Statement of

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Hearing on

# The Government's Response to the Nation's Emergency Room Crisis

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Introduction

America's emergency departments are underfunded, understaffed, overcrowded and overwhelmed – and we find ourselves on the brink of collapse. That was the conclusion of the Institute of Medicine's reports on the "Future of Emergency Care" that were released in June 2006.

Mister Chairman and members of the committee, my name is Ramon Johnson, M.D., F.A.C.E.P. I am an emergency physician from southern California where I have practiced for the past 23 years. I completed my residencies in emergency medicine and pediatrics at the UCLA Center Health Sciences in 1985 and 1982, respectively. Currently, I serve as the director of pediatric emergency medicine at Mission Hospital Regional Medical Center in Mission Viejo.

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 state of emergency medical care in this country. In particular, I will address issues raised by 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 not only for day to day emergencies, but during a public health disaster.

ACEP is the largest specialty organization in emergency medicine, with more than 25,000 members committed to improving the quality of emergency care through continuing education, research, and public education. ACEP has 53 chapters 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.

Current State of Emergency Care

At an alarming and increasing rate, our patients are suffering. 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," released in June 2006.

I would like to tell you these findings are new to emergency physicians, but they are not. I would also like to tell you that action has been taken to alleviate these problems and improve access to emergency medical services since then, but it has not.

Patients are suffering, and we are starting to see reports on the consequences. An emergency patient last month in Los Angeles died on the waiting room floor of an emergency department while waiting to be seen.

Emergency physicians and nurses are dedicated to saving lives. But if we can't get to you, we can't save your life. What will it take for our nation's policymakers to respond?

ACEP for years now has been working to raise awareness among policymakers and the public of the critical conditions facing all emergency patients, not just the uninsured. 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 (Attachment A); and sponsoring a rally on the west lawn of the U.S. Capitol in September 2005 attended by nearly 4,000 emergency physicians and nurses to bring public attention to some of the critical impediments to emergency care.

In January 2006, ACEP's released its first "National Report Card on the State of Emergency Medicine" (Attachment B), which measured each state's commitment to train emergency physicians and provide appropriate practice environments for them and the patients they serve.

ACEP continues to promote the findings of the 2006 IOM reports, hosting another summit in March 2007 with other emergency care stakeholder organizations. The fifteen organizations that met in Washington, D.C. developed a consensus on several of the IOM reports recommendations and will be working together to see that they are put into effect. I will discuss the results of that summit meeting later in my testimony.

Over the past few years, we have also conducted numerous surveys to collect data and identify shortfalls in the emergency care network and we are currently working with Congress to enact the "Access to Emergency Medical Services Act of 2007" (H.R. 882/S. 1003), as well as other legislative initiatives that will improve emergency medical care.

As indicated in the breadth of the IOM report on hospital-based care, there are a variety of factors affecting timely access to emergency medical care. Today, I would like to discuss several of the most prominent issues. These include the problems of overcrowding, on-call shortages, the Emergency Medical Treatment and Labor Act (EMTALA), reimbursement and uncompensated care, boarding and ambulance diversion. I want to explain from the perspective of an emergency physician how these factors combine to overwhelm emergency medical services; and what Congress can do to help.

New Emergency Department Visit Data

While the numbers have not yet been released, I have permission to share the results of the CDC's 2005 National Hospital Ambulatory Medical Care Survey (NHAMCS), the longest continuously running, nationally representative survey of hospital emergency department and hospital outpatient department use.

As the CDC will report next week:

- Emergency visits are at an all-time high of 115 million in 2005 — an increase of 5 million visits in one year.
- From 1995 through 2005, the number of emergency department visits increased from 96.5 million to 115.3 million visits annually. This represents an average increase of more than 1.7 million visits per year.
- During this same period, the number of hospital emergency departments decreased from 6,291 to 3,890, therefore nearly doubling the annual number of visits per emergency department from 15,882 in 1995 to 29,646 in 2005.
- There were, on average, about 219 visits to U.S. emergency departments every minute during 2005.
- From 1995 through 2005, the overall emergency department utilization rate increased by 7 percent, from 36.9 to 39.6 visits per 100 persons.
- Visit rates were the highest for Medicaid recipients (88/100), followed by Medicare beneficiaries (51/100) and uninsured (46/100).

**To summarize, between 1995 and 2005 hospital emergency department visits increased by 20 percent while the number of emergency departments decreased by 38 percent!**

Emergency Department Overcrowding

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

> An emergency physician who said he practices at a level one trauma center that is so overcrowded that emergency patients wait 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 the emergency department is filled with patients being held for ICU beds. He said he is only able to see four to six patients in a 6-hour shift because there just are no beds to put them in. The hospital goes on diversion, but so do the other hospitals in the area.
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> Another emergency physician told a story of a teenage girl who 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 injures, including loose upper front teeth. He ordered an x-ray. Once he had the results several hours 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.

