The prepared statement of Mr. Kelly follows:]

Statement of Alan Kelly, Vice President and General Council, Scottsdale Healthcare, Scottsdale, Arizona

Good morning, Madam Chairwoman and members of the Committee, my name is Alan Kelly, Vice President and General Counsel for Scottsdale Healthcare. I am very pleased to be here today, on behalf of Scottsdale Healthcare and discuss issues related to emergency care. Scottsdale Healthcare is a three-campus health system located in Scottsdale Arizona. Our hospitals were founded in 1962 as a non-for-profit provider, led by a volunteer board of local residents.

The Scottsdale Healthcare Osborn campus is our original hospital facility. Expanded numerous times since 1962, it is a 337-bed hospital offering the only Level 1 Trauma Center for the eastern portion of the greater Phoenix metropolitan area, serving a population of approximately two and a half million people. The hospital recently expanded its emergency services and conducts the first community-based military trauma training program in the United States. Osborn's emergency department annually provides care for over 51,000 patient visits with over 3,200 trauma cases.

Scottsdale Healthcare Shea is a 405-bed hospital which opened in 1984. Also located on the Shea campus is the Virginia G. Piper Cancer Center. The Cancer Center combines the talents of community oncologists, faculty from the University of Arizona, and genomic researchers in one location to serve our cancer patients. Through these collaborations, we are able to offer Phase I and Phase II Clinical Trials of new cancer therapies. Shea's emergency department provides care for over 50,000 emergency department patient visits per year.

Our third hospital, Scottsdale Healthcare Thompson Peak, will open in late 2007. Now under construction, the hospital will initially open with 60 beds, expanding to 184 beds with ten dedicated to emergency care to meet the needs of our growing community.

Overcrowding

The Institute of Medicine's June 2006 report on the *Future of Emergency Care in the United States Health System* highlights the challenges hospitals and health systems face in providing emergency care to our communities. The report correctly indicates that emergency departments are the first place patients turn to address illness and immediate health care needs. Many of those patients' visits could be provided by primary care physicians in another care setting. Often, insured patients use emergency departments when their physician is not available to address their needs. Another cause of is the increasing number of uninsured patients who use emergency departments as their primary care setting. All of this utilization stretches emergency facilities beyond their capability. Many hospitals will divert incoming patients from their emergency department to another hospital emergency facility. The consequence is a domino effect moving the burden from one emergency department to another.

Nearly five years ago, Scottsdale Healthcare began the discussion of reorganizing its patient "throughput" processes. The development and implementation took three years, with a \$1.4 million dollar investment and annual commitment in increased staff. The intent was to improve patient care and provide for more efficiency through the Emergency Department to an inpatient bed or to discharge. The outcome was significant reductions in wait times. Scottsdale Healthcare averages a turn-around time of two to four hours, from entering the Emergency Department to either discharge or a patient bed. Yet, as Scottsdale Healthcare has improved its internal patient throughput process, we continue to experience increased emergency department volumes.

EMTALA

The Emergency Treatment and Labor Act (EMTALA) directs hospitals to provide a medical screening examination to people, regardless of their ability to pay, for the purpose of identifying an emergency medical condition. There is a provision within

EMTALA that requires a hospital to accept a transfer from another hospital's Emergency Department if the accepting hospital provides the necessary higher level of care for that patient, and the hospital has sufficient resources to accept the patient (beds, equipment, and personnel, including on-call specialists). While the objectives of this Act goes to the heart of healthcare's desire to provide all patients with quality care, the ramification is a burgeoning patient population flow through Emergency Departments and Trauma Centers.

Aggravating this growth is the population of undocumented immigrants, who do not qualify for emergency Medicaid services. Section 1011 of the Medicare Modernization Act of 2003 targets this population with supplemental resources. Unfortunately, access to the funding is contingent upon the hospital completing a Provider Payment Determination questionnaire. The process to receive reimbursement is cumbersome and required additional financial services personnel to manage and coordinate the implementation of Section 1011. Additionally, hospitals must gather from the patients complicated immigration documentation, which is time consuming and rarely forthcoming. We need to avoid turning healthcare professionals and hospital financial services personnel into immigration experts.

One undocumented patient from Scottsdale Healthcare's Trauma Center serves as a case example of the challenges that healthcare facilities face in treating undocumented persons. This patient was a 63 year-old Hispanic male brought to the Trauma Center via ambulance on January 18, 2006 as a Level I emergency. He had sustained a laceration on the neck from the branch of a small tree after falling off a ladder. He had a stroke secondary to traumatic carotid artery dissection. After being treated, the patient was transferred from the Emergency Department and admitted to the Intensive care unit. As a result of the stroke and difficulty swallowing, the patient required a feeding tube for nutritional intake.

On January 31, 2006, the patient was considered "stabilized" and ready for discharge to a skilled nursing facility. However, no facility would accept the patient due to lack of payor source. He was turned down for coverage from Arizona Health Care Cost Containment System, Arizona's Medicaid program, since he had no proof of residency. The Social Security number found in his personal belongings was determined to be invalid. His employer's name was also found in his personal belonging. When contacted, however, the employer denied knowledge of the patient's name. The following day, the employer's phone number was disconnected. The Mexican Consulate in Phoenix was contacted, but office staff requested information on where the patient was born in order to assist in locating family members.

On January 24, 2006 the patient was transferred to a medical unit and assigned "sitter care" for 24 hours, 7 days a week, due to repeated attempts to get out of bed unaccompanied. The result of the stroke rendered his body unable to support his own weight without assistance. Case management continued to explore skilled nursing facility options, but were unable to make a transfer due to the lack of payor source.

The Scottsdale Police Department finger-printed the patient for identification purposes. Scottsdale Healthcare authorized the hiring of a private investigator to determine the patient's identification. The private investigator uncovered several police reports indicating that the patient had several different names (10 on record). The patient had five different dates of birth and at least six different Social Security numbers. The private investigator's final report also indicated that the patient had been arrested 10 times over three decades, released, and deported.

The investigation report was faxed to the Mexican Consulate in Phoenix on April 17, 2006. A representative from the Consulate visited the patient on April 19, 2006 and issued a temporary Mexican ID for travel. The patient was transfer by ambulance to Hospital Integral in Agua Prieta, Mexico, to the services of an accepting physician.

Scottsdale Healthcare incurred costs of over \$260,000 for the patient's 93-day length of stay. In addition to the cost for inpatient care, which totaled over \$230,000, there was a cost of \$31,920 for 24 hour/7 day sitter care, and \$4,000 for ambulance transport to Mexico. Our system additionally incurred expenses for the numerous hours above the clinical care staff, including case managers, legal and government relations departments to facilitate the appropriate discharge.

Unfortunately, that is only one example of the massive challenge to treat and care for the undocumented crisis in our country's health care system. We have many more examples at Scottsdale Healthcare, including the following:

Citizenship	Cost	Date of Stay
Mexico	\$118,151 (including \$13,519 for air ambulance, and \$12,240 for respirator)	Nov 5, 2006
Mexico	\$166,138 (including \$20,565 for air ambulance)	Oct 26, 2004
San Salvador	\$87,359 (including \$18,500 for air ambulance)	July 11, 2004
Belize	\$107,203, including \$19,140 for air ambulance	May 8, 2004
Egypt	\$377,827 (including \$32,700 for nursing home sitter care)	Nov 25, 2003

Shortage of On-Call Specialists

Scottsdale Healthcare spent \$13 million on stipends for surgical specialist to ensure their on-call attention to patients in 2005 (\$10 million in 2005 and \$8 million in 2004). However, other hospitals in the region do not pay for specialist care. As such, patients are transferred to Scottsdale Healthcare for services rendered by specialists such as those in hand surgery.

The deficit in specialist care within Emergency Departments is directly correlated to the proliferation of specialty hospitals. Arizona is one of seven states with more than five specialty hospitals. The impact of the new genre of limited service hospitals is devastating. The emergence of limited service providers—hospitals that limit their scope of service to profitable specialties like orthopedic surgery and cardiac care—has exacerbated Arizona's shortage of on-call specialty physicians. These hospitals primarily do not provide a full range of emergency services cater to a commercially insured and Medicare population, and tend not to treat Medicaid or uninsured patients. The deadline for the extended moratorium on limited service providers is quickly approaching. While the Centers for Medicare and Medicaid Services are working to change the reimbursement systems for all hospitals including acute care and specialty, implementation will take the next two years. The opportunity exists for limited services providers to enter the market when the moratorium expires and carve out a service niche from community hospitals. Physician owned limited service providers will continue to have an advantage with physician self referrals.

Pediatric Care Shortages

In Maricopa County, there are only three hospitals that provide specialty pediatric emergency treatment. Hence, the region is severely lacking in terms of being able to handle emergency care for children.

Fragmentation

Complicating the overcrowding and specialist shortages in the Emergency Departments is the absence of a communication technology that would permit the seamless prioritization and transfer of patients from the field. Prehospital agencies are unable to rapidly communicate vital signs, scene details, and other information that would expedite Emergency and Trauma Center preparations for incoming patients.

Scottsdale Healthcare has supported the Arizona Department of Health Services on its efforts to integrate an automated diversion notification and management program, called the EMSsystem. The program is web-based and coordinated by dedicated dispatch sites throughout the State. A linked program, called the EMTrack, is a patient tracking device that employs patient banding in the field. PDA-inserted information supplements patient data bases. The data is transmitted to Emergency Departments to understand patient movement and final destinations. What is obviously lacking from the technology is an aligned program that conveys critical patient data.

Scottsdale Healthcare has been working closely with the academic research scientists at Arizona State University's BioDesign Institute for three years on a device that would automate vital signs and other patient information for communication from prehospital agencies to the Emergency Department. The technologies for vital sign assessment and collection of supplemental information are already available in the research arena. Yet, there exists no funding to integrate the technologies into a single and usable platform.

In addition, Scottsdale Healthcare has joined with General Dynamics, the Arizona National Guard, and the Fire and Police Departments of Scottsdale Healthcare on development an Internet-based chat room format for connecting "command centers," or key communication centers, together. Developed for a disaster drill in Scottsdale, this chat room communication methodology has proven to be effective for the military in battlefield settings. The initial phase of the communication strategy was tested in April of 2006 (during the Coyote Crisis Campaign, the disaster drill). The permits communication and coordination across the organizations as well as within them, on a secured and confidential patient management system. This technology, would also enable partners to address critical resource challenges immediately during a disaster (e.g., water, generator, staffing, and other resource problems). Yet, again, there is no funding available to advance this program.

Lack of Disaster Preparedness

A major disaster, with many casualties, is an event that many hospitals will not be able to manage well. Whether man-made, a disease outbreak, or a terrorist attack, Emergency Departments cannot accommodate the influx of patients due to facility and staff surge capacity deficits.

The bioterrorism funding available to hospitals for disaster preparedness is so minimal that it tends to generate only superficial disaster response equipment purchases and mediocre disaster program planning. The table-top drills that are generally being conducted by states with Homeland Security funding do not test for human error, nor do they coherently, comprehensively, or rapidly coordinate players. Exacerbating this problem is a grave shortage of medical professionals to handle surge increases in the Emergency Departments.

Scottsdale Healthcare and its community partners have accepted a leadership role in defining the future for disaster readiness in the nation, focusing on a practical, integrated, and proactively coordinated approach to regional disaster readiness. The grass-roots and groundbreaking program leverages and blends the resources of the Arizona National Guard, the state Air Force medical units, General Dynamics, and the City of Scottsdale with Scottsdale Healthcare. In April of 2006, the Coyote Crisis Campaign partnership launched its first drill to test new technologies and the medical and prehospital manpower merged to respond to a terrorist disaster. In 2007, the drill will focus on a Pandemic Flu theme. Yet, there exists no funding to plan and execute the drills. This is because Homeland Security funding is not available for healthcare programs to work on surge capacity enhancements with the military. And, there are no dollars to build with premier corporate experts the necessary command center technologies for resource identification and movement, field triage and transfer of large volumes of patients, or other disaster response needs. Homeland Security funding is meager, disjointed, and supportive of highly fragmented programming. Perhaps the only glimmer of light is found within the Department of Defense budget, which could generate 1) cross department coordination, 2) support for getting military assets to hospitals in a crisis, and 3) strengthen training between the military and the civilian worlds.

Concluding Comments:

More than 46 percent of the patients who are admitted to Arizona's hospitals are Emergency Department patients. The cascading impact of ever-tightening regulations, the flood of undocumented immigrants, and the spiraling of specialty hospitals is foreboding. While funding can ameliorate many of the consequences, congressional action offers even more hope. Prompt action is necessary to avoid a healthcare catastrophe that will shut the doors of Emergency Departments nationwide.

Chairman JOHNSON OF CONNECTICUT. Thank you very much, Mr. Kelly. Mr. Levine.

STATEMENT OF ALAN LEVINE, PRESIDENT AND CHIEF EXECUTIVE OFFICER, NORTH BROWARD HOSPITAL DISTRICT, FORT LAUDERDALE, FLORIDA

Mr. LEVINE. Thank you, Madam Chair, Representative Stark, and Members of the Committee. I'm the president of the North Broward Hospital District, one of the largest non-profit, public systems in the nation, located in Broward County, Florida. We consist

of four hospitals, two trauma centers, the Chris Everett Children's Hospital, and we serve over 200,000 emergency department visits a year. I'm also formerly the secretary of health care administration for the State of Florida under Governor Bush. In Florida, the percentage of our population over 65 is nearly 40 percent higher than the national average and our over-85 population is almost double the national average.

This offers a perspective of what America is going to look like in the coming decades and provides insight on how we should prepare. Consistent with national trends, emergency department visits to Florida's hospitals reached 7.2 million in 2004, up 50 percent from 1994, while in-patient admissions grew 34 percent. Hospital capacity during this period has actually decreased, with the ratio of beds per 1,000 population decreasing from four in 1994 to three in 2005, again mirroring a national trend and those numbers don't include and swelling of tourists that we have during the season, as well.

This decreasing capacity was not an accident. Federal and state policies implemented two decades ago were focused on cost containment, and hence capacity has been constrained. Indeed, the capacity constraints have helped the system become more cost effective, with hospital length of stay decreasing from an average of 10.2 days in 1981 to as low as 4 days today. On the issue of emergency department volume, however, growth in visits cannot be solely attributed to population growth, as the use rate per 1,000 increased from 348 visits in 1994 to 410 a couple years ago, thus demonstrating what could be the impact of an aging, more chronically ill, and also increasingly uninsured population.

The contributors to this crisis are numerous and complex and the capabilities of our system are being tested to a degree that could raise questions not only about our surge capacity in a mass emergency, but whether we can sustain the demand we face with our aging and more chronically ill population. From an operational standpoint, the more substantial causes for ER backup and unavailability of services are staffing shortages, substantial unavailability of call physician specialists, a less than optimal number of critical care and telemetry beds, the use of the emergency department as a safety net for routine or non-emergent visits which hospital are required by Federal law under EMTALA to treat, and the increasing influence the uninsured are having on hospital operations.

Only a decade ago, the average age of a practicing nurse was 35, and today it's 45. Vacancy rates for telemetry nursing is 13 percent, critical care nurses are 10 percent, and one in five emergency nursing positions are vacant. Florida alone will need 61,000 additional nurses by 2020, and this is a very relevant cause for this crisis. As the population has aged and become more chronic, the demand for critical care and telemetry beds has increased. Clearly, an inability to staff these beds requires hospitals to keep patients boarded in the emergency department, or worse, to divert ambulances once the ER beds are full.

Sadly, less than 6 percent of the nursing population is male, and only 13 percent represent minorities. I believe that represents a huge opportunity for us to draw new people into the nursing pro-

fession. This shortage does transcend other allied health care professions, including EMS, where in Florida, 61 percent of the more than 3.2 million EMS calls require transport to an emergency department. While new hospitals require regulatory approval in Florida, as in most states, Governor Bush approved allowing existing hospitals to add an unlimited number of beds without seeking state approval.

We can certainly build more hospital beds, but unless we can staff these beds, we only compound the shortage by creating additional capacity and demand for staffing, which will have the unintended consequence of increasing cost without any identifiable means for reimbursement. The issue of medical liability, an increase in non-hospital alternatives for specialists, and an impending physician shortage overall are major contributors to this crisis. Imagine being a neurosurgeon at Broward General Medical Center in Fort Lauderdale. Every time you get called for an emergency, there is a 55 percent likelihood the patient is charity, uncompensated, or Medicaid, and since most of the community hospitals in Broward County and neighboring Palm Beach County, two of the most populous counties in Florida, do not have 24/7 emergency neurosurgery coverage, there is a good chance this patient's care has been delayed because he or she is being transferred from another hospital, perhaps one at least 30 miles away.

At what point as a physician, given the likelihood of litigation and a lack of payment, do you say that you've had enough? Many, if not a majority and by the way, there are many, many more issues related to the liability issue that we can talk about if you choose to ask. Many, if not a majority of the specialists have gone bare, and they've opted to limit their coverage only to low-risk services within their specialty, often leaving many services without any coverage at all. In many cases, hospitals are paying enormous call fees in order to entice physicians to cover the emergency department, without any source of revenue to offset the cost, and are in fact left wondering if they will, at some point be accused of violating anti-referral or kickback laws.

Federal EMTALA requirements leave hospitals with no choice but to succumb to whatever short-term measures are necessary to cover call at any given time, whether or not these measures are even rational. Also, given the substantial opportunity for physicians to earn income outside the hospitals, their reliance on staff privileges and ER coverage has decreased for many subspecialties. Another problem on the horizon is the fact that one in four physicians in Florida is over the age of 65, and another 16 percent are between the ages of 55 and 65. Medical school enrollment combined with that fact, medical school enrollment has been flat for 10 years now, and new applications for 2005–2006, while increasing by 4.6 percent, still remain 21 percent below 1995 levels.

The supply of practicing physicians is expected to slow considerably after 2010, reflecting the aging physician population and the level enrollment in medical schools. Intuitively, the demand for physicians will increase as our population ages, and by 2015, the rate of population growth will exceed the rate of growth in the number of physicians. By 2020, it's estimated the United States will have a shortage of about 96,000 physicians. Many of the Insti-

tute of Medicine suggestions are plausible and merit our support. While I do not agree we need a new national bureaucracy, it is appropriate to have national standards with state flexibility, transparency using consistent measurement, a review of antitrust laws which would allow hospitals to regionalize call coverage, and enhanced use of information technology.

Addressing these issues and seeking resolutions to the other concerns I mentioned in my testimony I believe will move us toward a goal of an agile and prepared emergency system. I'm proud to come from Florida where we've demonstrated we have the best, in our opinion, emergency response system in the nation. We're proud of that, but we know it's been tested, and we're concerned about that. We look forward to answering your questions, and I do thank you for this opportunity, Madam Chair.

[The prepared statement of Mr. Levine follows:]

Statement of Alan Levine, President and Chief Executive Officer, North Broward Hospital District, Fort Lauderdale, Florida

Madam Chair, Representative Stark and Members; thank you for taking the time to inquire about the crisis of access to emergency care. I am currently the President of the North Broward Hospital District, one of the largest non-profit, public hospital systems in the nation, located in Broward County, Florida, and I am formerly the Secretary of Health Care Administration for the State of Florida. I will do my best to highlight the contributory factors to this crisis as I see them, and I will answer any questions you may have. In Florida, the percentage of our population over 65 is nearly 40 percent higher than the national average and our over-85 population is almost double the national average. Perhaps this offers a perspective of what America will look like in the coming decades and provide insight on how we should prepare. Consistent with national trends, Emergency Department visits to Florida's hospitals reached 7.2 million in 2004, up 50 percent from 1994, while inpatient admissions grew 34 percent. Hospital capacity during this period has actually decreased, with the ratio of beds per 1,000 population decreasing from 4 in 1994 to 3 in 2005—again, mirroring a national trend. This decreasing capacity was not an accident. Federal and state policies implemented two decades ago were focused on cost-containment and hence capacity has been constrained. Indeed, the capacity constraints have helped the system become more cost-effective, with hospital length of stay decreasing from an average of 10.2 days in 1981 to as low as 4 days today. On the issue of Emergency Department volume, growth in visits cannot be solely attributed to population growth, as the use rate per thousand increased from 348 visits in 1994 to 410 in 2004—thus demonstrating what could be the impact of an aging, more chronically ill, and also, increasingly uninsured population. The contributors to this crisis are numerous and complex and the capabilities of our system are being tested to a degree that could raise questions not only about our surge capacity in a mass emergency, but whether we can sustain the demand we face with our aging and more chronically ill population.

From an operational standpoint, the more substantial causes for ER backup and unavailability of services are; nursing, allied health and EMS staff shortages; substantial unavailability of on-call physician specialists, a less than optimal number of critical care/telemetry beds, the use of the Emergency Department as a safety net for routine or non-emergent visits which hospitals are required by federal law to treat, and the increasing influence the uninsured are having on hospital operations.

Only a decade ago, the average age of a practicing nurse was 35; today it is 45. Vacancy rates for telemetry nurses are 13 percent, critical care nurses 10 percent, and one in five emergency RN positions are vacant. Florida alone will need 61,000 additional nurses by 2020.

As the population has aged and become more chronic, the demand for critical care and telemetry beds has increased. Clearly, an inability to staff these beds requires hospitals to keep patients boarded in the Emergency Department, or worse, to divert ambulances once the Emergency Department beds are full. Sadly, less than 6 percent of the nursing population is male, and only 13 percent represent minorities. This shortage transcends other allied health professions, including EMS, where, in Florida, 61 percent of the more than 3.2 million EMS calls require transport to an ED. While new hospitals require regulatory approval in Florida, Governor Bush ap-

proved allowing existing hospitals to add an unlimited number of beds without seeking approval. We can certainly build more hospital beds, but unless we can staff these beds, we only compound the shortage by creating additional capacity and demand for staffing—which has the unintended consequence of increasing cost without any identifiable means for funding.

