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RESPONSE OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO THE NATION'S EMERGENCY CARE CRISIS

HEARING

BEFORE THE

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

FIRST SESSION

JUNE 22, 2007

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RESPONSE OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO THE NATION'S EMERGENCY CARE CRISIS

FRIDAY, JUNE 22, 2007

HOUSE OF REPRESENTATIVES,
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM,
Washington, DC.

The committee met, pursuant to notice, at 10:02 a.m., in room 2154, Rayburn House Office Building, Hon. Elijah E. Cummings (acting chairman of the committee) presiding.

Present: Representatives Cummings, Davis of Virginia, Platts, Issa, and Jordan.

Staff present: Phil Barnett, staff director and chief counsel; Karen Nelson, health policy director; Karen Lightfoot, communications director and senior policy advisor; Andy Schneider, chief health counsel; Molly Gulland, assistant communications director; Steve Cha, professional staff member; Earley Green, chief clerk; Teresa Coufal, deputy clerk; Caren Auchman, press assistant; Art Kellermann, fellow; David Marin, minority staff director; Larry Halloran, minority deputy staff director; Susie Schulte, minority senior professional staff member; Brian McNicoll, minority communications director; and Benjamin Chance, minority clerk.

Mr. CUMMINGS [presiding]. This committee will come to order. Today's hearing is regarding access to emergency care. Without objection, the Chair and Ranking Minority Member will have 5 minutes to make opening statements, followed by opening statements not to exceed 3 minutes by any other committee member who seeks recognition.

I will remind the committee members that it is anticipated that we will be out of here by 12, so we are going to stick strictly to our rules.

With that, I want to thank all of you for being here. Today we will examine the response of the Department of Health and Human Services to the Nation's emergency care crisis. In times of tragedy Americans rely on our emergency care system. Whether because of a car wreck, heart attack, stroke or pregnancy complication, Americans and their families show up at the doorstep of our Nation's emergency rooms seeking critical care every day.

Emergency care is the great equalizer. It is the only form of health care guaranteed to every American, regardless of his or her ability to pay. But in this way it also provides a chilling snapshot of what is wrong with our Nation's health care system.

We all want emergency care to work effectively for ourselves and for our loved ones. When it does work, and it usually does, by the way, lives are saved and lifelong disability is avoided. The many dedicated men and women who staff our Nation's ERs, trauma centers and ambulance services deserve our appreciation and our support.

But when the system fails, it can have fatal consequences. Earlier this week, USA Today carried a front-page story on the health crisis in Houston, where ERs divert ambulances 20 percent of the time. One doctor described a patient who died after being diverted from a Houston area hospital to one in Austin 1,600 miles away. He said, "diversion kills you."

In my hometown of Baltimore, a city health department study documented that between 2002 and 2005 the total hours city hospitals were on red alert status, meaning that they had no cardiac-monitored beds for arriving ER patients, increased by 36 percent; the length of time it took ambulances to offload patients in the ER increased by 45 percent; and the number of hours ambulances were diverted from over crowded ERs shot up by 165 percent. Unfortunately, the emergency care crisis is not limited to Houston, and it is certainly not limited to Baltimore.

Failures in the ER have led to an increase in preventable deaths from treatable conditions like heart disease. An article in this morning's edition of USA Today indicates that seven of our Nation's hospitals have worse heart attack death rates than the national average, while 35 have higher death rates for heart failure.

The L.A. Times reported this past May that a 40-year-old woman collapsed on the waiting room floor of the ER at Martin Luther King-Harbor Hospital in Los Angeles while janitorial staff literally mopped the floor around her. Overburdened staff ignored her pleas for help, and her boyfriend, desperate for assistance, dialed 911 from the hospital. He was told to find a nearby nurse. His girlfriend died 45 minutes later.

Last month, Newsweek.com described the critical challenges facing Grady Memorial Hospital in Atlanta. Grady Hospital supports one of the busiest ERs in the State and the only Level I trauma center in a metropolitan area of 5 million people. On any given day it is not unusual for eight Atlanta hospitals to be diverting patients at the same time. What will Atlanta do if Grady closes its ER?