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 technical and support staff.

I would also like to dispel the misconception that emergency department overcrowding is caused by patients seeking treatment for non-urgent care. According to the latest CDC emergency department NHAMCS data, less than 14 percent of all emergency department visits are classified as "non-urgent," meaning the patient needed to be treated within 24 hours. **Overall, almost 70 percent of the patients arriving at the emergency department need to be seen within two hours and 15.3 percent of those patients need to be seen within 15 minutes.**

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 EMTALA 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; and increased risk of being sued/high insurance premiums. Another factor is the relaxed 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.
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> 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

When it became known that many hospitals were refusing to treat patients who did not have health insurance and, instead, would send them to another facility for care, Congress enacted the Emergency Medical Treatment and Labor Act (EMTALA) of 1986. ACEP has long supported the goals of EMTALA as being consistent with the mission of emergency physicians.

The congressional intent of EMTALA, which requires hospitals to provide emergency medical care to everyone who needs it, regardless of their ability to pay or insurance status, was commendable. Since its enactment, however, the flow of EMTALA regulations has been uneven and for many the intent altered. We therefore welcomed the creation of the EMTALA Technical Advisory Group as called for in the Medicare Modernization Act.

When CMS revised EMTALA regulations in September 2003, 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 115 million emergency department visits in 2005, individuals with private insurance represented nearly 40 percent, 25 percent were Medicaid or SCHIP enrollees, 17 percent were Medicare beneficiaries and another 17 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 45 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, a survey conducted by the American Medical Association (AMA) in 2000 estimated that emergency physicians incurred an annual average of $138,000 in bad debt by providing care mandated by EMTALA. While this average is based on charges, not payments, a conservative estimate of 50 percent reimbursement still represents a significant amount of foregone income that has not been corrected through changes in the CMS practice expense relative value units (RVUs).

Boarding

Reductions in reimbursement from Medicare, Medicaid and other payers, as well as payment denials, continue to reduce hospital resource capacity. To compensate, hospitals 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 full.

The majority of America's hospital emergency departments are operating "at" or "over" critical capacity. As mentioned previously, emergency department visits increased by 20 percent between 1995 and 2005 while the number of emergency departments decreased by 38 percent, leaving fewer emergency departments left to treat an increasing volume of patients. As individuals live longer and more Americans go without health insurance, the patients we typically see now have more serious and complex illnesses, which require more time to diagnose and treat. These factors have 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:

- Inpatient beds that could be used for admissions from the emergency department 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 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.

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To put this in perspective, I would like to share with you the findings of the IOM report on hospital-based emergency care from 2006:

> "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 emergency departments 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 and when there is another hospital that can handle the diverted patients.

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 2006 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 emergency department survey data, reported air and ground ambulances brought in about 14 percent of all emergency department patients (16.2 million patients) 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.

Pediatric Emergency Care

Children who are ill or injured have different medical needs than adults with the same problems. Their physiologic and psychological characteristics are different. While they often require equipment that is smaller than what it used for adults, they more importantly require medication in much more carefully calculated doses and physician and nursing coordinators who have the responsibility to ensure that the needs of children are not lost in the day to day delivery of care in our general hospital emergency departments. Although children make up 27 percent of all visits to the emergency department, many hospitals and EMS agencies are less likely to have pediatric expertise, equipment, policies or adequate staff to optimally handle these patients.

Lack of adequate reimbursement for admitted children has resulted in some Los Angeles hospitals closing their inpatient services, resulting in children and their families spending numerous hours and sometimes days in the emergency department receiving care. In addition, the low reimbursement rates for children create an even greater challenge for finding certain subspecialty services.

While some of the deficiencies in the emergency care of children have been addressed through collaboration between the American College of Emergency Physicians, the American Academy of Pediatrics (AAP) and the federal EMSC program, there is still much more that needs to be done.

Nursing

In the United States, there are between 75,000 and 100,000 nurses working in emergency departments. According to the Emergency Nurses Association (ENA), emergency nurses perform the following tasks: assessment, analysis, nursing diagnosis, planning, implementation of interventions, outcome identification, evaluation of responses, triage and prioritization, emergency operations preparedness, stabilization and resuscitation and crisis intervention for unique patient populations (e.g. sexual assault survivors).

Nurses in the emergency department have a median age of 40 and generally have worked in nursing for less time than other nurses. Nurses in the emergency department have reported feeling that they are under great stress, significantly more often than registered nurses in other settings. Thirty –seven percent of emergency department registered nurses have reported feeling under great stress “almost every day” compared to 30 percent of other registered nurses. Surveys also show that nurses in the emergency department tend to be more pressed for time and have heavier workloads than nurses working in other settings.