The issue of Medical Liability, an increase in non-hospital alternatives for specialists, and an impending physician shortage overall are major contributors to the problem. Imagine being a neurosurgeon at Broward General Medical Center, in Fort Lauderdale. Every time you get called for an emergency, there is a 55% likelihood the patient is charity, uncompensated or Medicaid. And since most of the community hospitals in Broward County and neighboring Palm Beach County do not have 24/7 neurosurgery coverage, there is a good chance this patient's care has been delayed because he or she is being transferred from another hospital—perhaps one 30 miles away. At what point, as a physician, given the likelihood of litigation and lack of payment, do you say you have had enough? Many—if not a majority—of specialists have gone bare, so while the data may show they take call, they have opted to limit the coverage to only low-risk services within their specialty, often leaving many services without any coverage at all. In many cases, hospitals are paying enormous call fees in order to entice physicians to cover the Emergency Department—without any source of revenue to offset the cost, and are in fact left wondering if they will, at some point, be accused of violating anti-referral or kickback laws. Federal EMTALA requirements leave hospitals with no choice but to succumb to whatever short-term measures necessary to cover call at any given time—whether or not these measures are rational. Also, given the substantial opportunity for physicians to earn income outside the hospitals, their reliance on staff privileges and Emergency Department coverage has decreased for many subspecialties, including orthopedics, gastroenterology, otolaryngology, cardiology and plastic surgery. Another problem on the horizon is the fact that one in four physicians in Florida is over the age of 65, and another 16 percent are between the ages of 55 and 65. Medical school enrollment has been flat for ten years and new applications for 2005–06, while having increased by 4.6 percent, still remain 21 percent below 1995 levels. The supply of practicing physicians is expected to slow considerably after 2010, reflecting the aging physician population and the relatively level medical school enrollment over the past two decades. Intuitively, demand for physicians will increase, and by 2015, the rate of population growth will exceed the rate of growth in the number of physicians. By 2020, it is estimated the United States will have a shortage of about 96,000 physicians.

Many of the IOM suggestions are plausible and merit our support. While I do not agree we need a new national bureaucracy, it is appropriate to have national standards with state flexibility; transparency using consistent measurement; review of anti-trust laws which would allow hospitals to regionalize call coverage; and enhanced use of information technology. Addressing these issues and seeking resolutions to the concerns I mentioned in this statement will, in my opinion, move us toward our goal of an agile and prepared Emergency System. I look forward to answering your questions, and I thank you for this opportunity.

Chairman JOHNSON OF CONNECTICUT. Thank you very much for your testimony, Mr. Levine. Dr. Blum.

STATEMENT OF FREDERICK C. BLUM, M.D., ASSOCIATE PROFESSOR OF EMERGENCY MEDICINE, PEDIATRICS AND INTERNAL MEDICINE, WEST VIRGINIA UNIVERSITY SCHOOL OF MEDICINE AND PRESIDENT, AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

Dr. BLUM. Thank you, Madam Chairman. My name is Rick Blum. I am the president of the American College of Emergency Physicians. I'm a practicing emergency physician in West Virginia. I'm here to deliver a simple message. Mr. Kelly asked the question, what physician, if given the options of practicing and treating the patients with the problems and in the setting that he described would take that option? Well, that would be me and the 24,000

people that I represent as the American College of Emergency Physicians. We take that challenge every day.

You don't have to have money. You don't have to be clean or smell good. You don't even have to be nice to me. You just have to come to the emergency department and need what I have to give, which is care. I'm very proud of that. I'm here to deliver a really simple message today, which is that America's emergency departments are underfunded, they're understaffed, they're overcrowded, and in fact, they're overwhelmed.

I'm glad to address the issues raised by the Institute of Medicine Report, because they're an independent body that confirmed what we've been saying for a long time. Emergency physicians are proud of the fact that they could ramp up or ramp down as the circumstances allow. We are traditionally the most elastic part of any hospital operation. Frankly, we're sometimes too good at it, because I think I get the impression that people think we have the infinite ability to ramp up and ramp down.

I'm here to tell you that anything that's elastic eventually reaches the point where it breaks, and when it does, it does to catastrophically, and that's where we are today. This Subcommittee has a long history of promoting quality health care for the citizens of the U.S. Your leadership on EMTALA my associates welcome. EMTALA simply put into law what we had long practiced and the values that we hold that I just described to you. The original intent of EMTALA we have not a single problem with, because we believe what is embodied within that law, but the challenges are still there.

It is a gigantic unfunded mandate for American health care, and it's an escalating mandate that has no end in sight, and that mandate is increasing in the face of overall declining reimbursement from all payers, both in the private and public sectors. As other parts of the health care system fail, those failures are felt in the emergency departments, and so the result is our departments are overcrowded, we have no surge capacity to deal with the next big thing that happens with regard to natural disasters or terrorist attacks.

We have an ambulance diverted in this country every minute of every hour of every day, and that probably under-represents the problem, because many communities have said, "Well, we're not going to divert," but yet the ambulance crew will sometimes wait in the hallway of the emergency department for hours waiting for a bed to open up to offload their patient. Patients wait hours for admission. There are millions of Americans that come to the emergency department, and we determine they need to be admitted to the hospital, who wait hours, if not days, to move upstairs to hospital beds that don't exist. There's a huge on-call crisis that has already been, I think, very, very aptly described. None of this is new to emergency physicians. Why has this occurred? Well, we have reduced resources. Fifty percent of all emergency care in this country is now un-reimbursed.

We have a lack of in-patient beds that's been described. We've tried to control health care spending in this country by controlling the number of beds that we've had. I think we now believe that that's a flawed public policy. We have a growing demand, and by

the way, the baby boomers are still pretty healthy. They're yet to get sick. When they start getting sick in large numbers, I frankly don't know what we're going to do. We have a shortage of nurses and a looming shortage of physicians. We've already seen it in parts of the country, like Phoenix, but in most parts of the country, that is still a looming crisis, but I can tell you, the crisis we have right now is a shortage of nurses. As was said, we can't staff the beds that we have, and we don't have enough beds. From 1993 to 2003, the number of ED visits have gone up 26 percent in this country.

At the same time, the population only went up 13 percent. During that same period of time, 425 emergency departments in this country closed. So, we're seeing more and more patients in fewer and fewer emergency departments with less and less resources. Ladies and gentlemen, that's not sustainable. The on-call crisis we talked about already. We did a study a while back with Johns Hopkins that showed that 73 percent of ED medical directors report regular lack of coverage in their on-call panels. We have the surgeons who are talking about the fact that fewer and fewer specialty surgeons, like neurosurgeons and orthopedists, are now taking call to the emergency departments, so you have a smaller and smaller number of specialists caring for a larger and larger number of people again, not sustainable.

What can we do about all this? We have proposed several recommendations. We have included at least three of them in a bill that we proposed and have asked for your support for. It's House Bill 3875, which includes three provisions. One would provide incentives for hospitals to move patients upstairs more quickly. Those incentives currently do not exist. They would provide some professional liability protection for EMTALA-mandated services that would basically treat our EMTALA mandate the way any other federalized health care worker would be treated with regard to professional liability.

It would provide a 10 percent add-on for Medicaid payments to the emergency department to acknowledge this gigantic unfunded mandate that we have. Every day we have the privilege of impacting and saving people's lives. I guess what I'm here to ask for today is your help in allowing us to do that, because, quite frankly, it's getting to the point where I cannot. Thank you.

[The prepared statement of Dr. Blum follows:]

**Statement of Frederick C. Blum, M.D., President, American College of
Emergency Physicians, Morgantown, West Virginia**

Introduction

America's emergency departments are underfunded, understaffed, overcrowded and overwhelmed—and we find ourselves on the brink of collapse.

Madame Chairman and members of the subcommittee, my name is Rick Blum, M.D., F.A.C.E.P., F.A.A.P., and I would like to thank you for allowing me to testify today on behalf of the American College of Emergency Physicians (ACEP) to discuss the current state of emergency medical care in this country. In particular, I will address issues raised by ACEP's "National Report Card on the State of Emergency Medicine" and the Institute of Medicine (IOM) reports on the "Future of Emergency Care," which must be resolved to ensure emergency medical care will be available to the American public during a public health disaster.

ACEP is the largest specialty organization in emergency medicine, with nearly 24,000 members who are committed to improving the quality of emergency care through continuing education, research, and public education. ACEP has 53 chap-

ters representing each state, as well as Puerto Rico and the District of Columbia, and a Government Services Chapter representing emergency physicians employed by military branches and other government agencies.

At an alarming and increasing rate, emergency departments are overcrowded, surge capacity is diminished or being eliminated altogether, ambulances are diverted to other hospitals, patients admitted to the hospital are waiting longer for transfer to inpatient beds, and the shortage of medical specialists is worsening. These are the findings of the Institute of Medicine (IOM) report “Hospital-Based Emergency Care: At the Breaking Point,” which was just released on June 14. I would like to say that these findings are new to emergency physicians, but they are not.

ACEP for years now has been working to raise awareness of the critical condition that exists in delivering high-quality emergency medical care with lawmakers and the public. More recently, these efforts included promoting the findings of a 2003 Government Accountability Office (GAO) report on emergency department crowding; conducting a stakeholder summit in July 2005 to discuss ways in which overcrowding in America’s emergency departments could be alleviated; sponsoring a rally on the west lawn of the U.S. Capitol in September 2005 attended by nearly 4,000 emergency physicians to promote the introduction of H.R. 3875, the “Access to Emergency Medical Services Act;” and releasing our first “National Report Card on the State of Emergency Medicine” in January 2006.

ACEP National Report Card on the State of Emergency Medicine

ACEP’s “National Report Card on the State of Emergency Medicine” is an assessment of the support each state provides for its emergency medicine systems. Grades were determined using 50 objective and quantifiable criteria to measure the performance of each state and the District of Columbia. Each state was given an overall grade plus grades in four categories, *Access to Emergency Care, Quality and Patient Safety, Public Health and Injury Prevention, and Medical Liability Reform*.

In addition to the state grades, the report card also assigned a grade to the emergency medicine system of the United States as whole. Eighty-percent of the country earned mediocre or near-failing grades, and America earned a C-, barely above a D.

Overall, the report card underscores findings of earlier examinations of our nation’s safety net—that it is in desperate need of change if we are to continue our mission of providing quality emergency medical care when and where it is expected.

Emergency Department Overcrowding

As the frontline of emergency care in this country, emergency physicians are particularly aware of how overcrowding in our nation’s emergency departments is affecting patients. Here are two true patient stories that have been anonymously shared with ACEP that illustrate this point:

I am at a level one trauma center, and we are so overcrowded that people are waiting up to 11 hours to be seen, patients are on stretchers lined up against the walls waiting for beds for three or more hours, and we are filled with patients being held for ICU beds. I am only able to see four to six patients in a 6-hour shift because there just are not beds to put the patients in to see them. We go on diversion, but so do the other hospitals in the area.

A teenage girl was hit in the mouth playing softball, causing injury to her teeth. She arrived in the emergency department, which was full, at 6 pm and sat in a waiting room, holding a cloth to her face, bleeding for 2 hours. Finally, when a bed opened for her, the doctor saw she had significant dental injuries, including loose upper front teeth. He ordered an x-ray. Once he had the results several hours to obtain later, he called an orthodontist who fortunately agreed to see her right away. By then, it was 12 midnight.

The root of this problem exists due to overcrowded emergency departments. To be clear, I am not discussing crowded emergency department waiting rooms, but the actual treatment areas of emergency departments.

Overcrowded emergency departments threaten access to emergency care for everyone—insured and uninsured alike—and create a situation where the emergency department can no longer safely treat any additional patients. This problem is particularly acute after a mass-casualty event, such as a man-made or natural disaster, but we are stretched beyond our means on a daily basis as well.

Every day in emergency departments across America, critically ill patients line the halls, waiting hours—sometimes days—to be transferred to inpatient beds. This causes gridlock, which means other patients often wait hours to see physicians, and some leave without being seen or against medical advice. Contributing factors to overcrowding include reduced hospital resources; a lack of hospital inpatient beds;

a growing elderly population and an overall increase in emergency department utilization; and nationwide shortages of nurses, physicians and hospital support staff.

On-Call Shortage

ACEP and Johns Hopkins University conducted two national surveys, one in the spring of 2004 and another in the summer of 2005, to determine how current regulations and the practice climate are affecting the availability of medical specialists to care for patients in the nation's emergency departments. The key findings of these reports include:

- Access to medical specialists deteriorated significantly in one year. Nearly three-quarters (73 percent) of emergency department medical directors reported inadequate on-call specialist coverage, compared with two-thirds (67 percent) in 2004.
- Fifty-one percent reported deficiencies in coverage occurred because specialists left their hospitals to practice elsewhere.
- The top five specialty shortages cited in 2005 were orthopedics; plastic surgery; neurosurgery; ear, nose and throat; and hand surgery. Many who remain have negotiated with their hospitals for fewer on-call coverage hours (42 percent in 2005, compared with 18 percent in 2004).

As indicated by the IOM report, another factor that directly impacts emergency department patient care and overcrowding is the shortage of on-call specialists due to: fewer practicing emergency and trauma specialists; lack of compensation for providing these services to high percentage of uninsured and underinsured patients; substantial demands on quality of life; increased risk of being sued and high insurance premiums; and relaxed Emergency Medical Treatment and Labor Act (EMTALA) requirements for on-call panels.

Two anonymous reports on emergency crowding explain the on-call shortage well:

A 23 year-old male in Texas arrived unconscious with what turned out to be a subdural hematoma. We were at a small hospital with no neurosurgical services. Ten minutes away was a hospital with plenty of neurosurgeons, but that hospital would not accept the patient because the on-call neurosurgeon said he needed him to be at a trauma center with an around-the-clock ability to monitor the patient. All the trauma centers or hospitals larger were on "divert." The patient was FINALLY accepted by a hospital many miles away, with a 90-minute Life flight helicopter transfer. The patient died immediately after surgery there.

A 65 year-old male in Washington State came to an emergency department at 4:00 a.m. complaining of abdominal pain. The ultrasound showed a six-centimeter abdominal aortic aneurysm (AAA) and he was unstable for CT scanning. We had no vascular surgeon available within 150 miles; a general surgeon was available, but he refused to take the patient out-of-state. We reversed the Coumadin and transferred the patient in three hours to the nearest Level I trauma center, but he died on the operating table. He probably would have had a better outcome without a three-hour delay.

EMTALA

This committee has a long history of promoting quality health care for the citizens of this country, including its role leading the way to the enact EMTALA in 1986. We are pleased that the Congress, and your committee in particular, have begun a focused examination of emergency care in this country and thank you for your efforts to create an EMTALA Technical Advisory Group (EMTALA TAG) as part of the "Medicare Prescription Drug, Improvement and Modernization Act of 2003" (P.L. 108-173), which is looking at important issues facing emergency medicine.

ACEP has long supported the goals of EMTALA as being consistent with the mission of emergency physicians. While the congressional intent of EMTALA, which requires hospitals with emergency departments to provide emergency medical care to everyone who needs it, regardless of ability to pay or insurance status, was commendable, the interpretation of some EMTALA regulations have been problematic.

When CMS issued its September 2003 EMTALA regulation, uncertainty was created regarding the obligations of on-call physicians who provide emergency care that could potentially increase the shortage of on-call medical specialists available and multiply the number of patients transferred to hospitals able to provide this coverage. Under this new rule, hospitals must continue to provide on-call lists of specialists, but they can also allow specialists to opt-out of being on-call to the emergency department. Specialists can also now be on-call at more than one hospital simultaneously and they can schedule elective surgeries and procedures while on-call. Without an adequate supply of specialists willing to take call, some hospitals may

choose not to provide emergency care at all, which would only shift the burden to the already strained hospital emergency departments that remain open.

Reimbursement and Uncompensated Care

The patient population can vary dramatically from hospital to hospital and the differences in payer-mix have a substantial impact on a hospital's financial condition. Of the 110 million emergency department visits in 2004, individuals with private insurance represented 36 percent, 22 percent were Medicaid or SCHIP enrollees, 15 percent were Medicare beneficiaries and another 16 percent were uninsured. These numbers demonstrate the large volume of care provided in the emergency department to individuals who are underinsured or uninsured. According to an American Hospital Association (AHA) statement from 2002, 73 percent of hospitals lose money providing emergency care to Medicaid patients while 58 percent lose money for care provided to Medicare patients. Even private insurance plans still frequently deny claims for emergency care because the visit was not deemed an emergency in spite of the "prudent layperson standard" which ACEP has strongly advocated for years.

While emergency physicians stand ready to treat anyone who arrives at their emergency department, uncompensated care can be an extreme burden at hospitals that have a high volume of uninsured patients, which now exceeds 51.3 million Americans and continues to rise. Hospital emergency departments are the provider of last resort for many people, including undocumented aliens, who have no other access to medical care. As such, emergency departments experience a high-rate of uncompensated care.

As pointed out in the IOM report, the estimated annual cost to emergency care providers nationwide for undocumented aliens is \$1.45 billion and the cost to the 28 counties along the border in Texas, New Mexico, Arizona and California is \$232 million. Congress attempted to alleviate some of this burden by including a provision in the "Medicare Prescription Drug, Improvement and Modernization Act of 2003" (P.L. 108-173) that provided \$1 billion (\$250 million per year) between FY 2005—FY 2008 to help pay for unreimbursed emergency health care services provided to undocumented aliens and other specified aliens. While ACEP strongly supported this provision to help provide relief for this uncompensated burden, this program has been underutilized due to the overly burdensome and impractical regulations that were implemented by CMS in 2005.

Boarding

Reductions in reimbursement from Medicare, Medicaid and other payers, as well as payment denials, continue to reduce hospital resource capacities. To compensate, hospitals have been forced to operate with far fewer inpatient beds than they did a decade ago. Between 1993 and 2003, the number of inpatient beds declined by 198,000 (17 percent). This means fewer beds are available for admissions from the emergency department, and the health care system no longer has the surge capacity to deal with sudden increases in patients needing care.

The overall result is that fewer inpatient beds are available to emergency patients who are admitted to the hospital. Many admitted patients are "boarded," or left in the emergency department waiting for an inpatient bed, in non-clinical spaces—including offices, storerooms, conference rooms—even halls—when emergency departments are overcrowded.

The majority of America's 4,000 hospital emergency departments are operating "at" or "over" critical capacity. Between 1992 and 2003, emergency department visits rose by more than 26 percent, from 90 million to 114 million, representing an average increase of more than 2 million visits per year. At the same time, the number of hospitals with emergency departments declined by 425 (9 percent), leaving fewer emergency departments left to treat an increasing volume of patients, who have more serious and complex illnesses, which has contributed to increased ambulance diversion and longer wait times at facilities that remain operational.

According to the 2003 report from the Government Accountability Office (GAO), overcrowding has multiple effects, including prolonged pain and suffering for patients, long emergency department waits and increased transport times for ambulance patients. This report found 90 percent of hospitals in 2001 boarded patients at least two hours and nearly 20 percent of hospitals reported an average boarding time of eight hours.

There are other factors that contribute to overcrowding, as noted by the GAO report, including:

- Beds that could be used for emergency department admissions are instead being reserved for scheduled admissions, such as surgical patients who are generally more profitable for hospitals

- Less than one-third of hospitals that went on ambulance diversion in fiscal year 2001 reported that they had not cancelled any elective procedures to minimize diversion.
- Some hospitals cited the costs and difficulty of recruiting nurses as a major barrier to staffing available inpatient/ICU beds.

To put this in perspective, I would like to share with you the findings of the IOM report on hospital-based emergency care, which was just released on June 14:

“Emergency department overcrowding is a nationwide phenomenon, affecting rural and urban areas alike (Richardson et al., 2002). In one study, 91 percent of EDs responding to a national survey reported overcrowding as a problem; almost 40 percent reported that overcrowding occurred daily (Derlet et al., 2001). Another study, using data from the National Emergency Department Overcrowding Survey (NEDOCS), found that academic medical center EDs were crowded on average 35 percent of the time. This study developed a common set of criteria to identify crowding across hospitals that was based on a handful of common elements: all ED beds full, people in hallways, diversion at some time, waiting room full, doctors rushed, and waits to be treated greater than 1 hour (Weiss et al., 2004; Bradley, 2005).”

ACEP has been working with emergency physicians, hospitals and other stakeholders around the country to examine ways in which overcrowding might be mitigated. Of note, ACEP conducted a roundtable discussion in July 2005 to promote understanding of the causes and implications of emergency department overcrowding and boarding, as well as define solutions. I have included an addendum to my testimony of strategies, while not exhaustive or comprehensive, which still hold promise in addressing the emergency department overcrowding problem.

Ambulance Diversion

Another potentially serious outcome from overcrowded conditions in the emergency department is ambulance diversion. It is important to note that ambulances are only diverted to other hospitals when crowding is so severe that patient safety could be jeopardized.

The GAO reported two-thirds of emergency departments diverted ambulances to other hospitals during 2001, with crowding most severe in large population centers where nearly one in 10 hospitals reported being on diversion 20 percent of the time (more than four hours per day).

A study released in February by the National Center for Health Statistics found that, on average, an ambulance in the United States is diverted from a hospital every minute because of emergency department overcrowding or bed shortages. This national study, based on 2003 data, reported air and ground ambulances brought in about 14 percent of all emergency department patients, with about 16.2 million patients arriving by ambulance, and that 70 percent of those patients had urgent conditions that required care within an hour. A companion study found ambulance diversions in Los Angeles more than tripled between 1998 and 2004.

According to the American Hospital Association (AHA), nearly half of all hospitals (46 percent) reported time on diversion in 2004, with 68 percent of teaching hospitals and 69 percent of urban hospitals reporting time on diversion.

As you can see from the data provided, this nation’s emergency departments are having difficulty meeting the day-to-day demands placed on them. Overcrowded emergency departments lead to diminished patient care and ambulance diversion. We must take steps now to avoid a catastrophic failure of our medical infrastructure and we must take steps now to create capacity, alleviate overcrowding and improve surge capacity in our nation’s emergency departments.

Congress can begin to address these problems today by enacting H.R. 3875/S. 2750, the “Access to Emergency Medical Services Act.” This legislation provides: (1) limited liability protections for EMTALA-related care delivered in the emergency department to uninsured individuals; (2) additional compensation for care delivered in the emergency department; and (3) incentives to hospitals that move boarded patients out of the emergency department in a timely manner. As noted in my testimony, and supported by the findings of the GAO and IOM, these are three of the most critical issues facing emergency medicine.

Conclusion

Emergency departments are a health care safety net for everyone—the uninsured and the insured. Unlike any other health care provider, the emergency department is open for all patients who seek care, 24 hours a day, 7 days a week, 365 days a year. We provide care to anyone who comes through our doors, regardless of their ability to pay. At the same time, when factors force an emergency department to close, it is closed to everyone and the community is denied a vital resource.

America's emergency departments are already operating at or over capacity. If no changes are made to alleviate emergency department overcrowding, the nation's health care safety, the quality of patient care and the ability of emergency department personnel to respond to a public health disaster will be in severe peril.

While adopting crisis measures to increase emergency department capacity may provide a short-term solution to a surge of patients, ultimately we need long-term answers. The federal government must take the steps necessary to strengthen our resources and prevent more emergency departments from being permanently closed. In the last ten years, the number and age of Americans has increased significantly. During that same time, while visits to the emergency department have risen by tens of millions, the number of emergency departments and staffed inpatient hospital beds in the nation has decreased substantially. This trend is simply not prudent public policy, nor is it in the best interest of the American public.