Even here in the District of Columbia it is not unusual for ambulances to be parked seven deep in front of one or more of the city's bigger ERs waiting to offload patients. Not to be too blunt, but these are the same ERs that Members of Congress and our families would turn to in an emergency.

The fact of the matter is that we have a crisis in emergency care, and it is nationwide. This begs the question, with a national emergency and trauma care system as fragile as ours, how will we manage the real threats of a terrorist bombing, a natural disaster, or an outbreak of pandemic flu? Where is the surge capacity?

The emergency room crisis is nothing new. More than 5 years ago, U.S. News and World Report published a cover story entitled, "Crisis in the ER: Turnaways and delays Are a Recipe For Disaster." A copy is displayed on the easel before me.

If you look closely, you will note, ironically, that the issue was published on September 10, 2001. Five weeks after September 11th, Chairman Waxman released a report detailing the national problem of ambulance diversions and the shortage of emergency care. His report identified over 20 States in which hospitals were turning away ambulances because of overcrowding and funding shortfalls. Subsequent reports reached similar conclusions. A 2003 report by the Centers for Disease Control and Prevention found that ER rooms in U.S. hospitals diverted more than 1,300 patients a day—1,300 patients a day—365 days per year. A 2003 GAO report documented ER crowding throughout the country.

One year ago, the Institute of Medicine of the National Academy of Sciences released a three-volume report on the future of emergency care in the U.S. health system. This landmark study concluded that our Nation's emergency and trauma care system is at the breaking point.

Last summer, Congress enacted the Pandemic and All Hazards Preparedness Act. This act assigned responsibility for leading all Federal public health and medical responses to public health emergencies to the Department of Health and Human Services. But despite this clear responsibility, and despite the billions of taxpayers' dollars that Congress has appropriated for biodefense and pandemic preparedness, HHS appears to be ignoring the mounting emergency care crisis.

The Department has not made a serious effort to identify the scope of the problem and which communities are most affected. It has failed to require hospitals that participate in Medicare to report data on the extent of ER boarding and ambulance diversion. It has failed to use its purchasing power through the Medicare program to encourage hospitals to properly admit ill and injured patients to inpatient units rather than boarding them in ER hallways and forcing staff to divert inbound ambulances. It has done nothing to promote the regionalization of highly specialized trauma and emergency care services, a key recommendation of the IOM report.

Worse yet, the Department has recently taken some actions that will make matters worse. It is undisputed that part of the emergency care crisis is a result of the historic underfunding of safety net hospitals, many of which serve as cornerstones of trauma and emergency care systems in their communities. However, rather than asking Congress for additional resources to assist these hospitals, the Department has attempted to bypass Congress by issuing rules that would cut hundreds of millions of dollars in supplemental Medicaid funding from these facilities.

Ladies and gentlemen, this simply makes no sense. Last month the Congress enacted a 1-year moratorium that blocks the Department from implementing these funding reductions, but HHS has shown no signs of modifying its position.

Today, we will hear from leading private-sector experts on emergency care, trauma care, and ambulance services. They will describe the emergency care crisis from the front lines. We will also hear from representatives of two agencies within HHS that have a particularly important role to play in addressing the crisis: the Office of the Assistant Secretary for Preparedness and Response, and the National Institutes of Health.

I hope that the testimony we hear today will help provide our committee with an understanding of the emergency care crisis that confronts us all. Nearly 6 years have passed since the wakeup call of September 11th, and HHS has yet to tackle this problem. The time for action is long overdue.

With that I yield to the distinguished ranking member of the full committee, Mr. Davis.

[The prepared statement of Hon. Elijah E. Cummings follows:]

Statement of Rep. Elijah E. Cummings
Committee on Oversight and Government Reform
Hearing on
HHS's Response to the Nation's Emergency Care Crisis
June 22, 2007

Today, we will examine the response of the Department of Health and Human Services to the nation's emergency care crisis.

In times of great tragedy, Americans rely on our emergency care system. Whether because of a car wreck, a heart attack, a stroke, or a pregnancy complication, Americans and their families show up at the doorstep of our nation's Emergency Rooms seeking critical care everyday. Emergency care is the great equalizer—it is the only form of health care guaranteed to every American, regardless of his or her ability to pay. But in this way, it also provides a chilling snapshot of what is wrong with our nation's health care system.