These factors have exacerbated an already critical problem that exists due to a national nursing shortage. Currently, it is estimated that 12 percent of nursing positions for which hospitals are actively recruiting are in emergency departments (the third most common source of nursing position openings). This nursing shortage results in patients not receiving timely care or appropriate attention and contributes to the problem of

emergency department crowding because if nurses are not available to staff inpatient beds, admitted patients from the emergency department become boarders awaiting an available bed.

ACEP Convened IOM Summit

ACEP earlier this year convened a summit of organizations involved in emergency care issues about the IOM recommendations. Participating organizations, among others, included the American Public Health Association, American College of Surgeons, the American Academy of Neurological Surgeons, the National Association of EMS Physicians, the American Academy of Orthopaedic Surgeons, the American Academy of Family Physicians, the American Academy of Pediatrics and the Emergency Nurses Association.

Participants discussed some of the key recommendations from the IOM report which called for:

- HHS to study the gaps and opportunities for emergency and trauma care research and to recommend a strategy for organizing and funding a research effort.

- Congress to dedicate funding, separate from Disproportionate Share Hospital (DSH) adjustment payments, to reimburse hospitals [and providers] that provide significant amounts of uncompensated emergency and trauma care for financial losses incurred by providing those services.

- Congress to appropriate $37.5 million each year for the next five years to the Emergency Medical Services for Children (EMSC) program.

- Congress to establish a demonstration program, administered by the Health Resources and Services Administration (HRSA), to promote regionalized, coordinated and accountable emergency care systems throughout the country and appropriate $88 million over five years to this program.

- CMS to convene an ad hoc work group with expertise in emergency care, trauma and EMS systems to evaluate the reimbursement of EMS and make recommendations regarding inclusion of readiness costs and permitting payment without transport.

- Hospitals to work to end the practices of boarding patients in the emergency department and ambulance diversion, except in the most extreme cases, such as a community mass casualty event.

- CMS to convene a working group that includes experts in emergency care, inpatient critical care, hospital operations management, nursing and other relevant disciplines to develop boarding and diversion standards, as well as guidelines, measures, and incentives for implementation, monitoring, and enforcement of these standards.

Congressional Action

**Congress can begin to address the problems discussed today by enacting H.R. 882/S. 1003, the "Access to Emergency Medical Services Act of 2007."** This bill is ACEP's top legislative priority and it: (1) creates a national, bipartisan commission to examine all the factors affecting access to emergency medical services and requires a report to Congress with potential solutions; (2) provides additional compensation for care delivered in the emergency department; and (3) directs CMS to examine the effects associated with boarding admitted patients in the emergency department and to work with stakeholders to alleviate this problem and its related consequences. This legislation currently has the support of nearly 80 bi-partisan co-sponsors in the House, including several members of this committee. As noted in my testimony, and supported by the findings of the GAO and IOM, these are some of the most critical issues facing emergency medicine and action must be taken immediately to provide support to America's emergency departments and the patients we serve.

Other legislation that ACEP supports that will improve the delivery of emergency medical care includes the reauthorization of the EMSC program, Health Information Technology (HIT) initiatives, relief for providing mandatory uncompensated care, and appropriate reimbursements for Medicaid emergency psychiatric care and Medicare ambulance transport.

The EMSC program, which would be reauthorized by the "Wakefield Act" (H.R. 2464), provides grants to states or medical schools to support projects that expand and improve emergency medical services for children who need treatment for trauma or critical medical care. These scientific endeavors are vitally important in our efforts to improve medical care for children who are not just "small adults" and require specific diagnoses and treatments.

ACEP continues to press for adoption of health information technology legislation—similar to legislation passed by the Senate in the 109th Congress—that will promote uniform standards needed to facilitate the nationwide adoption of interoperable health IT. The Institute of Medicine (IOM) has identified health IT as a key tool to improve healthcare quality. ACEP has also taken an active role in the process of developing and harmonizing health IT standards at Health Level Seven (HL7), Integrating the Healthcare Enterprise (IHE), and the Health Information Technology Standards Panel (HITSP), as well as the certification of health IT products meeting those standards, at Certification Commission for Health Information Technology (CCHIT).

While federal mechanisms, such as DSH payments and the ability to write-off bad debt, exist for hospitals to recoup a small portion of the uncompensated care provided in their facilities, no such means exist for physicians. As stated previously, emergency and on-call physicians bear the brunt of uncompensated care that must be provided under EMTALA. The "Mitigating the Impact of Uncompensated Service and Time Act of

2007" (H.R. 1233) would provide some relief to physicians who provide uncompensated, EMTALA-related services by allowing a bad debt tax deduction for their costs to provide those emergency medical services.