Every day we save lives across America. Please give us the capacity and the tools we need to be there for you when and where you need us . . . today, tomorrow and when the next major disaster strikes the citizens of this great country.

Attachment

Overcrowding strategies outlined at the roundtable discussion "Meeting the Challenges of Emergency Department Overcrowding/Boarding," conducted by the American College of Emergency Physicians (ACEP) in July 2005

Strategies currently being employed to mitigate emergency department overcrowding:

- Expand emergency department treatment space. According to a Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standard (LD.3.11), hospital leadership should identify all of the processes critical to patient flow through the hospital system from the time the patient arrives, through admitting, patient assessment and treatment and discharge.
- Develop protocols to operate at full capacity. In short, when emergency patients have been admitted, they are transferred to other units within the hospital. This means that the pressure to find space for admitted patients is shared by other parts of the hospital.
- Address variability in patient flow. This involves assessing and analyzing patient arrivals and treatment relative to resources to determine how to enhance the movement of patients through the emergency department treatment process and on to the appropriate inpatient floors.
- Use queuing as an effective tool to manage provider staffing. According to an article in the *Journal of the Society for Academic Emergency Medicine*, surveyors found that timely access to a provider is a critical measure to quality performance. In an environment where emergency departments are often understaffed, analyses of arrival patterns and the use of queuing models can be extremely useful in identifying the most effective allocation of staff.
- Maximize emergency department efficiency to reduce the burden of overcrowding and expanding their capacity to handle a sudden increase or surge in patients.
- Manage acute illness or injury and the utilization of emergency services in anticipatory guidance. In its policy statement on emergency department overcrowding issued in September 2004, the American Academy of Pediatrics noted: "The best time to educate families about the appropriate use of an emergency department, calling 911, or calling the regional poison control center is before the emergency occurs. Although parents will continue to view and respond to acute medical problems as laypersons, they may make better-informed decisions if they are prepared."
- Place beds in all inpatient hallways during national emergencies, which has been effectively demonstrated in Israel.
- Improve accountability for a lack of beds with direct reports to senior hospital staff, as done in Sturdy Memorial Hospital (MA).
- Set-up discharge holding units for patients who are to be discharged in order not to tie-up beds that could be used by others. The 2003 GAO report found that hospitals rely on a number of methods used to minimize going on diversion, including using overflow or holding areas for patients.
- Establish internal staff rescue teams. This concept involves intense collaboration between emergency department staff and other services in the hospital when patient volume is particularly high.
- Improve coordination of scheduling elective surgeries so they are more evenly distributed throughout the week. For example, Boston Medical Center had two cardiac surgeons who both scheduled multiple surgeries on Wednesdays. The

Medical Center improved the cardiac surgery schedule by changing block time distribution so one surgeon operated on Wednesdays and the other operated on Fridays.

- Employ emergency department Observation Units to mitigate crowding.
- Strive to minimize delays in transferring patients.
- Support new Pay-for-Performance measures, such as reimbursing hospitals for admitting patients and seeing them more quickly and for disclosing measurements and data.
- Monitor hospital conditions daily, as done by some EMS community disaster departments.
- Institute definitions of crowding, saturation, boarding by region with staged response by EMS, public health and hospitals. For example, the Massachusetts Chapter of ACEP has been working with its Department of Public Health (DPH) on this issue for several years, which has resulted in the development of a “best practices” document for ambulance diversion and numerous related recommendations including protocols regarding care of admitted patients awaiting bed placement. The chapter’s efforts also resulted in the commissioner of DPH sending a letter to all hospitals outlining boarding protocols.
- Seek best practices from other countries that have eased emergency department crowding.
- Improve internal information sharing through technology.

Strategies and innovative suggestions to solve the crowding crisis that are in the planning or testing phases:

- Physicians should work to improve physician leadership in hospital decision-making.
- Hospitals should expand areas of care for admitted patients. In-hospital hallways would be preferable to emergency department hallways. If 20 patients are waiting for admission and there are 20 hallways available, putting one patient per hallway would be preferable to putting all 20 in the emergency department, which only prevents others from accessing care.
- Design procedures to facilitate quicker inpatient bed turnover, with earlier discharges and improved communications between the housekeeping and admission departments.
- Offer staggered start times and creative shifts that would offer incentives to those who couldn’t work full-time or for those who would benefit from having a unique work schedule.
- Collect data to measure how patients move through the hospital.
- Address access to primary care and issues to facilitate patient care that supply lists of clinics and other community-based sources of care.
- Communities should increase the number of health care facilities and improve access to quality care for the mentally ill.
- Policymakers should improve the legal climate so that doctors aren’t forced to order defensive tests in hopes of fending off lawsuits.
- Ensure emergency medical care is available to all regardless of ability to pay or insurance coverage and should therefore be treated as an essential community service that is adequately funded.
- Lawmakers should enact universal health insurance that includes benefits for primary care services.

Chairman JOHNSON OF CONNECTICUT. Thank you very much, Dr. Blum. Dr. Bedard.

STATEMENT OF LARRY BEDARD, M.D., SENIOR PARTNER, CALIFORNIA EMERGENCY PHYSICIANS, EMERYVILLE, CALIFORNIA

Dr. BEDARD. Good morning, Madam Chair and Members of the Committee. I’m Dr. Larry Bedard. I’m an emergency physician, a pit doctor. I really appreciate the opportunity to share with you my perspectives on the growing crisis facing the emergency care system in this country. I’m not going to talk about the problems. I’m assuming that you agree that there are significant problems. I

would like to congratulate Mr. Warden on the excellent report that came out from IOM. I agree with virtually all of their findings.

What I would like to spend my time on is talking about some of the solutions. In my written testimony I submitted to you a copy of a "Top 10 List," "Dr. Bedard's Top 10 List," in order to try to deal with this crisis. First and foremost, I think we need to enforce EMTALA prospectively, not retrospectively. I believe hospitals should be surveyed and certified that they meet and comply with the EMTALA rules and regulations. We've heard 75 percent of emergency department directors have a problem with on-call physicians. Seventy-five percent of these hospitals do not comply with EMTALA, yet the number of investigations and violations is only a handful.

There are many reasons why physicians are intimidated or reluctant to report or deal with this issue. Secondly, I think we need to have a different organization than Joint Commission on Accreditation of Healthcare Organizations (JCAHO) certifying hospitals or certifying the emergency care system. Last year, our hospital went through a JCAHO survey. We passed with glowing colors. What happened is, the night before the surveyor showed up, we took all the gurneys and the patients we board and hid them elsewhere in the hospital. Immediately after the surveyors left, the gurneys were back in the hallways and patients were being boarded in our emergency department. The fact that 75 percent of ED directors have problems with on-call, I'll guarantee you, every one of those medical directors practices at a hospital that JCAHO has certified.

It is obvious to me, and I think that the certification process is in effective as currently conducted by JCAHO. Number three, I agree that regionalization is one way of helping with the on-call problems and you need to get the patient to the right hospital, to the right doctors, at the right time. However, in order to regionalize emergency care, I believe Congress is going to have to enact some antitrust legislation which would allow competing hospitals and health systems to get together to coordinate and regionalize care. Perhaps, my most controversial solution is the way I would reimburse physicians for serving on call. I refer to it as the "play or pay system."

Every physician in the United States who went to medical school here, who has done residency training in the United States has been heavily subsidized by the taxpayers. A common approach of professional associations, for example, the American College of Surgeons, says, "Gee, give us tax deductions or tax credits for the charity care that we provide." I believe before physicians are given tax credits or tax deductions, that they should pay back the debt to the taxpayers for our education. In order to do this, you would have to do two things: One, Centers for Medicare and Medicaid Services (CMS). You do an actuarial study to determine the amount of taxpayer subsidy that went into physicians' education and training.

We then have CMS work with American Medical Association's Reimbursement Update Committee to set a value or in essence, a payment for what it's worth to be on call for 24 hours. Then physicians would have the opportunities, say over 20 years, to pay back their taxpayer subsidy by serving on call. If you were a neurosurgeon who was netting \$500,000 a year, you might want to take

the other option, which is to pay at the going rate, say \$1,000, so you don't have to take call. You could pay one of your other colleagues to provide that service for you. Six. I think we do need to come up with some meaningful malpractice reform. Physicians should not have to pay an extra premium for agreeing to serve on call.

I think the Congress also needs to support and incentivize hospitals to have information technology so we can coordinate, we can regionalize emergency care. I think the ultimate solution is Congress needs to create a system of universal basic health care for all citizens of the United States. I look forward to answering any of your questions.

[The prepared statement of Dr. Bedard follows:]

Statement of Larry Bedard, M.D., Senior Partner, California Emergency Physicians, Emeryville, California

Chair Nancy Johnson and Members of the House Ways and Means Subcommittee on Health. I want to thank for the opportunity to share my perspective and views about the worsening crisis in the emergency care system of the United States.

In particular, I want to thank, Congressman Pete Stark who invited me to testify. In 1985 Congressman Stark introduced legislation, the "Emergency Medical Treatment and Active Labor Act" (EMTALA). When President Ronald Regan signed EMTALA into law on April 6, 1986 it answered the question for once and for all: "Is medical care a right or privilege?" EMTALA made emergency care a legal right. Before April 1986 the only people who had a legal right to health care were prisoners. After April 1985 all people had a right to go a hospital emergency facility and be evaluated and treated for an emergency medical condition. It is difficult to underestimate the impact that the passage of EMTALA had on the development and practice of emergency medicine in the United States. We needed EMTALA in 1986 and we need a strengthened EMTALA in 2006.

However, from the perspective of Emergency Physicians, the 1986 law was fatally flawed. EMTALA defined a responsible physician as one who "was employed by or contracted with a hospital." Since the vast majority of emergency physicians contract with hospitals, we were clearly responsible physicians. The California Medical Association's position however, was that EMTALA did not apply to on-call physicians. California law prohibits hospitals from employing physicians so clearly on-call physicians were not employees. The CMA did not consider medical staff privileges a contract. In 1987 the California Chapter of the American College of Emergency Physicians (CAL/ACEP) working with a broad coalition of health care organizations passed SB12 which defined on-call physicians as responsible physicians under California transfer law.

In 1988, as an individual, I met with Congressman Stark and two aides. I explained to the congressman how EMTALA was fatally flawed. Emergency physicians can not stand alone! We and our patients need the availability and access to many on-call specialists if we are to provide high quality emergency care. In 1989, much to his credit, Congressman Stark successfully amended EMTALA to define on-call physicians as responsible physicians.

EMTALA, however, did not solve the access and availability of on-call physicians to back up hospital emergency departments. Indeed, many physicians refuse to take call, sighting the EMTALA unfunded mandates and threats of significant fines.

In 2005, nearly three quarters of emergency department medical directors indicate they had a problem with on-call back up.

The issue in 1985 was availability and access to on-call specialists.

The issue in 1989 was defining the role and responsibility of on-call physicians.

The issue in 2006 is the availability and access to on-call physicians.

I view the Institute of Medicine's Committee on the Future of Emergency Care in the United States Health System report "Hospital-Based Emergency Care At the Braking Point" from two perspectives. First, from the perspective of someone who has been involved in medical politics for more then 25 years. I have engaged in policy discussions as a Delegate to the American Medical Association and a Trustee of the California Medical Association As President of ACEP, my national professional association and CAL/ACEP, my state professional association, I represented the views and interests of emergency physicians in Washington DC. and Sacramento. Locally, I was an elected public official, serving on the Marin Hospital Dis-

strict Board. I just completed my tenure as President of the county medical society. Today, I'm glad to say I represent none of these organizations!

Today, I speak from the perspective of an individual emergency physician. A pit doctor! A patient advocate. And believe me, when you present to the ER with a significant illness or injury you need your emergency physician to be your advocate. Your ER doc needs to help you navigate the chaotic and difficult world of emergency medicine. You're my patient, I'm your doctor.

I would like to share with the committee a recent experience I had in the ER. A mid 60ish Asian male got up from the dinner table, complained of a severe headache and collapsed. 911 was called and the patient was brought to the nearest hospital, our overcrowded ER. You do not need to a rocket scientist or a brain surgeon to know that an intracerebral bleed was the most likely diagnosis. The CAT obtained and read by the radiologist within 45 minutes did in fact reveal a large bleed. Since we had no neurosurgeon or neurologist on-call at our hospital, I contacted the neurosurgeon on call at the premier private hospital in San Francisco. When I asked for him to accept the patient in transfer, he informed me that he was not on call for my hospital and then hung up the phone. I next phoned San Francisco General Hospital, a nationally renowned trauma center. I was informed that they were holding their neurosurgeon in reserve for any trauma cases. At that time I thought maybe I should have told them the patient tripped and hit his head. I next called the University of San Francisco Medical Center, one of the premier academic centers in the country. The neurosurgery fellow indicated that he needed to talk with the neurosurgery attending and the hospital admissions staff. He promised to get back to me shortly. A half hour later I received his call: "This is the kind of patient we would like to accept but we are boarding patients in the ED for 2 days. We will be happy to accept him in 2 days." At that time I called the patients personal physician, the ED Medical Director and the Chief of Staff of the Hospital to apprise them of the situation and seek their assistance in arranging an appropriate transfer. Hopefully, one of these physicians could call in a favor from a colleague. I next called Stanford University Hospital but their ICU was full and they were also boarding patients in their ER. Four physicians worked for more than 4 hours but we failed in our attempts to arrange a safe transfer for this patient. The emergency physicians guardian angel came to my and the patients rescue. The man's daughter, who worked for an internist, called her boss for help. This internist asked a neurosurgeon, who was not on call to accept the patient in transfer. After nearly 5 hours the patient was transferred to the premier private hospital for neurological care. What is wrong with this picture? How ironic that the patients daughter could arrange for a transfer when four physicians could not. This situation occurred in San Francisco, everybody's favorite city. In San Francisco, a city with one of the highest physician to patient ratios in the country.

This single situation epitomizes many of the problems revealed in the IOM report. "Hospital Based Emergency Care At the Breaking Point." A fragmented system was unable to provide, coordinated effective emergency care. The ER was overcrowded, hospitals were on diversion, and boarders jammed up other ERs preventing transfer and the necessary on-call specialists were not available.

I want to congratulate the IOM's Committee on the Future of Emergency Care in the United States Health System for a comprehensive, thought provoking report on the current state of emergency care. I agree with virtually all their key findings. I believe they did an excellent job of evaluating and diagnosing the afflictions of the emergency care system. In my comments I will offer additional or alternative treatments or solutions to cure the problems identified in the IOM Report. Hopefully, my comments will help the committee to take appropriate actions in solving some of the problems that we face.

I applaud and share the committee's "vision for the future of emergency care that centers around three goals: coordination, regionalization, and accountability."

REGIONALIZATION: "The committee recommends that hospitals, physician organizations, and public health agencies collaborate to regionalize critical specialty care on-call services." I strongly support this recommendation.

Take the patient to the doctor, instead of taking the doctors to the patients. Take the patient to the right hospital with the right doctors the first time. If a hospital doesn't have a readily available on-call neurologist they should not receive stroke patients. Regionalization makes a lot of sense.

However, when such a regional system was proposed for the Sacramento area by the 1998-1999 CMA,CAL/ACEP,CHA "On-Call" Task Force, lawyers from Sutter, Kaiser and Catholic Health Care West (CHW) immediately cautioned their hospital systems that regionalizing emergency care may violate federal anti-trust law. They advised them against sitting down with competitors to allocate and divide market share. If we are to implement regionalized on-call services Congress needs to

amend, federal anti-trust laws to expressly permit competing hospital and health care systems to regionalize emergency care.

ACCOUNTABILITY: “Accountability is perhaps the most important of the three goals of the emergency care system envisioned by the committee because it is necessary to achieving the other two. Lack of accountability has contributed to the failure of the emergency care system to adopt needed changes in the past. Without accountability, participants in the system need not accept responsibility for failure, and can avoid making changes necessary to avoid the same outcomes in the future.” IOM Pg 73

“We don’t need new laws, we just need to enforce the ones already on the books.” Is a well worn cliché in Washington In the case of the emergency care system this is probably true.

I believe that we could address and solve many of the problems confronting the emergency care system if we **proactively** audited and enforced the EMTALA rules and regulations and interpretative guidelines. Under current law, EMTALA is only **reactively** enforced. The only times there is an investigation is when some one complains. Isn’t it a little strange that when 73% of ED medical directors have problems with on-call coverage there are only a handful of EMTALA investigations? “To get along, go along” is often an essential requirement for a medical director. Working on a contract that can be cancelled in 90 days is another inducement to go along. I believe that a proactive enforcement of EMTALA many years ago would have helped us address, mitigate and solve some of the problems facing us.

The IOM request that “The federal government should support the development of national standards for: emergency care performance measurement; categorization of all emergency care facilities; and protocols for the treatment, triage, and transport of prehospital patients”

The question arises: Who should do the certification, monitoring, and auditing of emergency care facilities and pre-hospital systems?

“The committee recommends that the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) reinstate strong standards that sharply reduce and ultimately eliminate ED crowding, boarding, and diversion. Pg 122

I disagree with this recommendation. I believe that JCAHO is not the appropriate organization to accredit and certify emergency care systems. I am disappointed but not surprised to learn that JCAHO “under pressure from the hospital industry” withdrew requirements for hospitals “to take serious steps to reduce crowding, boarding and diversion” IOM pg 122. In some respects, having JCAHO regulate the emergency care system is like having the proverbial fox guarding the hen house.

In my career, I have participated in several JCAHO inspections both as the Medical Director of the Emergency Department and as an attending emergency physician. We passed a recent inspection with glowing colors. What a joke. We moved the gurneys and the patient boarders from the hallways the night before JCAHO came and immediately returned them the moment they left. JCAHO had no interest in looking at the on-call schedule. If they saw the numerous holes for specialty coverage, perhaps they would have to do something about it.

In a 2005, ACEP study, 73 percent of EDs reported problems with on-call coverage, in contrast to 67 percent the year before. How many of these EDs and hospitals did JCAHO refuse to certify? How does JCAHO address and resolve the “problems with on-call coverage.”? I think the committee should have answers to these questions before deciding which agency should certify and regulate the emergency care system.

Lead agency. “The federal government should consolidate functions related to emergency care that are currently scattered among multiple agencies into a single agency in the Department of Health and Human Services (OHHS).” I believe that there should be such a lead agency. I believe that the lead agency should monitor, audit, accredit and certify emergency care facilities The federal government should not outsource the regulation of the emergency care system, a vital national interest, to JCAHO.

TRANSPARENCY Make the system transparent to patients. Educate the public about the access and availability of on-call specialists and hospital capability. Require hospitals to post in the daily paper, on TV or on the internet which on-call specialists are available. This would save tourists in San Francisco from bringing their sick kid to a hospital that did not have a pediatric department or service.

Make the system transparent to EMS pre-hospital providers. Ambulance destination guidelines should take into consideration the availability of on-call specialist. Dispatchers and paramedics need to know in real time what on call physicians are available.

Boarding and diversion. “Current CMS payment policies should be revised to reward hospitals that appropriately manage patient flow. Conversely, hospitals that fail to properly manage patient flow should be subject to penalties” IOM Pg 121

The IOM recommendation is both a carrot and stick. I recommend trying the carrot first. Have The Centers for Medicare and Medicaid Services (CMS) s develop Pay For Performance (P4P) (P\$P) incentives to award hospitals for improving efficiency in admitting patients from the ED. It would be relatively easy to monitor, record and audit admission times—the time from the moment the emergency or other admitting physician writes the admit order until the time the patient arrives in their hospital room or surgical suite.

Disaster Management: The IOM notes: “With many EDs at or over capacity, there is little surge capacity for a major event, whether it takes the form of a natural disaster, disease outbreak, or terrorist attack.” The truth be told that in many metropolitan area in the U.S., the emergency care system is not equipped to handle a busy Saturday night this weekend. One of the scariest aspects of the IOM report was how poorly we are prepared for a major disaster.

ON-CALL Specialist: “One of the most troubling aspects of the current emergency and trauma care system is the lack of available specialists to provide on-call services to hospital EDs and trauma centers. This is particularly true for highly skilled specialties such as neurosurgery, interventional cardiology, and orthopedic surgery.” IOM Pg 17

Critical specialists are often unavailable to provide emergency and trauma care. This is a chronic and increasing problem in emergency medicine. Nothing is more painful, frustrating and depressing for an emergency physician then to have a patient suffer or die because there is no on-call specialist to back you up. Solving the on-call crisis is a dilemma with no easy solutions. However, I don’t believe that you can solve boarding or ambulance diversion without solving the on-call problem.

One promising solution is to regionalize the services of certain on-call specialties, so that every hospital need not maintain on-call services for every specialty.” IOM 8

Another issue that needs to be addressed is the malpractice liability exposure and costs for being an emergency physicians and an on-call specialist. You can not expect a physician to pay a 25–50% premium on their malpractice insurance because they have volunteered to serve on-call. for the ER.HR 3875, the Access to Emergency Medical Services Act of 2006 is a vehicle to address the malpractice issue.

A common approach and request is to throw more money at the problem. Physicians are resentful of EMTALA’s unfunded mandate. Personally, I would welcome this solution but I realize that this is unlikely. The projected Medicare shortfall in 2040 is \$63 trillion dollars. Society security is a relatively easy fix at \$8 trillion dollars. Medicare and Medicaid are much, much bigger problems.

Another approach is to ask the federal government to provide tax credits or tax deductions for charitable or uncompensated care. This is the policy of the American College of Surgeons.

Increasingly, physicians have responded to the on-call issues by demanding and receiving stipends from hospitals for agreeing to serve on-call. In essence, we are witnessing a transformation from an “implicit social contract” whereby physicians voluntarily provided on call services to their communities and hospitals to an “explicit financial contract” whereby physicians demand and receive significant stipends from hospitals for providing on-call services to their communities. On-call stipends which vary from a few hundred dollars to several thousands of dollars a day can only be afforded by some hospitals. These hospitals tend to be located in more affluent areas with good payer demographics. Hospitals located in areas with poor payer demographics cannot afford such stipends and are in danger of losing their on-call panels.

Congress created an EMTALA Technical Advisory Group (TAG) to review the interpretation and implementation of EMTALA. The EMTALA tag is very limited in scope. It can only recommend regulations or interpretative guidelines to the Center on Medicare and Medicaid Services (CMS). At one of the TAG’s earliest meeting the American Hospital Association proposed requiring physicians to serve on-call as a condition of Medicare participation. This proposal was quickly rejected when it was pointed out that physicians would stop participating in or possibly boycotting Medicare. I have very little optimism that the EMTALA TAG it will develop necessary and creative solutions to the on-call crisis.