We all want emergency care to work effectively for ourselves and our loved ones. When it does work, and it usually does, lives are saved, and lifelong disability is avoided. The many dedicated men and women who staff our nation's ERs, trauma centers, and ambulance services deserve our appreciation and support.

But when the system fails, it can have fatal consequences.

Earlier this week, *USA Today* carried a front page story on the health crisis in Houston, where ERs divert ambulances 20% of the time. One doctor described a patient who died after being diverted from a Houston area hospital to one in Austin, 1,600 miles away. "Diversion kills you," he said.

In my hometown of Baltimore, a city Health Department study documented that between 2002 and 2005, the total hours City hospitals were on "red alert" status, meaning they had no cardiac monitored beds for arriving ER patients, increased by 36%. The length of time it took ambulances to offload patients in the ER increased by 45%, and the number of hours ambulances were diverted from overcrowded ERs shot up by 165%.

Unfortunately, the emergency care crisis is not limited to Houston and Baltimore.

Failures in the ER have led to an increase in preventable death, from treatable conditions like heart disease. An article in this morning's edition of *USA Today* indicates that seven of our nation's hospitals have worse heart-attack death rates than the national average, while 35 have higher death rates for heart failure.

The LA Times reported this past May that a 40-year-old woman collapsed on the waiting room floor of the ER at Martin Luther King-Harbor Hospital in Los Angeles, while janitorial staff literally mopped the floor around her. Overburdened staff ignored her pleas for help and her boyfriend—desperate for assistance—dialed 911 from the hospital. He was told to find a nearby nurse. His girlfriend died 45 minutes later.

Last month, *Newsweek.com* described the fiscal challenges facing Grady Memorial Hospital in Atlanta. Grady Hospital supports one of the busiest ERs in state and the only Level I trauma center in a metropolitan area of 5 million people. But on any given day, it is not unusual for 8 Atlanta hospitals to be diverting patients at the same time. What will Atlanta do if Grady closes its ER?

Even here in the District of Columbia, it is not unusual for ambulances to be parked 7-deep in front of one or more of the city's bigger ERs, waiting to off-load patients. Not to be too blunt, but these are the same ERs that Members of Congress and our families would turn to in an emergency.

The fact of the matter is that we have a crisis in emergency care, and it is nationwide.

This begs the question: With a national emergency and trauma care system as fragile as ours, how would we manage the very real threats of a terrorist bombing, a natural disaster, or an outbreak of pandemic flu? Where is the surge capacity?

* * *

The Emergency Room crisis is nothing new.

More than 5 years ago, *US News and World Report* published a cover story entitled, "Crisis in the ER: Turnaways and Delays are a Recipe for Disaster". A copy is displayed to on the easel before me. If you look closely, you will note that—ironically—this issue was published on September 10, **2001**.

Five weeks after September 11, Chairman Waxman released a report detailing the national problem of ambulance diversions and the shortage of emergency care. His report identified over 20 states in which hospitals were turning away ambulances because of overcrowding and funding shortfalls.

Subsequent reports reached similar conclusions.

- A 2003 report by the Centers for Disease Control and Prevention found that ER rooms in U.S. hospitals diverted more than 1,300 patients a day, 365 days per year.

- A 2003 GAO report documented ER crowding throughout the country.

- One year ago, the Institute of Medicine of the National Academy of Sciences released a three-volume report on emergency care in the United States health system. This landmark study concluded that our nation's emergency and trauma care system is "at the breaking point."

Last summer, Congress enacted the Pandemic and All Hazards Preparedness Act. This Act assigned responsibility for leading all federal public health and medical responses to public health emergencies to the Department of Health and Human Services.

But despite this clear responsibility, and despite the billions of taxpayer dollars that the Congress has appropriated for biodefense and pandemic preparedness, HHS appears to be ignoring the mounting emergency care crisis.

- The Department has not made a serious effort to identify the scope of the problem and which communities are most affected.

- It has failed to require hospitals that participate in Medicare to report data on the extent of ER boarding and ambulance diversion.

- It has failed to use its purchasing power through the Medicare program to encourage hospitals to promptly admit ill and injured patients to inpatient units, rather

than "boarding" them in ER hallways and forcing staff to divert inbound ambulances.