An area of growing concern in emergency medicine is the steady rise in emergency department patients who are afflicted with mental illness and require appropriate care within a psychiatric facility. Studies have shown that psychiatric patients are boarded in the emergency department twice as long as other patients and emergency physicians and their staff spend more than twice as long looking for beds for psychiatric patients than for non-psychiatric patients. As state health care budgets have declined, so to have the number of available psychiatric beds and boarding these patients in the emergency department is affecting access to all patients. For these reasons, ACEP supports H.R. 2050, the "Medicaid Emergency Psychiatric Care Act of 2007," which will reimburse facilities that are specially designed to provide hospital-level psychiatric treatment while relieving the increased volume burdens on community hospital emergency departments.

ACEP also supports enactment of the "Medicare Ambulance Payment Extension Act" (H.R. 2164) to extend ambulance relief, initiated by the Medicare Modernization Act, with an increase in the Medicare ambulance fee schedule for 2008 and 2009. Ambulance services are an important component of the health care and emergency response systems of our local communities and the nation. ACEP's concerned that if this relief is not provided, essential pre-hospital transport may be diminished and affect access to life-saving medical care.

## Conclusion

Emergency departments are the 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 net, 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. By 2030, there will be 77 million Medicare beneficiaries, up from 40 million today. How will we maintain capacity

to provide emergency care services? The status quo 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 A

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 in 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.

# Attachment B

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 Sates 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.

Here is the summary of grades by state and category:

| | OVERALL GRADE | GRADE: Access to Emergency Care | GRADE: Quality & Patient Safety | GRADE: Public Health & Injury Prevention | GRADE: Medical Liability Environment |
|---|---|---|---|---|---|
| Alabama | **D+** | D+ | C- | D+ | D- |
| Alaska | **C+** | B+ | D+ | D | C |
| Arizona | **D+** | D+ | C | C- | D- |
| Arkansas | **D** | D+ | D | D | F |
| California | **B** | C | C+ | A+ | A+ |
| Colorado | **C** | C+ | D- | D+ | B- |
| Connecticut | **B** | A- | A+ | B | F |
| Delaware | **C+** | B- | A- | C+ | D- |
| District of Columbia | **B** | A+ | A- | D+ | F |
| Florida | **C-** | C- | B- | D- | D |
| Georgia | **C+** | D+ | A | C | B- |
| Hawaii | **C-** | C+ | D+ | C+ | D- |
| Idaho | **D** | D | D | D- | D |
| Illinois | **C** | B+ | C | D+ | D- |
| Indiana | **D+** | C- | D | C | D- |
| Iowa | **C+** | B- | A- | C | D- |
| Kansas | **C-** | B- | F | D | D |
| Kentucky | **C-** | C | C | C | D- |
| Louisiana | **C-** | C- | B | D | D |
| Maine | **B-** | A | C+ | C- | D |
| Maryland | **B-** | B+ | B+ | A+ | F |
| Massachusetts | **B** | A | B | A- | D- |
| Michigan | **B-** | B+ | B+ | A | D- |
| Minnesota | **C+** | B+ | C+ | C | D- |
| Mississippi | **C-** | C | C+ | D- | D- |
| Missouri | **C+** | B+ | C- | D+ | C- |
| Montana | **C** | C+ | D- | F | A- |
| Nebraska | **C-** | C+ | C- | D+ | D+ |
| Nevada | **C-** | D+ | F | D- | A- |
| New Hampshire | **C** | B+ | D- | C- | D- |
| New Jersey | **C+** | C+ | A+ | B+ | F |
| New Mexico | **D+** | D+ | C- | D+ | D- |
| New York | **C+** | B- | B- | A+ | D- |
| North Carolina | **C-** | C- | C | B+ | F |
| North Dakota | **C-** | B- | D | D | D |
| Ohio | **C+** | A- | B- | D | D |
| Oklahoma | **D+** | C- | D- | C- | D- |
| Oregon | **C-** | C+ | D | B+ | D- |
| Pennsylvania | **B-** | A | A- | C- | F |
| Rhode Island | **B-** | A | B+ | C- | F |
| South Carolina | **B-** | C | B+ | D | B+ |
| South Dakota | **D+** | C+ | F | F | D |
| Tennessee | **C-** | C | C | D+ | F |
| Texas | **C** | D+ | D+ | D | A+ |
| Utah | **D** | D+ | D- | D | D |
| Vermont | **C** | B+ | C | C | F |
| Virginia | **D+** | C- | D+ | C | F |
| Washington | **D+** | C | D | B- | D- |
| West Virginia | **C+** | C+ | A | D | D |
| Wisconsin | **C-** | B- | D+ | D+ | D |
| Wyoming | **D+** | C+ | D- | D- | F |