I offer the following Play or Pay system as a possible solution.

“Play or Pay” is a policy whereby an organization or group is required to participate in activities or programs or pay into a fund to support such activities or programs. For example, a “Play or Pay” policy has been advocated by many national specialties to require small businesses to either “play” by providing health insurance

for their employees or “pay” into a fund that would then be used to purchase health insurance for their employees.

The On-Call Play or Pay system would require physicians to “play” by serving on a hospital’s on-call panel or “pay” into a fund that would be used to compensate physicians for serving on-call.

Every physician who graduates from an American medical school or who trains in a specialty residency program is heavily subsidized by the taxpayers. The tuition paid to attend medical school pays only a small proportion of the total cost to educate that physician. The difference between the total educational costs and the student’s tuition is the amount of the taxpayers’ subsidy.

Implementation of an On Call Play or Pay system requires that the following issues be addressed.

EDUCATION/TRAINING ACCOUNT: An actuarial study would determine the amount of tax subsidy provided for medical school and residency training. Such actuarial studies could be done for individual medical schools and training programs or the average cost for medical school and residency could be used to determine each physician’s tax subsidy. The tax subsidy would vary by specialty. Some specialties such as neurosurgery or cardiovascular surgery which are longer than family practice probably receive a larger taxpayer subsidy. Upon completion of their education and residency training each physician would be assigned their individual education/training account. The physician could then pay off their taxpayers’ subsidy by “playing” by serving the community by being on-call at a local hospital or the physician could “pay” into a fund which would be used to pay for physicians who serve on-call. Another possibility would be for a physician to have a colleague serve on-call on their behalf. Each physician could pay off their individual education/training account over a 20–30 year period. For physicians who do not have hospital privileges, a Domestic Peace Corp for Health Care or some other public service could be established.

PAY RATES: A system needs to be developed to determine the monetary value of serving on-call. One process would be to use the AMA’s Reimbursement Update Committee (RUC) to determine the relative value of being on-call. The RUC uses a consensus process to develop recommendations for CMS to assign relative value to new or modified physician services. CMS, although not required to, usually accepts the RUC’s recommendations for assigning relative values to the Common Procedural Terminology (CPT) codes.

CMS then uses the CPT codes to reimburse physicians for providing necessary services to Medicare patients. Since the Medicare system is a ‘zero sum game’ if some codes increase in value all other codes decrease in value. This is a strong incentive for the RUC not to overvalue codes.

Currently on-call stipends are based upon the ability of physicians to negotiate such stipends. Specialties in short supply such as neurosurgeons have used the EMTALA mandate to leverage on-call stipends of large and in some cases exorbitant amounts. The use of the RUC to establish on-call fees would probably result in more fair, equitable and reasonable stipends.

Disproportionate Share Hospitals: Currently the federal government has a policy whereby some hospitals are classified as disproportionate share hospitals (DSH). DSH hospitals by definition provide excess amounts of uncompensated or charity care. Because of their poor payer demographics physicians may avoid seeking medical privileges at such hospitals. Physicians who serve on-call at such hospitals should have a significantly higher “On call Pay Rate” in order to attract physicians to serve on call at these DSH hospitals. In addition, the money paid by physicians to pay off their education/training debt could be used to pay physicians for serving on call at DSH hospitals.

The lack of availability and access to on-call physicians backing up our ERs is a chronic and worsening problem. The transformation from an implicit social contract whereby physicians voluntarily served on call for the benefit of hospital privileges to an explicit financial contract whereby physicians receive stipends for serving on call is a solution that can only be used by some hospitals and communities. Community hospitals that cannot afford to provide such solutions as paying large stipends require new creative solutions. Taxpayers in all communities have paid both federal and state taxes to educate and train physicians in the United States. The “On-call Play or Pay” program whereby physicians either play by serving on-call or pay off their education/training debts is a solution to the on-call problem.

The ultimate solution to the on-call crisis is to develop a universal basic health care system. The vision of Dr. John Kitzhaber, the former two term governor of Oregon is to “maximize the health of the population by creating a sustainable system which reallocates the public resources spent on health on health care in a way that ensures universal access to a defined set of effective health services.” Governor

Kitzhaber is working on a legislative approach to bring such a system to Oregon. His policies and perspectives can be viewed on the Archimedesmovement.org web site. Perhaps the committee should study this as a possible solution for providing universal care for the country.

I hope I have given you some ideas and solutions to think about. Thank you listening to the voice of this emergency physician. I will conclude by where the IOM report begins.

“Knowing is not enough, we must apply.

Willing is not enough; we must do”

Goethe

I urge you; Do reform the emergency care system. It is desperately needed.

Larry A. Bedard, MD FACEP

Chairman JOHNSON OF CONNECTICUT. Thank you. Now, I'd like to yield to Mr. Stark.

Mr. STARK. Thank you, Madam Chair for holding this hearing, and I apologize for being late. Mr. Warden, I'm sorry I missed the beginning of your testimony. Had I been here on time to charm you with my opening remarks, Madam Chair, I would have reviewed the experience of a New York Times reporter in Washington, D.C. recently who died—was attacked, robbed on the street, mugged. They thought he was drunk, so there was a failure on the part of the first responders.

Then the ambulance driver took him to a hospital—well, took him to Howard, because it was closer to his home and he was going to go home after he dumped this guy off, when Sibley was much closer. Then he sat around in the emergency room because they said he was a drunk, and evidently had massive brain trauma. A guy beat him up, hit him over the head. He died. A lot of failures on a lot of people's part. I'm not sure that we don't have those same problems in every branch of medical care.

We can hear the horror stories all the time about the wrong the pharmacist giving you the wrong pill, somebody else cutting off the wrong leg, and I think that the emergency room physicians take a bad rap for a system that perhaps the population at large has failed to address. I think our entire medical care delivery system really is the fault. You guys are a critical part of it. If we had universal coverage, a great portion, I suspect, of the work you do in the emergency room would be handled by nighttime pediatrics or a “doc in the box,” or clinics that would get reimbursed for preventive care and treatment of minor aches and pains, whereas people today don't go, because they don't have the money.

They know if they go and take their kid with an earache to the doc in the box nighttime pediatrics it's going to cost them 65 or 70 bucks and their insurance may or may not cover it if they have insurance, and they ain't got \$65 or \$70 bucks, so they come and wait 2 or 3 hours in the emergency room for you to see the child and give them the antibiotics they need for their earache.

I do, as I would have suggested in my opening remarks, think that if we had a system where people could pay and high deductible insurance isn't going to be the answer. I would love to have the Institute of Medicine or the emergency room, Dr. Blum, your organization, tell us how many people show up with high deductible policies, but you guys hit them in the first \$1,000 bucks, and they don't have the cash to get over that deductible amount, so you

still end up treating them for free. I'd be curious to know what percentage you see there.

Mr. Kelly, his description of the patients that come into Phoenix as Larry Bedard knows, you've just described nine out of 10 people who come to Highland Hospital in Alameda County, only they have a longer rap sheet than this poor guy from Mexico. We treat them all the time. We can only send them back to county jail. That's standard procedure in our neighborhood for the people coming to our emergency rooms, and I don't know—as that's any I can just tell you a story.

We have an emergency at a classroom, at an elementary school. We have lockdown. It isn't a fire drill. This is a gun drill. You never heard of gun drills, but our teachers have learned when they heard a gunshot outside the elementary school, they put the kids under the desk, lock the doors, pull the blinds, and wait until the cops come. Two cars come to the intersection. One guy gets out of the car, starts shooting at the other guy. One guy gets shot up and gets hauled away.

The cops come. They aren't going to chase the cars. They're just going to wait for them at the emergency room. They're going to show up at Dr. Bedard's office, and that's where they'll haul the guy that got shot. This is part of a system wherein the rest of us are paying, and I don't think that cost shifting in the hospital system is going to do it. I think we have to, I think what you bring to us today is a problem that goes all through our delivery system, and I hope that at some point we can deal with how every resident, not necessarily citizen, but every resident if you go to Canada, you'll get treated as an American whether you got the money to pay or not, and they won't drive you home in an ambulance, they'll treat you. They may try and collect later, but they won't send bill collectors into America to do it.

I think the underlying system in both Dr. Blum and Dr. Bedard, in their remarks for how to correct the system have suggested that universal payment system or universal access is one of the critical parts. So, I hope that we can find a way. I like Larry's idea of a code, which I think the physicians to develop, under resource-based scale (RBS), as to what do you pay the neurosurgeon who is sitting at home in Arinda waiting to drive into Oakland because he's on call for an emergency room. \$3,000 a night? I don't know.

There's got to be some kind of a system, and I think you guys should work it out, and we should, because we do pay you, for better or for worse, under Medicare and Medicaid. It's those people who are uninsured that you don't collect from, and how are we going to do that? I don't know. I certainly appreciate all of you being willing to be here, particularly Larry, who came at his own expense, to bring his expertise to this. As the—I hate to admit it, Madam Chair, as the author of EMTALA some 20 years ago, I'd still like to continue to work to get it right, and with your help, maybe we can. Thank you.

Chairman JOHNSON OF CONNECTICUT. Thank you, Mr. Stark. I think one of the reasons that we're here today is that most of the laws we wrote 20 years ago no longer work, just because of the explosion of knowledge in medicine, the explosion of technology, the explosion of diagnostic and treatment capabilities, and a vari-

ety of other things. If you look at the physician payment law, it doesn't work; you look at the hospital payment law, it doesn't work; and it's not surprising that our EMTALA doesn't work. I just want to ask a few questions and then go on to the other Members, and then we can come back for a second round if we have time.

First of all, as you know from the proposed changes in the inpatient rule, we are moving from the system we invented in the eighties of diagnosis-related groups (DRGs) toward a system that is much more, going to be much more directly aligned with the cost of care, so as we adopt the International Classification of Diseases (ICD-10), we will have a more granular system by which to look at what we're going to pay for and to align cost and payment. As we do that, the ability of hospitals to shift the cost of emergency room care across all other categories will be diminished.

Are you prepared to help us understand exactly what the cost of emergency room care is, what the base cost of an emergency room facility is, what the base cost facility is, what the base cost of a trauma capability is, and how we should look at more accurately reimbursing for emergency care? Are you capable of working with us yet, you know, at this time, on that issue? Because right now, the hospitals are not capable of cost reports that honestly or uniformly allocate costs to categories all across America. We have a lot of difficulty in understanding ourselves and I need to know, is our first work to begin understanding how you cost emergency room care and whether it is consistent across the country and what's the relationship between the cost to you and the payment you get? Mr. Warden.

Mr. WARDEN. Madam Chair, the Institute of Medicine Committee spend considerable time talking about that topic, and one of the things that we concluded was that we do not have the data that you're suggesting is needed, and it reflects the fact that very little money has been put into research and studies to really document what's going on in emergency medicine, other than the clinical side; and secondly, that if we're going to be able to address those issues, we're going to have to set some performance standards, we're going to have to have a much better understanding of what the cost is.

Chairman JOHNSON OF CONNECTICUT. Well, I want you all to think about, I don't want to dwell on this, because there's so many other questions, but I want you all to think about this, because it may be that even this year we could develop a requirement that at least we start the process of finding out, because emergency room care costs now, just because of all the diagnostic equipment you're capable of, and years ago, are completely different, and not only do we not have any real understanding of that nor does the payment system reflect that, but we haven't developed any criteria for appropriateness.

I recently learned that one of my hospitals is seeing Magnetic Resonance Imaging (MRIs) for every appendectomy. Now, this is nice, because in court, it's absolute proof, but we cannot afford MRIs for appendectomy. So, I ask you to think with this Subcommittee about what we do do now to find out what it does cost, because as changes in hospital payment move forward, we're going to need to know, and if we don't pay you more accurately, you

won't be there. Then two other questions, and you can fold back in. You're dealing with a lot of uncompensated care, for whatever reason. How do we honestly recognize that? What is the spectrum of your payments from Medicaid, Medicare, real cost, non-payers? We need to better understand that piece of it.

Then we need to better understand what we can do to change EMTALA law so that those who are just who could be using regular facilities use the community health center system, because we pay for that, too. We need to think, where is our money going, and what incentives do we need to put in place so people get to the point where we already pay for care. So, that's one issue. Then on this malpractice, I think if we don't do something about that, you will not survive, and what we did about that in the community health center, because I passed that law, was we took that liability onto the Federal Government, period, the community health centers pay if they get sued. We would need to know how many of the uninsured that come through emergency rooms end up suing. Probably not a lot of them. Yet, we're paying huge premiums for that possibility.

Okay. Those are the things I need to know, because we need to pick out which portions of this problem we need information about and we need to start that aggressively now, which portion of these problems we could at least for a year or 2 years absorb malpractice costs or such and such, and what are the incentives for flow management, because I need to know why we can't do more of this through enlightened management and why we can't do more of this through regional planning. Mr. Levine.

Mr. LEVINE. Yes, ma'am. You asked a lot of questions there. Let me start with the last one first, related to liability, and some of the nuances of how this actually plays out and how it relates to the first question you asked about cost and coming up with a true cost. We stand absolutely ready. I think the weakness in our health care system generally has been a lack of transparency in understanding the cost structure and the inputs to what the actual cost of care is. For example, in the emergency department, in the last few years, the costs have changed so dramatically, being able to pin those down is very difficult. Let me explain. For example, the cost of paying for on-call coverage can exceed \$1,000, \$2,000, \$3,000 a day sometimes for certain specialists. That's a new cost that isn't built into any of the reimbursement structures.

Number two, what do you do about the fact for example, we're a public system, and as a result, we have sovereign immunity. So, perhaps the only tool we have at our disposal is to employ physicians, and we employ over 200 physicians, for the purpose of trying to deal with, to extend our sovereign immunity to those doctors. Think about the thousands of other doctors in the community who are not employees of our health system. Here's what happens to us. We're the public safety net system. More than half of our ER visits are charity, uncompensated, or Medicaid. What happens when they show up in our emergency department?

For a specialist in the community, who is a private doctor, who has insurance of their own, because we're public and we have sovereign immunity, now that doctor is the deep pocket. So, the doctors don't want to cover the safety net hospitals for that reason, so

they go to the private hospitals and they'll cover those hospitals, but not ours. So, that creates, you know, a really interesting wrinkle for us. The other problem is, and what I've seen really from our physicians, is now the incentive is to go bare, because for example, if you have a patient that has multiple system problems and they have four specialists taking care of that patient, if only one of the doctors has coverage and the other three doctors don't have any insurance, they're bare, the doctor that has insurance all of a sudden is the only target. They have a big bullseye on their back. So, they don't take the consults.

So, this contributes to the ER problem, in that that patient may be sitting in an in-patient bed needing a consult, but we can't get a doctor to see the patient, so the patient occupies a bed and that disrupts the flow of patients. Those things are interwoven, and those costs what winds up happening in those cases, we will sometimes have to pay a specialist to come see that patient in the hospital. So all of those costs are built into the system that we don't have a way right now of disclosing to the Federal Government. As far as EMTALA, you know, the hammer does work. As the secretary of health care administration for the State of Florida, it was our responsibility to administer EMTALA, and what we found was it was becoming increasingly difficult.

On top of EMTALA, the State of Florida has a law that says if you offer us an elective service like orthopedics, and you don't cover the emergency department for that specialty, then you can't offer the elective service. On the surface, that sounds great, except here's what can happen. What happens when an elderly patient falls in the hospital? If the ER didn't have full orthopedic coverage, and you don't offer the elective service, you now have no doctor to take care of the in-patient who needs the service. These are all interwoven problems that are, I think, relevant.

Now, in terms of EMTALA, and I have to disagree a little bit with what the doctor at the end said with regard to forcing doctors to pay, when you're 40 percent of the doctors in south Florida are foreign medical graduates. Twenty-five percent of the doctors in our country are foreign medical graduates. We've got to get more people to go into medicine, and putting hammers over their head and telling them they're going to be punished is not the right way to do it, though I do think EMTALA needs to take into consideration if we have a patient that's in our emergency department, and a doctor, we can't get a doctor to cover, how does EMTALA apply to the medical community?

That's part of the issue for the hospitals. When we go out and we survey hospitals for EMTALA violations, we fine them \$10, \$20, \$50 thousand dollars an incident. We publish it in the newspaper. We embarrass the heck out of them. Then, really, the hospital isn't the one that wasn't covering the ER. Even though they were willing to pay for it, they didn't have a doctor to cover it. So, who do you punish in that circumstance? I think that's a relevant issue to talk more about.

Chairman JOHNSON OF CONNECTICUT. Dr. Blum, I think that is, Mr. Levine, a very relevant issue, and when I look at JCAHO, to some extent, how can you impose on institutions stand-

ards they couldn't possibly meet because we've been unable to deal with the underlying problems? Dr. Blum.

Dr. BLUM. There were a lot of questions.

Chairman JOHNSON OF CONNECTICUT. Incidentally, you know, my time has expired, so let's do this. Let's go on to the others and we'll come back. I wanted you to know what my concerns are, because we need to pick out and see what's the first step we can take on as many fronts as possible. My colleague from Arizona.

Mr. HAYWORTH. I thank the gentlelady from Connecticut, our Chairman, and again, to our witnesses, thank you. Perhaps, Madam Chairman, it's just with the appointment to the Health Subcommittee, but I find myself, this merger of public policy and medicine almost involved I guess offering political diagnoses, and to hear the array of maladies in terms of public policy confronting emergency rooms, it sounds as if the case is almost terminal, that the sclerosis, the inertia of public policy, and the failure to deal with a variety of competing interests, and the inability to enforce laws have contributed to a state of crisis that is very troubling.

Mr. Kelly, since you hail from the Fifth Congressional District of Arizona, and for obvious purposes, I have more than a casual interest in what transpires in that geopolitical subdivision, let's talk more about what transpired at the Osborn facility with the illegal immigrant. As I recall from your testimony, Scottsdale Healthcare incurred over \$260,000 in costs. Can you describe the lengths to which your hospital system has had to go to ensure that these patients are returned safely to their home country and to ensure they are receiving proper care once they get there?

Mr. KELLY. Yeah. In many instances, the consulate will not permit transport papers to be issued unless we can arrange for a facility, let's say in Mexico or in another country to accept that patient, and will not provide transportation. So, we have in the past also provided certain equipment for the care of that patient. For example, I believe, I have some figures here where we have given hospitals in Mexico and in other areas ventilators and other equipment and provided the transportation necessary along with the arrangements, the very complicated arrangements to get that patient from our facility to that foreign country.

Mr. HAYWORTH. So, on one hand, the Republic of Mexico oftentimes refuses to be involved in extradition of suspected murderers back to the United States, and yet the transfer of patients I guess we wouldn't call it extradition, medical extraditionists as if they say, "No, we're to set preconditions upon you in the United States to ensure the health care once they return to the sovereign nation." That's been something else that's happened recently within Maricopa County, Arizona, where we live, in Scottsdale. There have been threats by the Mexican Consulate to get involved in court action—

Mr. KELLY. Yes.

Mr. HAYWORTH. To ensure what I don't believe again, I'm not a lawyer, don't even play one here in Congress, much less on TV, but what I believe we would have to accurately describe not as rights, but as privileges, privileges they assume illegals should have in the United States. In your course of discourse in negotiations with the Mexican Consulate, were there any threats of legal

action against Scottsdale Healthcare during the course of this episode or any others?

Mr. KELLY. Indirectly, Congressman, yes. "You cannot definitively prove that, that we will take whatever action is necessary, including court action, to ensure that, you know, you are not going to transport this person back. We will not issue transport papers." Yes, sir, that is correct. In furtherance of your point, though, I'd like to point something out, and it's just not relative to Mexico. In my submission to this Committee, there is an Egyptian there. The cost of transportation, special air transportation back to Egypt was in excess of \$8,000. That patient came through our emergency room. That patient sued us. That patient sued the physician, the patient sued the hospital. The physician paid over \$400,000 and the hospital paid over \$70,000 with both \$100,000 in defense costs with the physician paying over \$120,000 in defense costs. These are just not Mexicans that we're dealing with.

Mr. HAYWORTH. No, indeed. It is a problem almost encyclopedic in scope.

Mr. KELLY. My colleague here has even some more shocking length of stay statistics that just blew me away in this chair right now.

Mr. LEVINE. Madam Chair, we have awe actually have cases in-house now, patients on ventilators from several South American countries. We have one case, a patient who needed a liver transplant, from another country, in the hospital for 85 days, ran up \$800,000 worth of charges. We have another patient that was in the hospital for 373 days, came in through the ER as a gunshot wound. Actually, the consulate from Guatemala called an attorney to try to delay the patient's discharge from the hospital. So, these are cases where they've cost us in excess of millions of dollars, just at our one trauma center in Broward County.

Mr. HAYWORTH. Madam Chair, you've been generous with the time. I look forward to the second round of questioning. Suffice it to say now, just as you're preparing your thoughts, panelists, again, a merger of medical and public policy terms, what do we do in terms of public policy triage to be reasonable and compassionate, and yet not bled dry financially by the abuse of our system? Think about that and we'll get back, I'll yield back, because you've been very generous with the time.

Chairman JOHNSON OF CONNECTICUT. Thank you. The gentleman from California.

Mr. THOMPSON. Thank you, Madam Chair. Thanks for having this hearing. This is a problem that I think that we all experience, irrespective of where we live, and I would certainly hope that we get an opportunity, Madam Chair, to work on this, even if it's incrementally trying to bring about some of the changes that may in the big picture not fix it all, but would certainly deliver some relief to folks who are having to deal with these problems every day in real life. Thank you all for being here to make presentations. I appreciate it very much. Mr. Warden, in your testimony you talked about the lack of surge capacity and what could happen if there was a big car crash and how that could really impact things.

I live in a district that is a rural district, and it has a whole set of problems just because of that, but in addition, we've had all

kinds of natural disasters. We have earthquakes and wildfires and floods, and we've even had a tsunami in my district that wiped out an entire town. There's one building standing today that was standing in 1964. So, the whole issue of surge capacity is of great concern to the people that I represent. Given the propensity for natural disasters across sequence of events of the different areas, is there one thing that you would recommend that Congress could do to improve our disaster preparedness?

Mr. WARDEN. Yes, sir. I think that one of the biggest challenges is that there's been very little funding available for disaster preparedness in hospitals, or for that matter, the health care system, and when you look at the amount of money that has been appropriated for those kinds of things, it just doesn't filter down to the level of the hospital and the hospital emergency room, and consequently, we're put in a situation where we have to react. Every hospital has an emergency preparedness plan, but at the same time, it's not as sophisticated as it should be, and they don't have the funding to do the kinds of things and get the equipment they need to be able to do it; and I think that's where it has to start.