- It has done nothing to promote regionalization of highly specialized trauma and emergency care services—a key recommendation of the IOM report.

Worse yet, the Department has recently taken some actions that will make matters worse.

It is undisputed that part of the emergency care crisis is the result of the historic underfunding of safety net hospitals, many of which serve as cornerstones of the trauma and emergency care systems in their communities.

However, rather than asking Congress for additional resources to assist these hospitals, the Department has attempted to bypass Congress by issuing rules that would *cut* hundreds of millions in supplemental Medicaid funding from these facilities. This makes no sense.

Last month the Congress enacted a one-year moratorium that blocks the Department from implementing these funding reductions. But HHS has shown no signs of modifying its position.

Today we will hear from leading private sector experts on emergency care, trauma care, and ambulance services. They will describe the emergency care crisis from the front lines.

We will also hear from representatives of two agencies within HHS that have a particularly important role to play in addressing the crisis: the Office of the Assistant Secretary for Preparedness and Response and the National Institutes of Health.

I hope that the testimony we hear today will help provide our Committee with an understanding of the emergency care crisis that confronts us all.

Nearly six years have passed since the wake up call of September 11th, and HHS has yet to tackle this problem. The time for action is long past due.

Mr. DAVIS OF VIRGINIA. Thank you very much. I want to thank Chairman Waxman for initiating this hearing. It is a very timely issue. We all know the value of a functioning emergency room. Millions of lives are saved annually only because emergency care is available.

But across America, it is critical care services that are in critical condition. Last year, a study by the Institute of Medicine [IOM], concluded our hospital-based emergency medical system was at the breaking point. Emergency rooms are finding it impossible to meet growing and competing demands for trauma care, mandated safety net care for the uninsured, public health surveillance, and disaster readiness.

The IOM panel found emergency care capacity suffering from an epidemic of crowding, with patients parked or boarding in hallways waiting to be admitted. Ambulances are routinely diverted to more distant facilities.

While demand for EMS facilities grows, the number of facilities shrinks, and they find it increasingly difficult to retain on-call specialists to meet standards for timely care. The inevitable tragic result: preventable deaths as critically ill patients literally die from neglect in hallways and in ambulance spaces waiting for the lifesaving help that never comes.

The simple truth is emergency care can and should be better, but it is the legal, financial and demographic trends that have converged to punish the success of hospital emergency departments transformed by Federal law into a de facto primary care provider for millions of under- and uninsured Americans. That unfunded mandate creates powerful incentives to close emergency rooms or limit admissions so that capacity to perform elective, fully reimbursed procedures will not be reduced.

Low reimbursement rates and high malpractice premiums also work to keep needed specialists, neurosurgeons, orthopedic surgeons, and pediatricians, among others, from accepting emergency and trauma patients.

The anemic state of emergency medical services means most hospital centers are already operating at or near capacity every day. A highway crash involving multiple casualties can overwhelm not just one, but all nearby hospitals because no one has information about the real-time availability of emergency beds in the region.

Such a fragile, fragmented system holds virtually no surge capacity in the event of a natural disaster or terrorist attack. This committee has held several hearings on pandemic planning and preparedness. A constant concern that emerged from those hearings was the lack of surge capacity in our Nation's hospitals.

We have made great strides in homeland security since 9/11, but our public health infrastructure, particularly emergency medical response capacity, is still not ready for prime time. When the influenza pandemic erupts, as many predict it will, more than half a million Americans could die, and over 2 million could need to be hospitalized.

How do we plan to move from the current inadequate emergency care structure to the coordinated, regionalized, scalable, and transparent system that we know that we need? What is the Federal role in building and sustaining affordable and efficient medical

services? How can we link emergency care capacity into a national response network to meet the full range of critical care demands from the predictable to a pandemic?

I look forward to a discussion with our witnesses today on these difficult questions. I am especially pleased to welcome Dr. Robert O'Connor, professor and chairman of the department of emergency medicine at the University of Virginia. He is widely regarded as one of our Nation's leading EMS physicians, and we are very grateful for his time and insights as we explore these urgent issues. Thank you.

Mr. CUMMINGS. Thank you, Mr. Davis.

[The prepared statement of Hon. Tom Davis follows:]

HENRY A. WAXMAN, CALIFORNIA
CHAIRMAN

TOM DAVIS, VIRGINIA
RANKING MINORITY MEMBER

ONE HUNDRED TENTH CONGRESS
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Statement of Rep. Tom Davis
Ranking Republican Member
Committee on Oversight and Government Reform
"Response of the Department of Health and Human Services to the Nation's Emergency Care Crisis"
June 22, 2007

Good Morning. I want to thank Chairman Waxman for convening this hearing on a timely issue. We all know the value of a functioning emergency room. Millions of lives are saved annually only because emergency care is available.

But across America, it's critical care services that are in critical condition. Last year, a study by the Institute of Medicine (IOM) concluded our hospital-based emergency medical system was "at the breaking point." Emergency rooms are finding it impossible to meet growing and competing demands for: trauma care, mandated safety net care for the uninsured, public health surveillance, and disaster readiness. The IOM panel found emergency care capacity suffering from an epidemic of crowding, with patients parked, or "boarding," in hallways waiting to be admitted. Ambulances are routinely diverted to more distant facilities.

While demand for EMS facilities grows, the number shrinks, and those still open find it increasingly difficult to retain on-call specialists and meet standards for timely care. The inevitable, tragic result: preventable deaths as critically ill patients literally die from neglect in hallways and in ambulance bays waiting for the life-saving help that never comes.

The simple truth is emergency care can and should be better. But legal, financial and demographic trends have converged to punish the success of hospital emergency departments transformed by federal law into the *de facto* primary care provider for millions of the under- and uninsured. That unfunded mandate creates powerful incentives to close emergency rooms or limit admissions so the capacity to perform elective, fully-reimbursed procedures will not be reduced. Low reimbursement rates and high malpractice premiums also work to keep needed specialists – neurosurgeons, orthopedic surgeons and pediatricians, among others – from taking emergency and trauma patients.

The anemic state of emergency medical services means most hospitals are already operating at or near capacity every day. A highway crash involving multiple casualties can overwhelm not just one but all nearby hospitals because no one has information about the real-time availability of emergency beds in the region. Such a fragile, fragmented system holds virtually no surge capacity in the event of a natural disaster or terrorist attack.

This Committee has held several hearings on pandemic planning and preparedness. A constant concern that emerged from those hearings was the lack of surge capacity in our nation's hospitals. We have made great strides in homeland security since 9/11, but our public health infrastructure, particularly emergency medical response capacity, is still not ready for prime time. When the influenza pandemic erupts, as many predict it will, more than half a million American could die and over 2 million could need to be hospitalized. In any large-scale public health crisis, emergency rooms would be overwhelmed by the genuinely sick hidden within waves of the "worried well."

The growing crisis in the emergency room compels us to ask: How do we plan to move from the current inadequate emergency care structure to the coordinated, regionalized, scalable and transparent system we know we need? What is the federal role in building and sustaining affordable and efficient emergency medical services? And how can we link emergency care capacity into a national response network able to meet the full range of critical care demands – from the predictable to a pandemic.

I look forward to a discussion with our witnesses today on these difficult questions. I am especially pleased to welcome Dr. Robert O'Conner, Professor and Chairman of the Department of Emergency Medicine at the University of Virginia. He is widely regarded as one of our nation's leading EMS physicians and we are grateful for his time and his insights as we explore these urgent issues.

Mr. CUMMINGS. It is my understanding that Ms. Watson has an opening statement. Ms. Watson, you are recognized for 3 minutes.

Ms. WATSON. Thank you, Mr. Chairman, for holding today's hearing. It is so relevant to constituents in my district in Los Angeles, the 33rd District.

We are going through a very serious crisis in our emergency care system. A functional emergency and trauma care system is important for all communities to deal with and respond to disasters, and we must remember that these emergency care centers are not only for those patients who use them on a day-to-day basis, but they are what our Nation will rely on if a natural disaster or a terrorist attack occurs.

This sector of the health care system is one of the most important aspects of our homeland security. As pointed out in the majority memo on May 19, 2007, you heard about the 40-year-old woman who collapsed on the waiting room floor at Martin Luther King Hospital, and her pleas for help were ignored, and she died 45 minutes later.