Mr. THOMPSON. I would appreciate it, I don't know if it's appropriate to ask that it be shared with the whole Committee, I don't know what the rest of my colleagues' level of concern is in this regard, but if you could, I'd like to see some ideas that you might have, not just we need more money, but, you know, what we could—what we actually need to do and how we would go about doing that. I'd find that very helpful.

Mr. WARDEN. There is information in the report, and we can see that that's provided to you.

Mr. THOMPSON. If you could get that to me, I would really appreciate it.

Mr. WARDEN. Yes, sir.

Mr. THOMPSON. Two of the witnesses, I think Mr. Levine and Dr. Blum both talked about the nursing shortage issue that faces us. In my home state, in California, it's projected that by 2010 we're going to have over a 100,000 nurse shortage, and it affects, I suspect, every place around the state. I see it at home. My wife is a nurse practitioner, and she's worked more in the last year on an on-call basis than she has probably in the last 5 years. So it's a real problem. I suspect that it has a real impact in regard to backups in emergency departments across there in every hospital. I'd like to know what your thoughts might be as to how we could help reduce that by doing a better job recruiting nurses.

Mr. LEVINE. Sir, you hit the problem right on the head. You know, you have to make nursing more attractive to a broader population. Historically, nursing has been a population and by the way, this isn't limited just to nursing. It's EMS professionals, it's allied health professionals, pharmacists, therapists, and so forth. You know, like I said in my testimony, only 5 percent of nurses are male and only 13 percent are minority, which is not reflective of the population. So, I think trying to make nursing more attractive as a profession for non-traditional populations is very critical. We can't do it without them, frankly. So, more recruitment, more incentives through the Federal and state government. I also think

more faculty is a problem. There's not enough faculty to train the additional nurses.

In fact, what was antithetical for me was the fact that we actually had waiting lists of people applying for nursing programs, but there's just not enough faculty to train them. To your question, if I may, on emergency preparedness, one of the best tools that we've got, and we used them for the eight hurricanes in Florida, at the Department of Health and Human Services is the use of the Disaster Medical Assistance Team (DMAT), and it is a tremendous relief a tremendous burden for the state and for the hospitals when we needed that surge capacity. Unfortunately, in a large-scale disaster, I don't think that there's enough resources there for those teams, but those are terrific tools that we made great use of during those disasters.

Dr. BLUM. On the nursing issue, I'm probably not the best person to ask about recruiting nurses, but I can tell you another aspect of the nursing shortage from the emergency medicine standpoint is not only the fact that we have not enough nurses in the entire hospital, therefore impacting the emergency department, but because the emergency department is asked to be infinitely elastic, we've asked our nurses to be infinitely elastic, and we've simply burnt them up and burnt them out.

I've lost hundreds of years of emergency nursing experience in my emergency department in the last few years. I have nurses with 25 and 30 years experience in emergency nursing who in the last couple years have decided, "I can't do this anymore, I'm going to take a lesser-paying job working in radiation therapy or somewhere else in the hospital." Many of them have not left the hospital, but they've left the emergency department. So, our workforce now in emergency medicine is much younger than it has been relative to the past. It used to be that you had to have several years of critical care experience before you could even work in the emergency department. That's not true anymore.

Mr. THOMPSON. Thank you very much.

Chairman JOHNSON OF CONNECTICUT. Thank you. We'll start the second round of questions. Mr. Stark.

Mr. STARK. Thank you, Madam Chair. I just want to put in a plug for my bill, which eliminates mandatory overtime for nurses. There's 500,000 nurses in this country who are not working, principally, we understand, because they don't want the mandatory overtime. So, we have that resource out there if we could somehow encourage them to come back into the system with a more friendly workplace. That might help somewhat. I want to get back to the payment thing for the on-call physicians. Just help me a little bit. I don't know whether, Mr. Warden, you remember. I mean, your former hospital system used to staff Kieren Mountain where I once went. They had doctors, all they had to know is how to pick fishhooks out of people, and that was a plum assignment for the Henry Ford physicians in the summer.

Recently, we had a guy from Indiana who ran a bunch of hospitals in Indiana, and it turned out that in this hospital system, the not-for-profit hospital system, so he could see the 990, the five highest-paid people in the hospital system were radiologists. It ran from \$600,000 bucks a year for the lead guy to \$490 thousand for

the next lowest. Is that we can't do that in California. It's against the law to hire, for a hospital to hire a physician. Do any of you, Mr. Warden, anybody who runs a hospital, know, what say, neurosurgeons do, any hospitals hire neurosurgeons, teaching hospitals? If so, what do they earn? Larry?

Dr. BEDARD. Our hospital had an incident where we did not have a neurosurgeon. I live and practice in Marin County, one of the wealthiest counties. They were outraged. So, the hospital administrator started to pay. It was \$1,000 a day. Once you paid the neurosurgeons, you had to pay the surgeons, the orthopedists. Now, we're paying \$10 million a year to get on call. The going rate for neurosurgeons now is \$3,000 per day.

Mr. STARK. Where they're hired—what I'm trying to get at is, when they're hired by the year, on salary.

Dr. BEDARD. No, they were contracted, so—

Mr. STARK. What does Kaiser pay, do you know?

Dr. BEDARD. I'm not sure what Kaiser pays—

Mr. STARK. Do you know what—

Mr. KELLY. I know what I pay neurosurgery, Congressman Stark. It's \$3,000 per day.

Mr. STARK. Does anybody have a hospital, Mr. Levine, Mr. Warden, where they hire, where the hospital hires a neurosurgeon on salary? It

Mr. WARDEN. I think in university teaching hospitals, medical centers—

Mr. STARK. Okay.

Mr. WARDEN. Or institutions like ours, which has an organized medical group, all the specialists are on salary, and they are expected to cover the emergency room. If you have a trauma center, you have to have that coverage—

Mr. STARK. Can you give me to the nearest \$50 or \$100 thousand bucks what a neurosurgeon would make?

Mr. WARDEN. In our system, a neurosurgeon makes about \$350,000.

Mr. STARK. Okay.

Mr. KELLY. In my previous experience at Jefferson, I would concur with that.

Mr. STARK. Okay. So, I guess what I'm getting at is, it doesn't seem to me unreasonable, though maybe there aren't enough of them, to increase that salary or to expect that person on salary to be available one or two nights a week when they're on salary. I just, I'm just trying to, I'm sure that we find that many of these people have a high income and they don't want to sit around for a couple hundred bucks. That seems wrong. Mr. Levine.

Mr. LEVINE. I don't know that you can—I don't know that you can make an accurate comparison in academic medicine salaries, because in academic medicine they don't cover ER call themselves. They have residents and interns that do it. So—

Mr. STARK. I'm just trying to, and I want to kick this back to the, you know, onto the AMA and the people who do the resource-based relative value scale (RVRVS), and say, as I think you recommended, Dr. Bedard and Dr. Blum, we ought to figure out whether there's we can't make Blue Cross do that. If we had a code under Medicare, it pretty soon trickles down to the other insurers,

and say, "Look, here's what we pay." I would hope, and I would hope the chair would join with me, that we could encourage the medical societies to come up with a resource-based charge that we would then institutionalize through Medicare and say, "Okay, this is the way to do it." Perhaps, we could get that problem solved for you, and I would ask any of you who are involved in this if you would have any other ways that we could do it, but one of you in your testimony said that's what we should do, is go back and find a code to reimburse for this. Dr. Blum.

Dr. BLUM. Well, first of all, I explained the mindset of my colleagues and myself. To us, paying for on-call services is kind of antithetical. We believe a better solution is to remove the barriers that keep physicians like neurosurgeons and orthopedists from taking call in the hospital. That makes much more sense to us. We believe being on call is part of as part of being on the medical staff of a hospital is a responsibility. What has happened is there have been significant barriers to being on call for those folks, and if we remove those, I think that would solve the problem.

If we could ensure, you know that they get some payment for what they do, if we could ensure they have some protection from unreasonable liability, I think that that would help them. Quite frankly, part of the issue is that it's very uneven. You have some of those specialists that are willing to take call and others who are not, and so again, fewer and fewer specialists are caring for more and more patients, and I can tell you, in a busy trauma center, a neurosurgeon may be up all night caring for the emergency department patients, and then he can't do his regular, you know, operating room (OR) schedule the next day.

Mr. STARK. I would come back to you guys and the neurosurgeon. You don't want us to define that for you, believe me. If you all would come up, as you did with the RVRVS or others, something that the physicians are comfortable with, and come back to us, I think we could move ahead. I warn you that having us design that system, you wouldn't be very comfortable with it. I'm over my time, Madam Chair, but maybe Mr. Levine and Dr. Bedard could respond—

Mr. WARDEN. Can I just speak one comment?

Mr. STARK. Go ahead.

Mr. WARDEN. I think, just two comments, Madam Chair and Mr. Stark. Number one, I think that one of the issues that is silent, that we're not recognizing, in some of the specialties where there's a shortage, it's because the specialists are not being turned out because they have basically limited the number of education or training positions and residencies in the particular specialties, so we're never going to catch up as long as that occurs.

The second thing is that in the report, in our discussion on regionalization, we talk about the regionalization of specialty coverage, and, you know, in a community like Detroit, there's no reason why every institution has to offer every specialty, and if we regionalized it and had a coordinated plan, we could solve a lot of the problems, and I think that's one of the other things that has to be considered.

Mr. LEVINE. I think that would, the second part of what the doctor just said is accurate, in that one thing that the Congress could do is look at the antitrust issues related to hospitals—

Mr. STARK. Could antitrust help solve that?

Mr. LEVINE. I believe so. We have hospitals in Palm Beach County, for example, that have been trying to do that, but are afraid to move forward for fear of antitrust. Also, too, I don't think you have to reinvent the wheel, if we look at what's been tried and has worked. For example, in Texas, they implemented reforms in 2003. Since they implemented their reforms in 2003, their medical liability reforms, they've brought 4,000 new doctors to Texas, including neurosurgeons, pediatric surgeons, obstetricians and gynecologists (OB/GYNs). It's been a huge, huge change, a sea change in Texas, and they've gone from a net exporter of physicians to they're bringing them back in the state.

Mr. STARK. Even in the summer?

Dr. BEDARD. I served on the AMA's RUC, the Reimbursement Update Committee, and there's about 50 different organizations of specialty represented. The interesting thing, it's a zero-sum game. So, if we increase the fees of one physician specialist, the other ones take a slight cut. That has a very mild effect on the overall, I think, cost of health care. In California, I know where neurosurgeons are getting \$3,000 a day for being on call from three separate hospitals, so they're getting \$9,000 for being on call. So, regionalization makes a lot of sense. Have them at one hospital. Take the patient to where the neurosurgeon is. Don't allow them to be on three different hospitals. They use EMTALA as a tremendous leverage in any negotiation with the hospital, and I think that's one of the reasons why there are such high rates and somewhat exorbitant costs.

It's also, I think, interesting to note, the physicians with the highest income neurosurgeons, orthopedic surgeons, ear-nose-and-throat (ENT) surgeons are the ones that are most difficult to get to serve on call. The lowest-paid specialty is pediatrics, and in my career, I've never had a problem getting a pediatrician to come in, smile on his face, taking care of a little kid. So, it's kind of paradoxical that neurosurgeons, who may be making, you know, \$500,000 a year, or \$9,000 a night, want to complain about the fact that they're going to have to take care of somebody who has no insurance and they may be uncompensated.

Chairman JOHNSON OF CONNECTICUT. The gentleman from Arizona.

Mr. STARK. Can we do that, Madam Chair?

Chairman JOHNSON OF CONNECTICUT. Well, we'll certainly look at it.

Mr. STARK. I'm not sure it's our jurisdiction.

Chairman JOHNSON OF CONNECTICUT. I think we can, you know, ask the Judiciary Committee to look at it with our staff over the break and see what comes out. The gentleman from Arizona.

Mr. HAYWORTH. Thank you, Madam Chair. Gentlemen, as we listen to this, I return back to the dynamic I presented at the conclusion of our first round. What do we do, specifically, as we talk about patients from foreign nations, wherever they may come from, receiving a quality type of care I mean, it seems that undergirding

western jurisprudence, and what we've done in the United States is the basic test of what is reasonable, and to hear the cases brought forward today, reasonableness went out the window. Mr. Kelly and others on the panel, what should we do? Should we set in statute and maybe it goes back to the way EMTALA was drafted or the threat of legal action.

What parameters could we set in terms of what is reasonable that certainly wouldn't be like triage in the wake of a disaster, but something that's reasonable to get people up and then get their on their way back to their home country without continuing to ask American taxpayers to foot the bill?

Mr. KELLY. That's an excellent question, Congressman. Let's treat these people and stabilize them, and the cost of their transport should be met by the government which they're a citizen of. We cannot afford this type of what's causing the backlog, the overcrowding, the length of stay, just not from the ER, but from the transport from the ER into the in-patient setting, because we can't get that foreign country or that foreign government or that person to cooperate with us. So, we should be able to treat and stabilize and that person should be taken back to their country at their country's expense. The 93-day length of stay, the 200-day length of stay that you heard from my colleague to my left here, this is what's causing tremendous amount of backlog and an enormous amount of expense. So, let's treat to stabilize in a humanitarian way, these illegal immigrants, and let's get them back to their country of origin.

Mr. LEVINE. There is nowhere, once they are in our emergency department, and we've identified they need treatment, even once we're done treating them, unless they can be discharged to the street, basically, there's nowhere for them to go. No post-op, post-acute facility will take them, so they're stuck in the hospital until we can find somebody. I think that my colleague is right on target. Stabilizing and transferring back and having some requirement that the foreign government take responsibility. In fact Canada does that. You know, when they come down from Canada, they either pay for the treatment or they pay to return them back, and that's exactly what other governments ought to do.

Mr. HAYWORTH. Dr. Blum?

Dr. BLUM. Well, I don't know that—

Mr. HAYWORTH. Excuse me, Dr. Blum, could you—

Dr. BLUM. I'm sorry. I'm not sure I'm the best person to answer how best to transfer them back once they're stabilized. I can tell you what does not work for emergency physicians is denying people care that need it, no matter what they are. You know, they could be, you know, felons in other countries, but if they need our care, you know, we don't want to be put in the position where we have to deny care. Neither one of these gentlemen have said that, but that has been proposed by some people, actually, in some cases. So, I just want to be real clear about that.

Mr. HAYWORTH. Likewise, let me be clear, doctor. I think perhaps the best way, not to put words in your mouth, but I think we're describing compassion and our sense of humanity. When the question is asked of me, and we'll get into political theater, because it's inevitable as people try to draw distinctions and perhaps exag-

gerate distinctions, the law should deal in humane fashion. Medical ethics is not a contradiction in terms, as perhaps political ethics might be, and you obviously have responsibility as a physician to treat people, and indeed the law caught up with your sense of ethos, but the question becomes how then do we deal in a humane manner and also show some compassion in terms of public policy for those who get stuck with a bill that continues to drain your system and deny care to the mom and dad with a youngster who is waiting three and four and five hours, not just in border states, and I don't know anecdotally what happens in West Virginia where you practice there at the university, Dr. Blum, but all these things are interrelated. I think the point is well taken. Yes, sir.

Dr. BLUM. It's a very complex problem. It's not even just the patients that get admitted. I'm aware, I do not practice in a border state, but I'm aware from my colleagues in the specialty of patients that come and present to the emergency department a couple times a week for dialysis. You know, they get treated, they get dialyzed, they go back across the border, and then they repeat the whole process again, you know, later in the week, which isn't that person doesn't even necessarily need admitted to the hospital, but they present with an acute problem, which is the need for dialysis, and we treat them. So,——

Mr. HAYWORTH. Is it fair to call that serial abuse of our medical system, because that comes not with malice aforethought, with gaming our system, taking advantage of our laws?

Dr. BLUM. I do want to say something. This is not directly related to this. But several comments now have alluded to this. One of the important points that I want to make today is to correct what I believe to be a widespread misconception that the nation's emergency departments are crowded with people who do not need to be there. Our waiting rooms sometimes are crowded with people who do not need to be there, but our emergency departments are usually crowded with people that need to be there. They often are there because they can't get primary care somewhere else and their medical condition advances to the point where they need emergency care. It would be a great misconception to say, "If we could just remove all the patients that are inappropriately using the emergency department, we could solve this problem." That would not be the case.

Mr. HAYWORTH. Dr. Bedard, with your indulgence, Madam Chair?

Dr. BEDARD. First of all, the current law under EMTALA only requires treatment up to the point of stabilization, so I think it is compassionate and I think it addresses the issue. When that person was stabilized, his right to any future medical care ended. So, the issue, though, how do you repatriate that person to Nicaragua or Mexico, is obviously something that the medical profession can't do or deal with; that's something, whatever, treaty or an agreement to send them back. Also, with Dr. Blum, we have to take care of these people. You can't deny them care. We're not going to let them bleed to death on the street. But once they're stable, we can discharge them.

Mr. HAYWORTH. Again, just one point about this. The root cause, however, as you say, law simply stipulates we stabilize.

What is the exterior threat? Is it lawsuit? Why over and above? Is that it, the threat of lawsuit?

Mr. KELLY. It's the threat of lawsuit of abandonment, that is correct. When they go from the emergency room, there's nowhere else to go. There is no long-term care facility that will take them.

Dr. BLUM. It goes way beyond that. I mean, oftentimes, they have medical conditions that simply do not allow you to send them out. You know, we talk about patients that require long-term ventilation or long-term feeding tubes. You know, you can't take a patient on a ventilator and roll them up to the border and say, you know, "There, take them back." I mean, that doesn't work unless you have a receiving facility with the ability to care for the kind of problems that patient has. So no medical professional, I don't care who he is, whether it's an emergency physician or whatever, is not going to discharge that patient to an inappropriate environment, whatever that might be. So we all kind of suck it up and, you know, try to do the best we can. What these gentlemen have described is just that.

Mr. LEVINE. The practical reality is just what you said, sir. The fact is, if we have a woman in the hospital who needs a liver transplant and, you know, she's stable, we could certainly discharge her, but practically speaking, it would be she would die. So, you know, we hold her until we figure out what we're going to do, and in that particular case, that patient stayed, in that case, it was over 300 days, over a year, actually, in the hospital, because and to the dialysis issue, as well. If other states, if other governments, rather, don't do dialysis for people over the age of 55, they show up in our emergency department, and at that point, they may not be stable, and we have to dialyze them.

Mr. HAYWORTH. Madam Chair, you have been very indulgent with the time, and I'm grateful for that. As you and the Ranking Member were talking about jurisdictional issues perhaps beyond the purview of this Committee, I'd certainly take a look at international relations, at not so much treaties, but the whole establishment of diplomatic relations. I'd take a look at the funds we spend on international Committees dealing with health. Certainly, there is a cross-jurisdictional challenge to prioritize the payment of these bills and to ensure that there is more than a diplomatic exchange, that there is responsibility on the part of nations with whom we have diplomatic relations to likewise be accountable.

The failure to see that, and the dynamic of the threat of lawsuits adding to what is obviously the ethos of the profession to care for people, and understanding that this is not just a simple cut-and-dried matter, all of this combines, and it's going to require some thought, and even into the whole realm of foreign relations and diplomacy with foreign nations, as we're dealing with the question. It's really, it's interesting the inter-relatedness of all these different topics coming to bear today in this hearing before our Health Subcommittee. Madam Chair, I thank you, and gentlemen, again, thanks to all of you for your thoughts.

Chairman JOHNSON OF CONNECTICUT. Thank you very much. The advantage of having one panel is that you do get a chance to allow Members to pursue their questions and the panelists to contribute. There is one other issue that I want to raise that

we haven't had a chance to plumb, that is important as we begin to think in this area. Mr. Warden, the Institute of Medicine report recommends that we establish an office of emergency care, emergency and trauma care. That certainly has some appeal when you see the chaos and mess of that service. However, establishing offices in the Federal Government has not always assured progressive, thoughtful, and effective law or management. A number of other things you recommend remind us that regional performance, institutional performance is really, in the end, what matters.

I want you each to make comment on what do you think. The recommendation to coordinate regional EMS and emergency room care is very logical. We certainly have to remove the legal barriers, and maybe even require that, as a condition of Medicare eligibility, you have to have in place a regional system that can bring a neuro patient a patient needing a neurologist to the emergency room that has a neurologist on call and a bed available, I mean, that we could do a lot about the many problems we've talked about if we could bring patients where there is space for them and expertise available for their care. So, that's a kind of simple example. Mr. Levine, in your testimony, you referred to things that you've done in Florida to better manage the resources of an institution so you don't have some of the problems that we've talked about.

Now, putting malpractice aside because we've discussed that a lot, and I think a solution to that is absolutely essential both in regard to the illegals and in regard to the liability of the individual physician. I was shocked the last time I was in Florida to see how many of the physicians there are just going bare, bare. People in America don't know that. So, it's ludicrous to say that somehow malpractice insurance provides you with some inalienable right when it is now so expensive that you have no right at all. So, putting malpractice kind of off to the side, and the problem of the illegals off to the side, just looking in terms of Federal structure because after all, in Medicare, we have a lot of leverage to pull. We can require that you do certain things.

So, whether we establish an office versus what has the institutional aspect of this, what can be done institutionally, what can be done regionally, and do you or do you not, each one of you, think some of you may have heard this idea for the first time and want to get back to us? We really need your thinking on the structure of not only responsibility but oversight. Mr. Warden, maybe you'd like to start with a clearer explanation of the Institute of Medicine's recommendation.

Mr. WARDEN. The Institute of Medicine's recommendation about the lead agency really stems from the fact that as we did the study and sought testimony from all the stakeholders, it was very clear that there were eight or 10 different agencies that were coming to bear on the issues that we've been talking about this morning. Each one of those agencies, in their own right, has contributed a lot, and a good example is NHSTA, the National Highway Safety and Traffic Administration. Yet at the same time, no one of those agencies had enough reach to be able to influence things sufficiently in any integrated fashion. We're not suggesting that we create a huge bureaucracy. We're suggesting that there needs to be an agency that takes responsibility for basically leading the coordina-

tion among these various organizations, establishing work groups, stimulating demonstrations that will begin to address the kinds of things—

Chairman JOHNSON OF CONNECTICUT. So, for example, a lead office within CMS, since both Medicare and Medicaid are located there, is that—

Mr. WARDEN. Well, we actually suggested that a lead office be within HHS, and were kind of silent on CMS, but—

Chairman JOHNSON OF CONNECTICUT. We'll have to look at that, because there are some advantages and some disadvantages to not being, right, working with the people who are running these two big systems.