This hospital serves a major portion of my constituency who has no insurance and who does not have access to any other means of health care. This incident was not the only one reported at the former King/Drew Hospital, and definitely not the only occurrence in many emergency rooms across the Nation. What are we showing the world by letting our citizens die in emergency rooms in the wealthiest Nation in the world?

The three Federal departments, DOT, DHS and HHS, that are responsible for the oversight of emergency and trauma care must start working together to make the system work better. I am sure there is along list of oversight errors and omissions that point to the core of many of the problems we are discussing today. I hope that by addressing this issue, it is not too little and not too late.

Hospitals in our Nation's urban areas have been plagued for years. They have been underfunded for so long that they cannot attract the type of doctors and nurses they need to run a high-quality hospital, and, in turn, due to a poor reputation, you limit the number of talented health care professionals you attract, creating a downward spiral.

Mr. Chairman, having hospitals such as King-Harbor in my community, even in the condition it is in, is better than not having a hospital at all. The risk of getting inadequate health care is outweighed by the potential loss from having to drive an extra 20 minutes to get care at any other hospital, leading to overcrowding at those other hospitals.

So I am looking forward to hearing from the witnesses, and I hope that we can get some answers so that we can remove the many risks that accrue to our public.

Thank you so much, Mr. Chairman.

Mr. CUMMINGS. Thank you, Ms. Watson.

[The prepared statement of Hon. Diane E. Watson follows:]

Opening Statement
Congresswoman Diane E. Watson
Oversight and Government Reform Full Committee Hearing
"Response of the Department of Health and Human Services to the Nation's Emergency Health Care Crisis"
June 22, 2007

Mr. Chairman, thank you for convening today's hearing. This hearing is particularly relevant to my constituents in the 33rd District of California because we are going through a serious crisis in our emergency care system.

A functional emergency and trauma care system is important for all communities to deal with and respond to disasters. We must remember that these emergency care centers are not only for those patients who use them on a day to day basis; but they are what our nation will rely on if a natural disaster or terrorist attack occurs. This sector of the healthcare system is

one of the most important aspects of "Our Homeland Security."

As pointed out in the majority memo, on May 9, 2007, a 40-year old woman collapsed on the waiting room floor of the emergency room at the Martin Luther King-Harbor Hospital in Los Angeles. Her pleas for help were ignored and she died 45 minutes later.

This hospital serves a major portion of my constituency who have no insurance and do not have access to any other means of healthcare. And this incident was not the only one reported at the former King-Drew hospital, and definitely not the only occurrence in many emergency rooms across the nation. What are we showing the world by letting our citizens die in emergency rooms in the wealthiest nation in the world?

The three federal departments (DOT, DHS, and HHS) that are responsible for the oversight of emergency and trauma care must start working together to make the system better. I am sure there is a long list of oversight errors and omissions that points to the core of many of the problems we are discussing today.

I hope that by addressing this issue here today, it is not too little, too late. Hospitals in our nation's urban areas have been plagued for years. They have been under funded for so long that they cannot attract the type of doctors and nurses they need to run a high quality hospital. And, in turn, due to poor reputation, you limit the number of talented healthcare professionals you attract, creating a downward spiral.

Mr. Chairman, having hospitals such as King-Harbor in my community, even in the condition it is in, is better than not having a hospital at all. The risk of getting inadequate healthcare is outweighed by the potential loss from having to drive an extra twenty minutes to get care at another hospital, leading to overcrowding at those other hospitals.

I hope that today we will find answers to the questions that may be putting many Americans in danger. While we are here evaluating the efficacy and safety of our emergency health care system, we need to focus on the major problem at hand; the errors in three one of our nation's most important federal departments. I thank our witnesses for testifying and I yield back.

Mr. CUMMINGS. What we will do now, without objections, we will recess because we have two votes. We have about 5 minutes left for the first vote, and then another vote will come immediately thereafter. I anticipate that we should be back here at quarter of the hour. Until then, we will recess.

Thank you, witnesses, for being patient with us. We will move this along as fast as we can. Thank you.

[Recess.]

Mr. CUMMINGS. Thank you all for waiting. We will resume the hearing now.

The committee will now receive testimony from the witnesses before us today. Our first panel consists of three distinguished experts in emergency and trauma care. Dr. William Schwab is professor and chief, division of traumatology and surgical critical care at the University of Pennsylvania Medical Center in Philadelphia. Dr. Ray Johnson is associate director of the department of emergency medicine, Mission Hospital Regional Medical Center, and director of pediatric emergency medicine, Children's Hospital, Mission Viejo. And Dr. Bob O'Connor is professor and chairman, department of emergency medicine, University of Virginia, Charlottesville.

Gentlemen, would you please stand to be sworn in.

[Witnesses sworn.]

Mr. CUMMINGS. I just remind you that we have your statements, your written statements, and we would just ask you to summarize within 5 minutes if you can. Then we will have questions.

Dr. Schwab.

STATEMENTS OF WILLIAM SCHWAB, M.D., FACS, PROFESSOR AND CHIEF OF DIVISION OF TRAUMA AND SURGICAL CRITICAL CARE, UNIVERSITY OF PENNSYLVANIA MEDICAL CENTER, PHILADELPHIA; RAMON JOHNSON, M.D., FACEP, ASSOCIATE DIRECTOR, DEPARTMENT OF EMERGENCY MEDICINE, MISSION HOSPITAL REGIONAL MEDICAL CENTER, DIRECTOR OF PEDIATRIC EMERGENCY MEDICINE, CHILDREN'S HOSPITAL, MISSION VIEJO, CA; AND ROBERT O'CONNOR, M.D., MPH, PROFESSOR AND CHAIRMAN, DEPARTMENT OF EMERGENCY MEDICINE, UNIVERSITY OF VIRGINIA, CHARLOTTESVILLE, VA

STATEMENT OF WILLIAM SCHWAB

Dr. SCHWAB. Thank you, Congressman. I think rather than try to summarize, what I might do is start with a bit of a story, since it is a relatively recent story and something that is very pertinent to the IOM report.

I sat for 2½ years as one of the 40 members of the IOM Commission and spent a considerable amount of time actually deliberating, analyzing, and trying to come up with solutions, both tactical and strategic, to look at this crisis in emergency care. But perhaps this story, more than anything, will make it real for you.

Just 2 days ago I was not on call for emergencies. There is a group of nine of us at the University of Pennsylvania, surgeons that do all the emergency surgery and all the trauma care. We are a Level I trauma center, we are one of the city's safety net hos-

pitals, and we are one of the hospitals that in a disaster for the greater Philadelphia area—a population of about 15 million people—would go into action.

2:30 in the afternoon, just a normal day, I had a call from my fourth partner, also not on call, to go to the emergency department to run a fifth room. I walked down to the emergency department and walked through our unit, and in that emergency department there were people everywhere on stretchers. There were patients in chairs. The emergency physicians, our strongest colleagues and friends, were administering to people.

And this wasn't a mass disaster, this was a fairly typical day with the exception that we had just been notified that, in fact, on Route 95 there was a significant crash, probably a few mortally wounded, and other people being brought in by helicopter and by ambulance.

I went into our trauma bay, very similar to that in Nashville or that in Baltimore, and this three-bed unit had five people in it, two people on stretchers who were side by side with three other people. And as we started to take care of the patients coming in from this terrible wreck and this collision, we had 30 seconds' warning that the Philadelphia Fire Department was bringing in yet another person, and that was a trauma code. It was a young man who had received a gunshot wound. And in the middle of that mayhem, I opened his chest, and I started to pump his heart. I tried to resuscitate him.

Now that is all part of our life in this business, but what is interesting is I looked up and I recognized that as I was doing that, about 40 feet away from me, watching me, were people brought in for routine care and other emergencies.

What was most interesting about this is you might say that is just Philadelphia, it is a big city, and it is like any other city, Los Angeles, Washington, or Atlanta. But that morning I had been on the phone thanking someone at Strong Memorial Hospital in Rochester, NY, because last week my brother-in-law, 63-year-old retired teacher, an All-American football player in his prime who had lost his kidneys a few years ago to a terrible infection, and a renal dialysis patient for years, had just been transplanted. He was home, became ill, and went back to Strong Memorial. But he could not be admitted, because the emergency department had 40 or 50 people waiting to be admitted in Upstate New York, where I grew up, in beautiful downtown Rochester.