Mr. WARDEN. It's really kind of beyond—

Chairman JOHNSON OF CONNECTICUT. Yeah, okay—

Mr. WARDEN. It's not just payment. The second point in terms of your question about regionalization, we believe that regionalization, wherever possible, ought to be accomplished at the state and local level, but that there ought to be some guidelines for making that happen. If we can do that, we don't need a large bureaucracy over seeing it if we can get these various organizations and the providers and all the stakeholders to buy into it. We really think that if we can get the regionalization and coordination and accountability developed at the state and local level and we can have basically a seamless experience for the patient, then it will solve a lot of the problems that we've been talking about.

Chairman JOHNSON OF CONNECTICUT. Mr. Levine.

Mr. LEVINE. I think my first reaction when I read that was at first to say I didn't like the idea of a national bureaucracy. I'm encouraged to hear that wasn't what they had in mind. I'm going to borrow a little bit from our emergency disaster experience in Florida and how we've handled the emergency system, because I think, I view the safety net in that from that perspective. It's bottom up. I think probably the one word that we want to use to describe our emergency system is we want it to be agile. We want there to be agility in the system. For example, after several of our hurricanes, dialysis centers became a problem. They didn't have water and they didn't have power.

So the emergency response system, the way it's established is locally they're responsible for coming up with a regional plan that the local emergency operations centers have to approve on an annual basis. There needs to be more regionalization and more coordination locally at that level for deciding, what we're going to do in the event there's a problem with dialysis, what are we going to do in the event one of our trauma centers is knocked out of commission or we don't have water? It's always better to have it be bottom up rather than top down, because each state is so different and each community is so different in unique.

I think if you have national standards for what the expectations are of our emergency system that are transparent, and then incentivizing states to implement those standards because typically states will look to the local leadership and encourage local leadership through grants or even financial incentives to participate. To me, then you get the right bottom up approach, as opposed to a Federal office that grows a life of its own and then develops its own

mechanisms for us to have to follow, and I think that would be additive and not necessarily constructive.

Chairman JOHNSON OF CONNECTICUT. Yes, Mr. Kelly.

Mr. KELLY. Yes. At Scottsdale, with the lead of the City of Scottsdale, our hospital, and the National Guard, we have one of the largest disaster drills in the country, at least west of the Mississippi, and it's called the Coyote Crisis. It has been a very successful drill, in bringing about all of the components necessary for everyone to talk to each other, whether it be the police departments, highway patrol, other hospitals, specialists, physicians, emergency rooms. I would hate to see it to be federalized or a specific office. I think that this can be done cooperatively among the various hospitals and states, and done on a regional basis. It's been done very successfully in Arizona. I think part of that has been placed in my report to the Committee. It is called the Coyote Crisis. It is really a fantastic partnership between the city, state, the medical profession, and it's worked.

Chairman JOHNSON OF CONNECTICUT. Thank you. Dr. Bedard.

Dr. BEDARD. First of all, I would support the concept of a lead agency, emergency medicine is really an essential public service. I think we provide a vital function for the country and I think it deserves to be carved out, looked at, standards set. As I mentioned, JCAHO, when they come to a hospital, the ER is frequently almost virtually ignored. I mean, I ask them, gee, I hope they ask me to show them the on-call list, because half the days are blank. They never ask the question.

So, if you had a lead agency, I think it would also be effective in proactively surveying hospitals' health care system. I think regionalization and coordination is critical. I think medicine is one of the more inefficient, wasteful services that we provide. I mean, I'm still astounded. Somebody has a Computerized Axial Tomography (CAT) scan done at a hospital 2 days ago because they had a seizure, I can't get that information. So, I think to regionalize and coordinate, you're going to have to have much more investment in information technology, have electronic medical records or some way for patients to carry their records with them, but I think to do that, you're really going to be it's essential to have superb information technology.

Chairman JOHNSON OF CONNECTICUT. Dr. Blum.

Dr. BLUM. I would cautiously support the idea of a lead agency. It depends on what that lead agency is charged with doing. I think it makes sense for a lead agency to do things like coordinate national response to disasters, and so forth, and so forth, things of national scope. I think to overdo that bureaucracy, though, does not make sense to a system that has so many fundamental flaws. The analogy that I would use is it would be like putting a sophisticated computer control module on a car that has no gas in the tank; and in emergency medicine right now, we have no gas in the tank, you know, and someone stole the engine, so that control wouldn't really help us very much.

We have much more fundamental problems, quite frankly. You alluded to costs earlier. You talked about costs earlier. You know, we currently pay for the uninsured by cost shifting, but that's be-

coming increasingly difficult. No payer wants to have costs shifted to them, including the Federal Government. Yet we still have to figure out a way to care for these people. We could call it a single payer system, but quite frankly, that's cost shifting. Anytime you provide care to a bunch of people who cannot pay for it, that's cost shifting, and you could call it a single payer system, you could call it taxes, you could call it whatever you want to, or you could call it what we call it now, which is cost-shifting, charging people more to pay for the people who can't pay at all.

I don't run away from cost-shifting. Quite frankly, it's the way we've figure out how to provide care under this kind of strange sort of system that we're in. Let's recognize it for what it is. You could call it something else, but it's still the same thing. It's those people who can pay paying for those people who can't.

Chairman JOHNSON OF CONNECTICUT. Thank you. Thank you all for your—Mr. Stark?

Mr. STARK. Can I just take another slice of the apple here, Madam Chair?

Chairman JOHNSON OF CONNECTICUT. All right. While I hold no brief for the state of the art of medical care in Mexico, we did get from the Mexican Embassy the laws there about treating people who were either in Mexico legally or illegally, and all I can suggest to you, I'd make these part of the record.

Mr. STARK. Madam Chair, they're very generous. In other words, basically, they say, regardless of why you're there, you're treated. I would make those rules part of the record. I did want to ask, particularly Dr. Bedard, Dr. Blum, I guess everybody but Mr. Warden, who may not have a horse in this race, but one of the issues that we've been talking about, and initially this hearing was designed to talk about, the burden placed on you all by immigration, by immigrants. That was changed for some reason.

Nonetheless, in the House bill that we're talking about, there's a question whether the possibility that providers of care to people who are here illegally would criminalize them, they would be subject to felony charges if that came about. Also, that would, I suspect, put your emergency departments somewhat in the position of being de facto immigration agents. I wanted to ask each of you if you think that's a good idea for you to you have enough trouble figuring out whether they may what their blood type is. Do you think it's a good idea for us to impose on Medicare emergency medical care providers the need to certify a citizenship? Just, I'll start with Doctor Bedard, go down the line.

Dr. BEDARD. Absolutely not. I'm a physician. I'm there to help people. I'm not an Immigration and Naturalization Service (INS) agent.

Mr. STARK. Dr. Blum?

Dr. BLUM. Absolutely not. Physicians have a contract with the patient to do what's in their best interests, and that would violate that.

Mr. STARK. Now, as the representative of a kindly bureaucracy, Mr. Levine, what would you feel from an administrative standpoint?

Mr. LEVINE. Let me clarify the question. Are you asking if we would support our staff or physicians being criminalized if they treat someone who is—

Mr. STARK. And/or the fact that they would have to somehow certify if investigate the people who came in were in fact citizens or here legally.

Mr. LEVINE. Well, we would not support that. Indeed, we don't even ask that question until we've started treatment, because of EMTALA requirements.

Mr. STARK. Mr. Kelly.

Mr. KELLY. Congressman Stark, we believe that that would have an extremely chilling effect upon our health care workers. You know, we can't do that now. We can't even ask that question on Form 1011. So, we would be very, very opposed to that.

Mr. STARK. As I say, I have no quarrel with the fact that people who can't pay, wherever they come from, are a burden to the system, but I'd like to think that there are better ways to resolve that than putting you all in the position of having to be law enforcement people. Thank you, each of you, for your interest and efforts and I hope you won't want not that the Chairman won't have another hearing, but I hop you won't wait until she does to offer us suggestions as to what we might do to help solve this problem by minor adjustments. I'm not sure we're going to run around and immediately have universal health care.

For example, the antitrust thing might be something that we could move on more quickly, and we really would appreciate, I'm sure I know that I don't want to speak for the chair, but I know that she is very receptive to these ideas from the providers, and I would join with her in asking for your assistance. Thank you all.

Chairman JOHNSON OF CONNECTICUT. Thank you. I certainly join with Mr. Stark in his last comments. We won't have another hearing until we have something to say or we see that there's some part of it we didn't hear, but you've laid out all aspects of the problem pretty completely, and we do invite you to share your thoughts, having listened to one another, you know, as to what are one or two things we could do now, what are the big issues that we ought to be laying a more substantial record knowledge base?

For instance, we really do have to get into medical education. We all know that. How do we fund it? But also, what do we teach? I mean, to what extent is our current medical education system going to prepare the doctors that are going to serve us in the future for a very different environment? It's got to be one based entirely in health information technology. It's got to be capable of absorbing new medical knowledge more rapidly, delivering it more accurately, providing necessary but not unnecessary care. It is going to be a different world that we're moving into, and we want the base of law that we lay in the next round of shaping our medical education system to understand that. That's going to be a big challenge just in and of itself.

It's clear that our old legal system doesn't work now with the way medicine is moving in America. It doesn't work partly because the state of the art is moving so rapidly you can't hold physicians liable for knowledge that wasn't available 2 months ago. So, we're having a lot of problems. Failure to diagnose is a terrible threat to

the medical profession, and so on and so forth. I just want to say the problems are big. We understand that. You've done a very good job for us today. We appreciate that.

If you want to follow up with specific recommendations as to what steps need to be taken in what order, that would be very helpful to us. I'm going to submit for the record two things that Mr. Stark asked me to submit. One is the District of Columbia Inspector General Report on the assault of David Rosenbaum. I'm submitting that for the record.

[The information follows:]

GOVERNMENT OF THE DISTRICT OF COLUMBIA OFFICE OF THE INSPECTOR GENERAL SUMMARY OF SPECIAL REPORT: Emergency Response to the Assault on David E. Rosenbaum

CHARLES J. WILLOUGHBY INSPECTOR GENERAL OIG No. 06-I-003-UC-FB-FA-FX June 2006 This Summary describes the D.C. Office of the Inspector General's review of the emergency response efforts provided by District agencies and hospital personnel in light of applicable policies and procedures. The OIG is providing this Summary in lieu of the full report in accordance with the exemptions provided in the District of Columbia Freedom of Information Act (D.C. Code §§ 2-531-539 (Supp. 2004)) to preserve the privacy interests of Mr. Rosenbaum and other individuals mentioned in the full report.

Background and Perspective

"Man Down." On January 6, 2006, at approximately 9:20 p.m., a resident of Gramercy Street, N.W. went to his car to retrieve an item and found an unknown man lying on the sidewalk in front of his home. The resident's wife called 911, and the Office of Unified Communications dispatched emergency responders to the scene for a "man down." The fire (first responders), police, and ambulance (second responders) personnel who were at the scene did not detect serious injuries, illness, or evidence that the then-unknown man had been physically attacked. He had no identification in his pockets, but was wearing a wedding band and a watch. Stereo headphones were found near him on the grass. Because he was vomiting, and because one or more responders thought they smelled alcohol, the man was presumed to be intoxicated. Consequently, the man was classified as a low priority patient and transported to the Howard University Hospital (Howard) Emergency Department where, after lying in a hallway for more than an hour, medical personnel discovered that he had a critical head injury.

At approximately 11:31 p.m., Rosenbaum's wife reported to the Metropolitan Police Department (MPD) that her husband, David E. Rosenbaum, had gone for an after-dinner walk at approximately 9 p.m., but had not returned. The police broadcast a descriptive lookout, and a police officer who had responded to the Gramercy Street "man down" call realized that the description of the missing person matched that of the man who had been found lying on the sidewalk. It was later determined that the "man down" was David Rosenbaum.

Mr. Rosenbaum's head injury was discovered at Howard in the early morning hours of January 7 and reported to MPD. MPD officers then returned to the Gramercy Street scene to look for evidence that might indicate the cause of the head injury. Later, on January 7, the Rosenbaum family was alerted by credit card companies to unusual activity on Mr. Rosenbaum's credit cards. MPD subsequently linked Mr. Rosenbaum's injuries, his missing wallet, and the unusual credit card activity, and initiated an assault and robbery investigation.

Despite surgery and other medical interventions to save him, Mr. Rosenbaum died on January 8, 2006. The autopsy report issued on January 13, 2006, by the Office of the Chief Medical Examiner concluded that Mr. Rosenbaum was a victim of homicide due to injuries sustained to his head and body.

Scope and Methodology

Following Mr. Rosenbaum's death, numerous questions were raised and complaints made by both citizens and District government officials about the emergency medical services provided to him by D.C. Fire and Emergency Medical Services Department (FEMS) and Howard personnel. Questions were also raised regarding the delayed recognition by MPD officers that a crime had been committed.

In a letter to the Inspector General dated January 19, 2006, City Administrator Robert C. Bobb requested that the Office of the Inspector General conduct a review of the response to David E. Rosenbaum's assault and subsequent death. Mr. Bobb

indicated that he and Mayor Anthony A. Williams wanted the review “to ensure the maintenance of public confidence in the emergency services provided by the District government.” In his letter to the Inspector General, Mr. Bobb asked that the Office of the Inspector General’s review specifically include answers to the following questions: ? Did the Office of Unified Communications properly handle, dispatch, and monitor the incident? ? Did FEMS employees follow all rules, policies, protocols, and procedures? ? Did first responders properly assess the patient? ? Were FEMS written reports and oral communication adequate? ? Did MPD responders properly assess the situation at the scene, and were steps taken by MPD responders prior to opening an investigation adequate? ? Did the second responders arrive with all due and proper haste? ? Did the second responders properly assess the patient? ? Did the second responders select an appropriate hospital? ? Are there any identifiable improvements to FEMS rules, policies, protocols, and procedures? ? Did Howard properly triage and assess the patient upon his arrival at the hospital? ? Did the Office of the Chief Medical Examiner promptly and completely discharge its review and report of the death?

In addition to Mr. Bobb’s questions, the Office also received inquiries from Councilmembers Phil Mendelson and Kathy Patterson regarding issues of concern with respect to this matter. Finally, the Rosenbaum family requested that the Office of the Inspector General answer questions they posed “so that errors [they] experienced are not repeated in the future. . . .” We believe that this report is responsive to many of the questions that have been raised. The scope of the Inspector General’s review included the entire emergency response provided to Mr. Rosenbaum on January 6, 2006, and the review conducted by the Office of the Chief Medical Examiner.² To conduct the review, the Inspector General appointed a team of inspectors and investigators to examine the circumstances surrounding the January 6, 2006 incident. The team members have training and experience in law enforcement, firefighting, medical, and pre-1 FEMS and MPD also conducted inquiries into the actions of their responders to the Gramercy Street emergency. In addition, the District’s Department of Health conducted a “complaint investigation” into Howard University Hospital’s response.² The care and treatment provided to Mr. Rosenbaum at Howard University Hospital subsequent to the discovery of his head injury, and the MPD assault and robbery investigation that was opened on January 7, 2006, were not part of the Inspector General’s review. hospital care.³ The team reviewed policies, procedures, protocols, General and Special Orders, personnel files, patient care standards, hospital and ambulance medical records, certification and training records, and reports issued by FEMS, MPD, the Office of the Chief Medical Examiner, and the Department of Health. The team also interviewed all District government and Howard personnel involved in Mr. Rosenbaum’s emergency care and autopsy. Upon conducting its review, the OIG team noted multiple discrepancies in statements made by interviewees. (See Appendix 1)

Findings and Recommendations

Office of Unified Communications

- The Office of Unified Communications properly handled, dispatched, and monitored the Gramercy Street call. The call taker and dispatchers who handled the 911 call carried out their duties appropriately.

Recommendation None.

Fire and Emergency Medical Services Department Engine 20

- Engine 20 personnel did not follow all applicable rules, policies, protocols, and procedures. The firefighter in charge of the Engine 20 crew on January 6 did not have a current CPR certification as required. In addition, the firefighter/Emergency Medical Technician (EMT) with the highest level of pre-hospital training did not take charge of patient care during the Gramercy Street call.
- Firefighter/EMTs did not properly assess the patient. None of the firefighter/EMTs performed a complete assessment of the patient, and not one of the patient’s vital signs⁴ was recorded at the scene. Once the firefighter/EMTs perceived an odor of alcohol coming from the patient, they did not focus on other possibilities as the cause of his altered mental status such as stroke, drug interaction or overdose, seizure, diabetes, head trauma, or other injury.
- Oral communication and standard reports were not adequate. Firefighter/EMTs did not pass on key information to the ambulance crew such as observing blood on the patient and detecting the patient’s constricted pupils. Engine 20 personnel did not prepare a written report on the Gramercy Street incident because the FEMS form for such purpose is being revised.

3 Emergency response by fire and ambulance personnel. 4 Heartbeat, breathing, and blood pressure. Recommendations

1. That FEMS ensure all personnel have current required training and certifications prior to going on duty.

2. That FEMS immediately implement a reporting form for firefighter/EMTs who respond to medical calls so that first responder actions and patient medical information can be documented.

3. That FEMS develop and implement a standardized performance evaluation system for all firefighters. The Office of the Inspector General team determined that FEMS employees are not evaluated on a regular basis, in the manner that other District government employees are evaluated. Consequently, FEMS lacks standards to guide firefighters' performance and for use in evaluating their performance.

4. That FEMS assign quality assurance responsibilities to the employee with the most advanced training on each emergency medical call. The designated employee should: (a) have in-depth knowledge of the most current protocols, General Orders, Special Orders, and other management and medical guidance; (b) monitor compliance with FEMS protocols by all personnel at the scene; and (c) provide on-the-spot guidance as required.

Metropolitan Police Department Responders

- MPD officers did not properly assess the situation upon arrival. The three responding MPD officers did not secure the scene, did not conduct an adequate preliminary investigation in accordance with MPD General Orders, and did not take adequate steps to determine if a crime had been committed. They also did not complete a report on the incident pursuant to the relevant MPD General Order.

Recommendations

1. That MPD immediately review and reissue the pertinent General Orders relating to officer responsibilities at emergency incidents. In addition, MPD should consider implementing or revising as necessary a quality assurance program that includes supervisory review of required reports, and a tracking system to ensure that reports are written and retrievable for every call.

2. That MPD assign quality assurance responsibilities to the senior officer responding to each call.

Fire and Emergency Medical Services Department Ambulance 18

- EMTs did not follow applicable rules, policies, and protocols. The highest-trained EMT, an EMT-Advanced, was not in charge of the patient as required by protocol. The EMT-Advanced did not assess the patient, or help her partner assess him. Neither EMT adequately questioned the first responding firefighter/EMTs about the patient's vital signs, or other care and treatment. The patient's low Glasgow Coma Scale results were disregarded, and not brought to the attention of Howard Emergency Department personnel.

The ambulance did not arrive on the scene expeditiously. The ambulance driver got lost after being dispatched from Providence Hospital, and then did not take a direct route to Gramercy Street. This error added 6 minutes to the trip. (See Appendix 2)

- EMTs did not thoroughly assess the patient. The EMT who assessed the patient failed to conduct all of the required assessments, and did not fully document his assessment and treatment on the FEMS 151 Run Sheet. (See Appendix 3)
- Transport of the patient to the hospital did not follow FEMS protocol. EMTs are required to transport patients to the "closest appropriate open facility." Although Ambulance 18 was closest to Sibley Hospital, the EMT in charge, for personal reasons, decided to transport the patient to Howard. Howard is 1.85 miles further from Gramercy Street than the Emergency Department at Sibley Hospital. (See Appendix 4)
- EMTs did not properly document actions. The EMT who cared for the patient did not completely fill out the FEMS 151 Run Sheet. For example, the form shows no times when treatment, care, or testing was provided or performed. An entire page of the form relating to patient care was left blank.

Recommendations

1. That FEMS ensure all personnel have current required certifications prior to going on duty.

2. That FEMS take steps to comply with its own policy on evaluating EMTs on a quarterly basis.

3. That FEMS promptly reassign, retrain, or remove poor performers.

4. That FEMS assign quality assurance responsibilities to the most highly-trained pre-hospital provider for each incident. This individual should: (a) have in-depth knowledge of the most current FEMS protocols and other management guidance; (b) monitor compliance with protocols and other guidance by all personnel at the scene; and (c) include the results of on-scene compliance monitoring in all reports required by management.

5. That FEMS consider installing global positioning devices in all ambulances to assist EMTs in expeditiously reaching their destinations on emergency calls.

Howard University Hospital

- Nurses did not properly triage and assess Mr. Rosenbaum. The triage nurse did not perform basic assessments and did not communicate an abnormal temperature reading. The patient was incorrectly diagnosed as intoxicated, but employees did not follow triage policy on treating an intoxicated patient. Howard's Patient Care Standards—including monitoring airway and breathing, assessing for trauma, conducting routine lab tests, and monitoring vital signs every 15 minutes—were not followed.

Recommendations

1. That Howard develop a system in the Emergency Department that will allow staff to readily identify patients' priority level while they are awaiting care.

2. That Howard consider adopting a patient records system that would enable nursing and medical staff to review documents when they are at a patient's side. The current system prevents staff access to such information in a timely manner.

Office of the Chief Medical Examiner

- The Office of the Chief Medical Examiner conducted the Rosenbaum autopsy expeditiously and promptly issued a report.

Recommendation

That Office of the Chief Medical Examiner consider using digital camera technology to photograph all autopsies. The Office of the Inspector General was unable to review requested autopsy pictures because of photo processing delays and mislaid slides.

5 The process of sorting out and classifying patients to determine the priority of needs and where a patient should be treated.

Conclusion

The OIG team concludes that personnel from the Office of Unified Communications properly monitored the 911 call from Gramercy Street and immediately dispatched adequate resources to respond to the emergency. However, FEMS, MPD, and Howard personnel failed to respond to David E. Rosenbaum in accordance with established protocols. Individuals who played critical roles in providing these services failed to adhere to applicable policies, procedures, and other guidance from their respective employers. These failures included incomplete patient assessments, poor communication between emergency responders, and inadequate evaluation and documentation of the incident. The result, significant and unnecessary delays in identifying and treating Mr. Rosenbaum's injuries, hindered recognition that a crime had been committed.

On January 6, 2006, David E. Rosenbaum consumed alcohol, both before and during dinner prior to leaving home for a walk. Neighbors discovered Mr. Rosenbaum lying on the sidewalk in front of their home and called 911. Upon assessment, emergency responders concluded that Mr. Rosenbaum's symptoms, which included poor motor control, inability to speak or respond to questions, pinpoint pupils, bleeding from the head, vomiting, and a dangerously low Glasgow Coma Scale, were the result of intoxication. Hospital laboratory and other tests, however, confirmed that Mr. Rosenbaum's symptoms were caused by a head injury. Emergency responders' approach to Mr. Rosenbaum's perceived intoxication resulted in minimal intervention by both medical and law enforcement personnel.

FEMS personnel made errors both in getting to the scene and in transporting Mr. Rosenbaum to a hospital in a timely manner. Ambulance 18 did not take a direct route from Providence Hospital to the Gramercy Street incident. In addition, for personal reasons, the EMTs did not take the patient to the nearest hospital. As a result of that decision, it took twice as long for Ambulance 18 to reach Howard than it would have taken to get to Sibley Hospital. Once FEMS personnel at the Gramercy Street scene detected the odor of alcohol, they failed to properly analyze and treat Mr. Rosenbaum's symptoms according to accepted pre-hospital care standards. Failure to follow protocols, policies, and procedures affected care of the patient and the efficiency with which the EMTs completed the call. In addition, FEMS employees'

failure to adequately and properly communicate information regarding the patient affected subsequent care givers' abilities to carry out their responsibilities.

MPD officers initially dispatched in response to the Gramercy Street call failed to secure the scene, collect evidence, interview all potential witnesses, canvass the neighborhood, conduct other preliminary investigative activities, or properly document the incident. Both FEMS and MPD failures were later compounded by similar procedural failures on the part of Howard Emergency Department personnel, who also initially believed Mr. Rosenbaum's condition to be the result of intoxication.

Upon Mr. Rosenbaum's arrival at Howard, Emergency Department personnel failed to properly assess his condition and failed to communicate critical medical information to each other, thereby delaying necessary medical intervention, all in violation of Howard's own patient care standards. Further, a number of Emergency Department staff members passed Mr. Rosenbaum in the hallway and neglected to provide clinical and therapeutic care.

The Office of the Inspector General's review indicates a need for increased oversight and enhanced internal controls by FEMS, MPD, and Howard managers in the areas of training and certifications, performance management, oral and written communication, and employee knowledge of protocols, General Orders, and patient care standards. Multiple failures during a single evening by District agency and Howard employees to comply with applicable policies, procedures, and protocols suggest an impaired work ethic that must be addressed before it becomes pervasive. Apathy, indifference, and complacency-apparent even during some of our interviews with care givers-undermined the effective, efficient, and high quality delivery of emergency services expected from those entrusted with providing care to those who are ill and injured.

Accordingly, while the scope of this review was limited, these multiple failures have generated concerns and perceptions about the systemic nature of problems related to the delivery of basic emergency medical services citywide. Such failures mandate immediate action by management to improve employee accountability. Specifically, we believe that several quality assurance measures may assist in reducing the risk of a recurrence of the many failures that occurred in the emergency responses to Mr. Rosenbaum: systematic compliance testing, comprehensive and timely performance evaluations, and meaningful administrative action in cases of employee misconduct or incompetence.

Chairman JOHNSON OF CONNECTICUT. Also this one-page memo on Mexican medical care for foreigners.

[The information follows:]

ACCESS TO EMERGENCY CARE IN MEXICO

FOR U.S. CITIZENS AND OTHER FOREIGNERS

A foreigner in Mexico is legally entitled to medical care in cases of emergency, according to the following laws:

Political Constitution of the United Mexican States

Article 1 stipulates that in the United Mexican States, **all persons shall enjoy the fundamental rights recognized by this Constitution**, which may not be abridged nor suspended except in those cases and under such conditions as herein provided.

Article 4 sets forth that **every person has the right to health protection** while in Mexican territory.

Article 33 stipulates that **aliens are entitled to the constitutional rights** granted under Chapter I, First Title of this Constitution.

International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (Ratified by Mexico on March 8, 1999)

This Convention stipulates that **migrant workers and members of their families shall have the right to receive any medical care that is urgently required** for the preservation of their life or the avoidance of irreparable harm to their health on the basis of equality of treatment with nationals of the State concerned. Such **emergency medical care shall not be refused them by reason of any irregularity with regard to stay or employment.**

Convention for the Coalition between the Secretariat of Governance, through the National Migration Institute, and the Mexican Red Cross. Signed on April 21, 2006.

The purpose of this Convention is to take joint actions to **protect the physical integrity of migrants, regardless of their nationality or whether they are documented or undocumented migrants. This is done by granting prehospital care in cases of emergency**, humanitarian assistance, help, and rescue, if necessary, as well as the equipment and training to carry out these measures.

Performance standards for the National Migration Institute migration centers

Chapter X Article 23 stipulates that, whether independently or by way of other institutions, the National Migration Institute shall grant medical care to any foreigner who may require it.

Regulation of the General Population Act

Article 209 sections I and VII. Foreigners in migration centers will receive all necessary medical care while in said migration center.

Chairman JOHNSON OF CONNECTICUT. I would say that a cursory reading of it means that their standards are roughly ours: treat and stabilize, and that there is explicitly the right to receive any medical care that is urgently required. Well, of course, that's the difficulty. What happens when you provide urgently required care and then you can't discharge the patient? So, we do have work to do. There are some difficult issues to face around what the charge should be in EMTALA.

I hope some of you have had some experience with Health Resources and Services Administration (HRSA) grants, which have been very successful in helping communities weed out how can we get people into the legal/medical systems, and so on and so forth. So, we look forward to hearing from you. We thank you for your participation and the excellent of your testimony and your patience with the individual Members as we have had the time to question today. Thank you. The hearing is adjourned.

[Whereupon, at 12:08 p.m., the Subcommittee was adjourned.]

[Submissions for the record follow:]

Statement of American Academy of Pediatrics

The American Academy of Pediatrics appreciates this opportunity to submit testimony for the record of the Ways and Means Subcommittee on Health's hearing regarding emergency care. The American Academy of Pediatrics is a non-profit professional organization of 60,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists dedicated to the health, safety, and well-being of infants, children, adolescents, and young adults.

BACKGROUND

Emergency medical services are the foundation of our nation's defense for public health disasters. The emergency care community is largely unified in communicating a concern shared by emergency care providers and healthcare consumers throughout our nation regarding the ability of a fragmented, over-burdened and under-funded emergency and trauma care system to meet the day-to-day needs of acutely ill and injured persons. The Institute of Medicine recently released a seminal report which indicates that our nation's emergency care delivery system is in a state of crisis. Without a strong emergency medical services system foundation, we will never be able to build an effective response for mass casualty events, including natural disasters or acts of terror.

In addition to the many concerns raised within the IOM report regarding the overall health of our nation's emergency medical services—issues that impact the day-to-day ability of pre-hospital and hospital-based emergency care providers to respond to the needs of all Americans—our emergency care systems also bear some specific and persistent limitations in their ability to meet the medical needs of chil-

dren.¹ Adding further to this gap in the level of emergency readiness between adult and pediatric care is the long-standing observation that federal, state and local disaster planning efforts have traditionally overlooked the unique needs of children. This testimony focuses on issues concerning pediatric emergency preparedness so Congress may better understand the unique challenges faced by emergency medical care professionals as they treat ill and injured children, as well as the readiness gap in pediatric emergency care.

Children Are More Vulnerable Than Adults

It has been said that children are not little adults, and this is especially pertinent in a medical emergency or during a disaster. Their developing minds and bodies place children at disproportionate risk in a number of specific ways in the event of a disaster or terrorist attack:

- Children are particularly vulnerable to aerosolized biological or chemical agents because they normally breathe more times per minute than do adults, meaning they would be exposed to larger doses of an aerosolized substance in the same period of time. Also, because such agents (e.g. sarin and chlorine) are heavier than air, they accumulate close to the ground—right in the breathing zone of children.
- Children are also much more vulnerable to agents that act on or through the skin because their skin is thinner and they have a larger skin surface-to-body mass ratio than adults.
- Children are more vulnerable to the effects of agents that produce vomiting or diarrhea because they have smaller body fluid reserves than adults, increasing the risk of rapid progression to dehydration or shock.²
- Children have much smaller circulating blood volumes than adults, so without timely intervention, relatively small amounts of blood loss can quickly tip the physiological scale from reversible shock to profound, irreversible shock or death. An infant or small child can literally bleed to death from a large scalp laceration.
- Children have significant developmental vulnerabilities not shared by adults. Infants, toddlers and young children may not have the motor skills to escape from the site of a hazard or disaster. Even if they are able to walk, young children may not have the cognitive ability to know when to flee from danger, or when to follow directions from strangers such as in an evacuation, or to cooperate with decontamination.³ As we all learned from Katrina, children are also notably vulnerable when they are separated from their parents or guardians.

Children Have Unique Treatment Needs

Once children are critically ill or injured, their bodies will respond differently than adults in similar medical crises. Consequently, pediatric treatment needs are unique in a number of ways:

- Children need different dosages and formulations of medicine than adults—not only because they are smaller, but also because certain drugs and biological agents may have adverse effects in developing children that are not of concern for the adult population.
- Children need different sized equipment than adults. In fact, emergency readiness requires the presence of many different sizes of key resuscitation equipment for infants, pre-school and school-aged children, and adolescents. From needles and tubing, to oxygen masks and ventilators, to imaging equipment and laboratory technology, children need equipment that has been specifically designed for their size.
- Children demand special consideration during decontamination efforts. Because children lose body heat more quickly than adults, mass decontamination systems that may be safe for adults can cause hypothermia in young children un-

¹Committee on Pediatric Emergency Medicine. Overcrowding Crisis in Our Nation's Emergency Departments: Is Our Safety Net Unraveling? *Pediatrics*, Vol. 114 No. 3 September 2004.

²Committee on Environmental Health and Committee on Infectious Disease. Chemical-Biological Terrorism and Its Impact on Children: A Subject Review. *Pediatrics*, Vol. 105 No. 3 March 2000. (update scheduled for publication in *Pediatrics* September 2006.)

³American Academy of Pediatrics. Children, Terrorism & Disasters Toolkit. The Youngest Victims: Disaster Preparedness to Meet Children's Needs. <http://www.aap.org/terrorism/topics/PhysiciansSheet.pdf>

less special heating precautions or other warming equipment is provided.⁴ Hypothermia can have a profoundly detrimental impact on a child's survival from illness or injury.

- Children sustain unique developmental and psychological responses to acute illness and injury, as well as to mass casualty events. Compared to adults, children appear to be at greater risk for acute- and post-traumatic stress disorders. The identification and optimal management of these disorders in children requires professionals with expertise in pediatric mental health.⁵
- Children may be developmentally unable to communicate their needs with health care providers. The medical treatment of children is optimized with the presence of parents and/or family members. Timely reunification of children with parents and family-centered care should be a priority for all levels of emergency care.

Children Need Care From Providers Trained to Meet Their Unique Needs

Because children respond differently than adults in a medical crisis, it is critical that all health care workers be able to recognize the unique signs and symptoms in children that may indicate a life-threatening situation, and then possess the experience and skill to intervene accordingly.⁶ As already noted, a child's condition can rapidly deteriorate from stable to life-threatening as they have less blood and fluid reserves, are more sensitive to changes in body temperature, and have faster metabolisms. Once cardio-pulmonary arrest has occurred, the prognosis is particularly dismal in children, with less than 20% surviving the event, and with 75% of the survivors sustaining permanent disability. Therefore, the goal in pediatric emergency care is to recognize pre-cardiopulmonary arrest conditions and intervene before they occur. While children represent 25 to 30% of all emergency department visits in the U.S., and 5 to 10% of all EMS ambulance patients, the number of these children who require this advanced level of emergency and critical care, and use of the associated cognitive and technical abilities, is quite small. This creates a special problem for pre-hospital and hospital-based emergency care providers, as they have limited exposure and opportunities to maintain their pediatric assessment and resuscitation skills. In a practice such as a pediatric emergency department located in a tertiary urban children's hospital and trauma center, providers are able to maintain those skills. However, over 90% of children receive their emergency care in a non-children's hospital or non-trauma center setting. Emergency care professionals in many of these settings, and most pre-hospital emergency care providers, simply may not have adequate ongoing exposure to critically ill or injured children.

This vital clinical ability to recognize and respond to the needs of an ill or injured child must be present at all levels of care—from the pre-hospital setting, to emergency department care, to definitive inpatient medical and surgical care. The outcome for the most severely ill or injured children, and for the rapidly growing number of special needs children with chronic medical conditions, is optimized in centers that offer pediatric critical care and trauma services and pediatric medical and surgical subspecialty care. As it is not feasible to provide this level of expertise in all hospital settings, existing emergency and trauma care systems and state and federal disaster plans need to address regionalization of pediatric emergency care within and across state lines and inter-facility transport as a means to maximize the outcome of the most severely ill and injured children.

Children with special health care needs⁷ are the fastest growing subset of children, representing 15 to 20% of the pediatric population.⁸ These children pose unique emergency and disaster care challenges well beyond those of otherwise healthy children. Our emergency medical services systems, and our disaster response plans, must consider and meet the needs of this group of children.

⁴American Academy of Pediatrics. Children, Terrorism & Disasters Toolkit. The Youngest Victims: Disaster Preparedness to Meet Children's Needs. <http://www.aap.org/terrorism/topics/PhysiciansSheet.pdf>

⁵Hagan, J and the Committee on Psychosocial Aspects of Child and Family Health and the Task Force on Terrorism. Psychosocial Implications of Disaster or Terrorism on Children: A Guide for the Pediatrician. *Pediatrics*, Vol. 116, No. 3, September 2005.

⁶Markenson D, Reynolds S, Committee on Pediatric Emergency and Medicine and Task Force on Terrorism. The Pediatrician and Disaster Preparedness. *Pediatrics*, Vol. 117 No. 2 February 2006.

⁷MacPherson M et.al. A New Definition of Children with Special Health Care Needs. *Pediatrics*, Vol. 102, No. 1, July 1998.

⁸Van Dyck P et.al. Prevalence and Characteristics of Children With Special Health Care Needs. *Arch Pediatr Adolesc Med*, Vol. 158, No. 9, September 2004.

Pediatric Emergency Care Preparedness

Our nation's EMS system was developed in response to observed deficiencies in the delivery of pre-hospital and hospital-based emergency care to patients with critical illness or injury, with adult cardiovascular disease and trauma representing the sentinel examples. The Emergency Medical Services Act of 1973 helped to create the foundation for today's EMS systems, stimulating improvements in the delivery of emergency care nationally. Despite those improvements, significant gaps remained evident in EMS care, particularly within the pediatric population.^{9,10}

These gaps were present because early efforts at improving EMS care did not appreciate that acutely ill and injured children could not be treated as "small adults." Children possess unique anatomic, physiologic, and developmental characteristics which create vitally important differences in the evaluation and management of many serious pediatric illnesses and injuries. Unique pediatric health care needs make it difficult for emergency care providers to provide optimal care in adult-oriented EMS systems (e.g. personnel training, facility design, equipment, medications).

In 1993, the Institute of Medicine (IOM) released a comprehensive report, "Emergency Medical Services for Children," on the status of pediatric emergency care. This study identified numerous concerns in several major areas, including gaps in the pediatric training and continuing education of emergency care providers, deficiencies in necessary equipment, supplies and medications needed to care for children, inadequate planning for pediatric emergency and disaster readiness, and insufficient evaluation of patient outcomes and research in pediatric emergency care.¹¹

Over a decade later, last month's IOM report "Emergency Care for Children: Growing Pains," demonstrates that while some improvements have been achieved, the pediatric emergency readiness gap still remains, noting:

- Only 6% of emergency departments across the nation have all of the supplies necessary for managing pediatric emergencies.
- Only half of hospitals have at least 85% of those critical supplies.
- Of the hospitals that lack the ability to provide care for pediatric trauma victims, only half have written transfer agreements with hospitals that possess that ability.
- Many medications used in the emergency room setting for children are prescribed "off label," i.e. without Food and Drug Administration approval for use in children.
- Pediatric emergency care skills deteriorate quickly without practice, yet training is limited and continuing education may not be required for emergency medical technicians (EMTs) in many areas.
- Pediatric emergency treatment patterns and protocols vary widely across emergency care providers and geographic regions.
- Shortages of equipment and devices and deficiencies in pediatric training are exacerbated in rural areas.¹²
- Disaster preparedness plans often overlook the needs of children even though their needs differ from those of adults.

As stated in the IOM report, "If there is one word to describe pediatric emergency care in 2006, it is uneven." The specialized resources available to treat critically ill or injured children vary greatly based upon location. Some children have ready access to a children's hospital or a center with distinct pediatric capabilities while others must rely upon hospitals with limited pediatric expertise or equipment. Some states have implemented pediatric readiness guidelines for hospital emergency departments, but most have not. Some states have organized trauma systems and designated pediatric facilities while others do not. As trauma remains the leading cause of death and disability for children, the absence of a trauma system is particularly problematic for children. Lastly, state requirements for the pediatric continuing education and certification for EMTs vary widely. As a result, not all children have access to the same quality of care.

⁹Seidel JS, et al: Emergency medical services and the pediatric patient: Are the needs being met? *Pediatrics*, Vol. 73, June 1984.

¹⁰Seidel JS, et al.: Emergency medical services and the pediatric patient: Are the needs being met II. Training and equipping emergency medical services providers for pediatric emergencies. *Pediatrics*, Vol. 78, December 1986.

¹¹Durch JS, Lohr KN (eds): Emergency Medical Services for Children. Report of the Institutes of Medicine Committee on Pediatric Emergency Medical Services. Washington, D.C., The National Academies Press, 1993. Available at: <http://books.nap.edu/catalog/2137.html>.

¹²Institute of Medicine. Future of Emergency Care Series, "Emergency Care for Children: Growing Pains." National Academies Press, June 2006.

Finally, more research is needed in all aspects of pediatric emergency care. Due to the lack of scientifically validated research in this area, most recommendations are the result of expert consensus, not scientific evidence. More study is needed to advance the field and ensure that the measures we are taking are effective.

Pediatric Disaster Readiness

Each of these shortcomings in day-to-day emergency care has major implications for disaster preparedness. Emergency departments and emergency medical services systems that are unable to meet everyday pediatric care challenges are, by definition, unlikely to be prepared to deliver quality pediatric care in a disaster.¹³

A unique consideration in pediatric emergency care and disaster planning is the role of schools and day care facilities. Children spend up to 80% of their waking hours in school or out-of-home care. Schools and day care facilities must be prepared to respond effectively to an acutely ill or injured child, and likewise, must be fully integrated into local disaster planning, with special attention paid to evacuation, transportation, and reunification of children with parents.¹⁴ Families should also be encouraged to engage in advance planning for emergencies and disasters.¹⁵

One key area of deficiency in our current disaster planning is in pediatric surge capacity. Most hospitals have limited surge capacity for patients of any kind. Even if beds may be available, appropriately trained or experienced staff and the necessary equipment, drugs and devices may not be. The use of adult critical care or medical/surgical inpatient beds in hospitals with limited pediatric expertise will likely prove to be an unacceptable option for the needs of many ill or injured children. Optimal outcomes for these children will only be achieved through regionalization of pediatric care and surge capacity.

One federal program provides a clear example of the general neglect of children's issues in disaster planning. The National Bioterrorism Hospital Preparedness Program (NBHPP), administered by the Health Resources and Services Administration (HRSA), is tasked with providing funds to states and localities to improve surge capacity and other aspects of hospital readiness. In the most recent grant guidance, HRSA required that all states establish a system that allows for the triage, treatment, and disposition of 500 adult and pediatric patients per 1 million population. While pediatric patients are referenced, it is unclear whether they are required to be represented in proportion to their numbers in the state's population. A state could arguably plan for 499 adults and 1 child and satisfy the guidance. Moreover, that guidance removed critical language that stated that NBHPP funds must not supplant funding received under federal Emergency Medical Services for Children grants and that strongly urged the incorporation of behavioral health and psychosocial interventions for adults and children into facility drills and exercises. Outside the pediatric mention in the benchmark for bed surge capacity, children's issues are essentially absent from the NBHPP guidance.¹⁶

Equipment and devices, as noted above, are a crucial component of readiness. Because "children" encompass individuals from birth through adolescence, it is often insufficient to have a single size device to serve all children. In the case of respiratory masks, for example, different sizes are needed for infants, young children, and teenagers. Both individual facilities and large-scale programs, such as the Strategic National Stockpile, must take this into account and provide for these needs.

Similarly, drugs and antidotes must be available in appropriate formulations and dosages for children. Infants cannot be expected to take pills. Needles must be provided in smaller sizes. In many cases, dosages for children should be determined not by age but by weight. A simple device known as a Broselow tape can allow health care providers to calculate dosages quickly and accurately. However, one study showed that 46% of Disaster Medical Assistance Teams were lacking these tapes, in addition to other critical pediatric equipment.¹⁷

Training is vital to pediatric preparedness. Many health care providers have few, if any, opportunities to use critical pediatric resuscitation and treatment skills.

¹³ American Academy of Pediatrics Committee on Pediatric Emergency Medicine and American College of Emergency Physicians Pediatric Committee. Care of Children in the Emergency Department: Guidelines for Preparedness. *Pediatrics*, Vol. 107 No. 4 April 2001.

¹⁴ Schools and Terrorism: A Supplement to the National Advisory Committee on Children and Terrorism Recommendations to the Secretary. August 12, 2003. <http://www.bt.cdc.gov/children/PDF/working/school.pdf>.

¹⁵ Family Readiness Kit. <http://www.aap.org/family/frk/frkit.htm>.

¹⁶ National Bioterrorism Hospital Preparedness Program FY 2005 Continuation Guidance, HRSA Announcement Number 5-U3R-05-001, <http://www.hrsa.gov/bioterrorism/hrsa05001.htm>.

¹⁷ Mace SE and Bern AI. Needs Assessment of Current Pediatric Guidelines for Use by Disaster Medical Assistance Team Members in Response to Disaster and Shelter Care. *Annals of Emergency Medicine*, 44(4): S35.

Skills that are not exercised atrophy quickly. Presently, there is great variation in state standards for required pediatric training and continuing education for pre-hospital care providers and other first responders. Regular training and education is central to ensuring that health care providers will be able to treat children in a crisis situation. The same holds true for facility and community emergency exercises and drills.

The issues of family reunification and family-centered care in evacuation, decontamination and in all phases of treatment are frequently overlooked. In the event of a disaster, both evacuation and treatment facilities must have systems in place to minimize family separation and methods for the timely and reliable reunification of children with their parents. In addition, facilities must take into account the need for family-centered care in all stages of care. Infants and young children are typically unable to communicate their needs to healthcare providers. Children of all ages are highly reliant upon the presence of family during an illness or periods of distress. Nearly all parents will be unwilling to be separated from their children in a crisis situation, many even willing to forego emergency treatment for themselves to be with their child. Hospitals must be prepared to deal with these situations with compassion and consistency.¹⁸

It has been a source of great frustration for many pediatric and emergency medicine providers, including the American Academy of Pediatrics, that our repeated calls for improved pediatric emergency preparedness have gone unheeded for the better part of a decade. As long ago as 1997, the Federal Emergency Management Agency raised the concern that *none* of the states it had surveyed had pediatric components in their disaster plans.¹⁹ That same year, the American Academy of Pediatrics issued its first policy statement entitled, "The Pediatrician's Role in Disaster Preparedness," with recommendations for pediatricians and communities.²⁰ In 2001, the American Academy of Pediatrics formed its Task Force on Terrorism and issued a series of detailed recommendations on various aspects of chemical, biological, radiological and blast terrorism.²¹ In 2002, Congress created the National Advisory Committee on Children and Terrorism to prepare a comprehensive public health strategy related to children and terrorism. In 2003, the federal government sponsored a National Consensus Conference on Pediatric Preparedness for Disasters and Terrorism which, again, issued a laundry list of dozens of specific recommendations.²² Just last month, the IOM issued its report on the pediatric aspects of the emergency care system.²³ Despite all of this, progress in pediatric preparedness has been slow, fragmented, disorganized, and largely unmeasured and unaccountable.

The Emergency Medical Services for Children (EMSC) Program

The federal government has a crucial role in assuring pediatric emergency and disaster preparedness through a variety of agencies and programs, including the Department of Homeland Security, the Federal Emergency Management Agency, the Centers for Disease Control and Prevention, HRSA's National Hospital Bioterrorism Preparedness Program, and others. Perhaps the most important and successful federal program in improving emergency health care providers' ability to provide quality care to children has been HRSA's Emergency Medical Services for Children (EMSC) program. Created in 1984, the EMSC program was established after data and clinical experience showed major gaps between adult and pediatric emergency care at all levels. The program has funded pediatric emergency care improvement initiatives in every state, territory and the District of Columbia, as well as national improvement programs.

Despite a modest budget allocation, EMSC has driven significant improvements in pediatric emergency care, including disaster preparedness. To its credit, EMSC has managed to effect these changes despite the lack of pediatric emphasis in other related government programs. EMSC has funded the development of equipment lists for ambulances and hospitals, pediatric treatment protocols, and handbooks for school nurses and other providers that would be critical in the event of an emergency. EMSC supports training for emergency medical technicians and paramedics

¹⁸ Committee on Hospital Care. Family-Centered Care and the Pediatrician's Role. *Pediatrics*, Vol. 112, No. 3, September 2003.

¹⁹ National Advisory Committee on Children and Terrorism. Recommendations to the Secretary. Washington, DC: DHHS, 2003.

²⁰ Committee on Pediatric Emergency Medicine. The Pediatrician's Role in Disaster Preparedness. *Pediatrics*, Vol. 99 No. 1, January 1997.

²¹ AAP Task Force on Terrorism. All related documentation at www.aap.org/terrorism.

²² Pediatric Preparedness for Disasters and Terrorism: A National Consensus Conference. 2003. http://www.ncdp.mailman.columbia.edu/files/pediatric_preparedness.pdf.

²³ Institute of Medicine. Future of Emergency Care Series, "Emergency Care for Children: Growing Pains." National Academies Press, June 2006.

who often have little background in caring for children, and has underwritten the development of vital educational materials and treatment guidelines. In the 21 years since the program was established, child injury death rates have dropped by 40%.

As outlined in the IOM report, the EMSC program's resources and over 20 years of effective leadership and collaboration with key stakeholders have indeed led to important changes in pediatric emergency care at the state level:

- 44 states employ pediatric protocols for online medical direction of pre-hospital care at the scene of an emergency;
- 48 states have identified and require all EMSC essential equipment on EMS advanced life support ambulances;
- 36 of 42 states with state-wide computerized data collections systems now produce reports on pediatric care;
- 20 states have pediatric emergency care laws or pediatric emergency care related rules or regulations; and
- 12 states have adopted and disseminated pediatric guidelines that characterize the facilities that have trained personnel and equipment, medications and facilities to provide pediatric care.

EMSC supports a National Resource Center (NRC) which acts as a clearinghouse for educational resources on pediatric emergency care, enabling countless communities to learn from each other's experience and adopt proven models. EMSC also supports the National EMSC Data Analysis Resource Center (NEDARC) which assists EMSC grantees and State EMS offices to improve their ability to collect, analyze, and utilize data to improve the quality of pediatric care.

EMSC has also been a very important source of funding for grants that have contributed to increasing evidence-based care for acutely ill and injured children. Research is an essential element in the development of an evidence-based practice of medicine. The practice of evidence-based pediatric emergency medicine is needed to provide the best treatment for acutely ill or injured children. Unfortunately, in many situations, emergency care providers must rely upon limited or anecdotal experience, or an extrapolation from adult care standards when treating children, because reliable research studies involving acutely ill and injured children are few.

In recent years, EMSC has funded the establishment of the Pediatric Emergency Care Applied Research Network (PECARN), the only network of its kind supporting pediatric emergency care research. PECARN is providing the infrastructure for critical research on the effectiveness of interventions and therapies used in pediatric emergencies.

The recent IOM report contained a strong endorsement of the EMSC program: "the work of the EMSC program today remains relevant and vital." The report acknowledged the need to address the serious gaps that remain in pediatric emergency care and stated that "The EMSC program, with its long history of working with federal partners, state policy makers, researchers, providers and professional organizations across the spectrum of emergency care, is well positioned to assume this leadership role."²⁴

The American Academy of Pediatrics fully endorses the IOM's comments regarding the value of the EMSC program. While enormous strides have been made in pediatric emergency care, much more remains to be done. The program should be reauthorized and funded at or above the level recommended by the IOM, which we hope would allow EMSC to pursue pediatric emergency and disaster preparedness thoroughly and aggressively.

POLICY RECOMMENDATIONS

The American Academy of Pediatrics has specific recommendations for all policy-makers regarding children and emergency and disaster preparedness:

- If our nation's over-burdened emergency and trauma care systems are to respond effectively to a significant mass casualty event, we must invest in creating effective local, state and federal disaster response systems involving a healthy, adequately-funded, well-coordinated and functional emergency medical services system.
- Standards for pediatric emergency readiness for pre-hospital and hospital-based emergency services, and regionalization of pediatric trauma and critical care, should be developed and implemented in every state.

²⁴Institute of Medicine. Future of Emergency Care Series, "Emergency Care for Children: Growing Pains." National Academies Press, June 2006.

- Evidence-based clinical practice guidelines for the triage, treatment and transport of acutely ill and injured children at all levels of care should be developed.
- Pediatric emergency care competencies should be defined by every emergency care discipline and professional credentialing bodies should require practitioners to achieve the level of initial and continuing education necessary to maintain those competencies.
- Primary care pediatricians and pediatric medical and surgical subspecialists should be included in emergency and disaster planning at every organizational level—at all levels of government, and in all types of planning.
- Emergency preparedness efforts should use an “all-hazards” model that allows for holistic planning and multipurpose initiatives, and should support family-centered care at all levels of treatment.
- Pediatric health care facilities (e.g. children’s hospitals, pediatric emergency departments, and pediatricians’ offices) should be included in all aspects of preparation because they are likely to become primary sites for managing child casualties.
- Financial support should be provided to health care facilities to address pediatric preparedness, including maintaining surge capacity and creating specialized treatment areas for children, such as isolation and decontamination rooms.
- Schools and day care facilities must be prepared to respond to emergencies and must be fully integrated into local, state and federal disaster plans, with special attention paid to evacuation, transportation, and reunification of children with parents.
- Federal, state, and local disaster plans should include specific protocols for the management of pediatric casualties, including strategies to:
 - Minimize parent-child separation and implement systems for the timely and reliable reunification of families;
 - Improve the level of pediatric expertise on disaster response teams (e.g. Disaster Management Assistance Teams);
 - Improve access to pediatric medical and surgical subspecialty care and to pediatric mental health care professionals;
 - Address the care requirements of children with special health care needs; and
 - Ensure the inclusion of pediatric mass casualty incident drills at both federal and state planning levels.
- More research is needed regarding all aspects of pediatric emergency planning, response, and treatment to support the development of effective emergency therapies, prevention strategies, and evidence-based clinical standards in pediatric emergency medicine.
- The Emergency Medical Services for Children (EMSC) program should be reauthorized and funded at the level of \$37.5 million per year, as recommended by the Institutes of Medicine report, to support the continued improvement in pediatric emergency and disaster preparedness.

Other Issues of Concern

In addition to hospital surge capacity and emergency room preparedness, a number of other critical issues continue to be neglected in the area of pediatric readiness.

Government organizational issues: Pediatric concerns must be represented in all aspects of disaster planning and at all levels of government, including issues such as evacuation strategies and large-scale protocols.

Federal systems issues: Children’s needs must be taken into account in various federal systems. The Strategic National Stockpile must contain equipment, devices and dosages appropriate for children. Disaster Medical Assistance Teams must include individuals with appropriate pediatric expertise. Pediatric casualties should be simulated in all disaster drills.

Special disasters: Children have unique needs in certain types of disasters. For example, in the event of a radioactive release, children must be administered potassium iodide as quickly as possible and in an appropriate form and dosage to prevent long-term health effects.²⁵

School and day care issues: Children spend up to 80% of their waking hours in school or out-of-home care. Schools and day care facilities must be integrated into

²⁵Committee on Environmental Health. Radiation Disasters and Children. *Pediatrics*, Vol. 111, No. 6, June 2003.

disaster planning, with special attention paid to evacuation, transportation, and reunification with parents.²⁶

Credentialing. Health care providers are critical volunteers in time of disaster. A comprehensive system for verifying credentials and assigning volunteers appropriately is vital. HRSA's Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) must be supported and accelerated.

Psychosocial concerns: Children's reactions vary greatly depending on the child's cognitive, physical, educational, and social development level and experience, in addition to the emotional state of their caregivers. This presents unique challenges to providing quality mental health care.²⁷

Evacuation and shelter issues: A top priority must be placed on not separating parents from children in evacuations. In shelters, special arrangements must be made for pregnant women and children with special health care needs, as well as for the safety and security of all children.

CONCLUSION

In conclusion, the American Academy of Pediatrics greatly appreciates this opportunity to present its views and concerns related to pediatric emergency care and disaster preparedness. While great strides have been made in recent years, with many of these improvements the direct result of the federal EMSC program, much more remains to be done. America's children represent the future of our great nation, our most precious national resource. They must not be an afterthought in emergency and disaster planning. With focused, comprehensive planning and the thoughtful application of resources, these goals can be achieved. The American Academy of Pediatrics looks forward to working with you to protect and promote the health and well-being of all children, especially in emergency and disaster situations.

National Coalition on Hispanic Health
Washington, DC 20005
August 9, 2006

Dear Members of Congress:

On behalf of the National Coalition on Hispanic Health, an association of major national Latino associations with extensive expertise, I write to urge Congress to get the facts about immigrants and health care. Study after study has proven that immigrants actually use much less of our nation's health resources than U.S. citizens. This was first carefully studied and documented by the prestigious National Research Council, in *The New Americans*, published in 1997. More recent reports have only served to reconfirm these findings. For instance, a recent study in Health Affairs shows that 6.3% of non-citizens used the emergency room in 2003, compared to 31.8% of the general population in the total U.S.

It is critical that Congress base decisions about immigration and health issues upon factual, comprehensive, longitudinal studies of the type cited above. Rhetorical examples will only serve to divert public policy from its essential goal of protecting our nation's health and well-being.

If you have any further questions, please do not hesitate to contact me.

Sincerely,

Elena Rios, MD, MSPH
President and CEO

Statement of William A. Sanger, Emergency Medical Services Corporation

Emergency Medical Services Corporation ("EMSC") is pleased to submit comments to the Health Subcommittee of the House Ways & Means Committee on the Institute of Medicine ("IOM") reports on Emergency Care in America. These reports were the subject of a public hearing held before the Subcommittee on July 27, 2006.

²⁶ Schools and Terrorism: A Supplement to the National Advisory Committee on Children and Terrorism Recommendations to the Secretary. August 12, 2003. <http://www.bt.cdc.gov/children/PDF/working/school.pdf>

²⁷ Hagan, J and the Committee on Psychosocial Aspects of Child and Family Health and the Task Force on Terrorism. Psychosocial Implications of Disaster or Terrorism on Children: A Guide for the Pediatrician. *Pediatrics*, Vol. 116, No. 3, September 2005.

EMSC has extensive experience in emergency medicine delivery and emergency care operations. Operating under the recognized brands of EmCare and AMR, EMSC is a leading provider of emergency medical services in the United States, serving more than nine million patients each year. EmCare provides outsourced emergency department staffing and management services to more than 340 hospitals in 39 states. AMR—American Medical Response—is America’s leading provider of ambulance services, with local operations serving more than 250 communities in 35 states.

Because of EMSC’s unique position in these healthcare sectors, we are very familiar with the complexities and challenges facing emergency departments, hospitals, emergency physicians, first responders, EMS and ambulance service providers, and all others associated with the delivery of emergency medical services across the nation. As identified in the IOM reports, some of the key issues facing emergency medical service providers include regionalization, coordination, the practices of “boarding” and “parking” emergency care patients, and patient flow management. We believe that Congress and others need to take immediate steps to address these issues in order to improve patient care delivery and maximize the efficiency of emergency department operations.

While no one organization can provide answers to the many problems facing emergency care in America, EMSC believes that our breadth and depth of experience makes us uniquely qualified to confront the many issues raised in the IOM reports. We, therefore, would like to share some of our experiences with the Subcommittee and others involved in policymaking in this important area. We believe our experiences and insights will help inform the next phase of deliberation and consideration of these critical issues.

Regionalization and Coordination

Regionalization of Emergency Services

In today’s world, an emergency in one town or one section of a city can quickly become a much larger incident requiring a response across jurisdictions and disciplines. The IOM *Emergency Medical Services* report makes clear that the objective of regionalization of emergency medical care services is to “improve patient outcomes by directing patients to facilities with experience in and optimal capabilities for any given type of illness or injury.” (*Emergency Medical Services: At the Crossroads* at p. 58.) Getting the patient to the best provider to treat their specific medical condition is a primary requirement to meet this stated goal. Our physicians, EMS professionals, and other emergency care providers have seen the benefits of regionalization. This helps ensure that patients receive the best available care with the result of better outcomes. Unfortunately, we have also experienced instances where a lack of regionalization has resulted in poor patient outcomes.

EMSC’s unique role in emergency medicine delivery and emergency care operations has given our team significant “on the ground” experience in finding the best ways to make regionalization work to improve emergency medical care for patients.

The EMS report also noted the concept of an “inclusive trauma system” for the treatment of all illnesses and injuries across the entire spectrum of emergency care. (*Id.* at p.58.) We share this vision for the future of emergency care and are already implementing methods to achieve this concept. EMSC has worked over the past years to develop procedures and processes to help our physicians and professionals ensure top quality emergency medical care to all patients but especially to those patients in immediate danger of death from traumatic injury or illness.

The *Emergency Medical Services* report notes a specific recommendation for a panel to develop “evidence-based categorization systems for EMS, EDs and trauma centers based on adult and pediatric service capabilities.” (*Id.* at p. 59.) We strongly support this proposal and believe that our depth of experience in delivering emergency care services would be useful considering ways to develop such categorization systems. We offer our expertise and experience to those individuals and organizations committed to this undertaking.

While we believe that regionalization is a positive development in the improvement of emergency medical care, it is a concept that will require some changes to current laws to realize its full potential. Issues like antitrust laws, physician licensure across state lines, obsolete corporate practice of medicine laws in certain states, and Good Samaritan laws potentially present certain legal issues that we and others in the profession will need to consider before regionalization can be accomplished. We, alongside our professional societies and fellow health care providers, look forward to working with Congress to achieve the important goal of regionalization.

Coordination of Emergency Services

The *Emergency Medical Services* report discussed the current emergency medical care system's lack of coordination among the different components of care, including 911 dispatch, pre-hospital EMS, air ambulance providers, hospitals, and trauma centers. In addressing this need, the report states that these elements, along with public safety and public health departments, "should be fully interconnected and united in an effort to ensure that each patient receives the most appropriate care, at the optimum level, with the minimum delay." (*Emergency Medical Services: At the Crossroads* at p. 7.) EMSC fully agrees with and shares this goal for the future of emergency care.

Coordination of services and emergency care is not just a goal for EMSC, but is important for all emergency care providers to ensure that patients receive the highest quality care. The efficiency and effectiveness of our emergency care delivery depends on how well our professionals can coordinate their response to an incident, the care provided to a patient in distress, and the communication with other providers along the service delivery chain to provide a continuum of care that achieves the optimum patient outcome.

To date, EMSC has invested several years in our continuing search for solutions to deliver the best possible emergency care services. This includes advanced technology to provide the most clinically appropriate and cost effective level of care to all patients, state of the art medical transportation software for high performance medical transportation management, and advanced technology to match physicians to hospitals' needs.

For example, many hospitals currently utilize software programs to assist them with bed management issues. When a bed is available, a nurse will use the software to notify housekeeping that a bed has become available so they can get the room ready for a new patient. We have learned, however, for a variety of reasons, nurses do not always adequately use the software, so empty beds are not filled timely. EMSC has formed partnerships with software developers, which allows us to become a part in the process of identifying empty beds. When an EMSC ambulance arrives to transport a discharged patient in these facilities, the dispatchers use the software to notify the hospital that there is an available bed to be filled. This helps hospitals that use EMSC's ambulances to more timely fill their empty beds, thus alleviating some of the bed shortage problems faced by these hospitals.

In developing these partnerships, we have gained a number of insights and new information that we believe will be useful as Congress explores ways to improve coordination and communications in emergency care. We stand willing and ready to work with the Subcommittee and other interested individuals and organizations to provide our expertise and experience to this very important effort.

Patient Care Issues

Patient "Boarding" and "Parking"

One important area of continuing concern is the practice of "boarding" where emergency departments are unable to timely admit patients into the hospital and must hold the patient in an emergency department bed or in a non-clinical space, such as an office or hallway. This practice reduces care capacity and contributes to an already overcrowded emergency room. The IOM *Emergency Medical Services* report urges elimination of the practice of boarding except in extreme cases, such as a mass casualty event. (*Emergency Medical Services: At the Crossroads* at p. 201; Recommendation 4.5.) Similarly, the American College of Emergency Physicians has cited the negative aspects of this practice and suggested solutions in testimony before this Subcommittee. EMSC echoes these concerns and joins our fellow emergency care professionals in calling for an end to the improper practice of boarding.

An additional practice that negatively impacts patient care is "patient parking." Some hospitals have significant issues with bed turnaround and availability and emergency department overcrowding. When an ambulance arrives at the hospital, the hospital will refuse to formerly "accept" the patient and instead tells the ambulance that there is inadequate emergency department staff to handle the patient. If there is not, which occurs in many cases, or the patient needs to be seen at that specific facility, because of a physician on staff or the appropriate level of care available at that facility, then the ambulance is often asked to wait in the parking lot until the patient can be brought into the facility. This practice not only negatively impacts the patient care for the individual in the ambulance, but it also prevents the ambulance from responding to another request for help since the EMS professionals cannot respond until the first patient is admitted into the emergency department.

EMSC has proactively acted to address this practice and to improve patient care by using extra rooms that hospitals make available, purchasing additional gurneys, and staffing the rooms with administrative and clinical personnel. For example, when an ambulance arrives at a hospital that would normally have told the crew to remain with the patient in the ambulance in the parking lot until adequate emergency room staff was available to provide care, EMSC personnel have brought the patient into a room in the hospital set aside for this purpose and our clinical personnel have monitored the patient until the hospital could formerly accept the patient. While this innovative strategy allows EMSC to keep our ambulances in service without having to call in additional crews to staff units to maintain response time requirements and provide clinically acceptable care in these areas, it is a costly procedure and currently, there exists no government or private payer reimbursement for this practice. We believe that Congress should work to establish standards on both patient boarding and patient parking to improve patient flow throughout the emergency medical care system.

In the IOM report, the committee calls for a panel to develop evidence-based model pre-hospital protocols for treatment, triage, and transport of patients. (*Emergency Medical Services: At the Crossroads* at p. 60) We believe that the issues of patient boarding and patient parking should be included in this discussion. Our widespread experience in treatment, triage, and transport would be useful in the national debate about how to improve and revamp this aspect of the emergency care system, and we offer our expertise and experience to those individuals and organizations committed to this undertaking.

Discharge Resource Rooms at Hospitals

Another area where we have been active in finding new solutions to overcrowding and congestion in emergency departments is in the discharge of patients from the emergency department. Many hospitals use “discharge resource rooms,” which are essentially “holding rooms” for patients who are ready to be discharged, but the mechanics of the actual discharge still need to occur, such as finding an available bed for the patient in a skilled nursing facility or rehabilitation facility, completing the discharge paperwork, and arranging for the correct level of transportation. These are all things that occur after the patient has been taken to the discharge resource room. We assist hospitals with staffing a coordinator that manages the conditions of patient travel and, in some cases, also help with clinical staffing of these rooms. This allows a hospital bed to become available for the next patient.

This is another way in which EMSC has helped develop innovative solutions to the overcrowding and patient flow issues faced by emergency departments across the country. We believe that our efforts in addressing emergency care patient flow issues would be useful in identifying ways find solutions to these problems.

Summary

To conclude: we believe that EMSC’s unique position in the emergency care healthcare sectors and our familiarity with the wide range of complexities and challenges facing the many elements involved in the delivery of emergency medical services make us a valuable resource in the continuing efforts to improve the delivery of emergency medical services. EMSC urges Congress and emergency medical health care organizations to consider and address the issues of regionalization of care, coordination of care, the practices of “patient boarding” and “patient parking” of emergency care patients, and other improvements to overall patient flow management. It is critical that we as a nation develop permanent solutions to address these problems to improve patient care and maximize the efficiency of emergency department operations, so that all patients receive the best quality emergency care. While EMSC has been innovative in working with hospitals and other emergency care providers to arrive at temporary solutions to these problems, it falls far short of the solutions needed to address the very significant problems facing the delivery of emergency care across the country.

We believe that the private sector companies in this field should be included in the working groups and task forces engaged in the next phase of the IOM’s work. EMSC stands ready and willing to assist in any way we can to offer perspectives, insights, and experience from the private sector in the range of issues confronting all of us who toil in the emergency medical services field.

We thank the Subcommittee for its attention to this crisis and for their actions to chart a course to find solutions and new ideas that will benefit emergency medical care providers, and most importantly, patients and our communities.