I couldn't believe it. But having spent 2½ years on the IOM trying to find solutions for the government and for us to take on the emergency care crisis, you have to believe it. It is universal, it is a terrible problem, and it is a hidden problem. It has been swept underneath the rug continuously, and it may be being swept under the rug because people believe there is no good way to solve it, and the only way to solve it is throw money at it. I will tell you the IOM did not conclude that, and our recommendations came after some thousands of hours of deliberation and looking at things.

I have to also tell you that as I walked through the emergency department, I saw teams of specialists down there, cardiology, neurology, but the one that really frightened me was an infectious disease specialist. This friend of mine in the infectious disease depart-

ment is a virologist, a virus expert. And after I finished with the emergency thoracotomy, and I was walking out to do my paperwork, I thought of all the things I am afraid of. What I am afraid of the most is that virologist was seeing something, and it was a virus, and that it was sitting in the middle of our emergency department with all those hundreds of people.

There is no way that simple solutions will fix this. This is going to take a concerted effort.

I would like to end by saying that I am absolutely shocked that there hasn't been more done in the past year, even just simple communication about how we could help our government agencies and how we can partner as health care, medicine, and nursing to help fix this.

We do need to look at better coordination from the government. We truly believe at the Institute of Medicine and in our committee, that it is spread out to too many agencies. There is no one agency that is responsible, there is no champion for emergency care. We believe that the whole system has to be looked at, and we believe that there has to be substantial thought, redesign, and reengineering—not of the system, but of things like why patients wind up in the emergency department when they could go to primary care.

We felt that we needed to look at making hospitals and EMS systems accountable. We just weren't going to make recommendations to you from the Institute of Medicine that said, do this for us. We want to make the system accountable. And we looked for one of the best successes in medicine to fix it, and that is the trauma system.

Trauma systems have been around for about 30 years. They actually come from the experience we had during Vietnam, and that military system was transformed and translated into civilian trauma care systems. Trauma systems are regionalized, they are accredited, they are credentialed, and they are accountable, because they report their results to the public and to the government. The Institute of Medicine in its interdisciplinary committee put this at the center of the committee report, to redesign emergency care based on regional systems that are accountable, and they report their outcomes. I think that is an important thing.

Last, there were two things that came about during the 2½ years that I served in the Institute of Medicine that I think you are aware of. One you are very aware of, and that is the inability of the health care system and specifically the emergency care system to respond with surge capacity for mass casualties and disasters. If on Wednesday afternoon we had another van or school bus crash, only the dedication and commitment of the nurses and physicians would have taken care of those patients, because we had no room.

You know about that. You know about that because of some of the hearings that have taken place, that emergency care cannot respond. We don't have the capability to do it, we don't have the capacity to do it.

The other one that I think is quite frightening, that the Institute of Medicine discovered, is the work force issues. If you look beyond the emergency department, there is a tremendous crisis developing on the surgical side to staff the in-house care that must take place after the emergency department care ends.

One of the biggest things that we revealed is, in fact, after the emergency physicians resuscitate—many specialists including cardiologists, and surgeons, are called to render care and complete care within the hospital. The shortage of physicians and specifically surgeons that are responding to emergencies is concerning. And in the future, as we try to cope with caring for about 80 million boomers, the shortage of surgeons is a profound thing in this report that needs to be addressed.

Thank you, Mr. Cummings.

Mr. CUMMINGS. Thank you very much.

[The prepared statement of Dr. Schwab follows:]

The State of Emergency Care for America: at the Breaking Point, In Need of Resuscitation and Going Nowhere

Testimony of
C. William Schwab
before the
Committee on Oversight and Government Reform

U.S. House of Representatives
June 22, 2007

INTRODUCTION

I have been a surgeon at an academic medical center for the past 27 years. My primary interest has been in trauma care and trauma services development. I have established three Level I trauma centers and helicopter programs to support regional emergency and critical care systems in three different states: Virginia, New Jersey and Pennsylvania. Additionally, I have acted as a consultant to help more than a dozen hospitals develop trauma care and trauma services. At the state level, I served on Governor advisory committees and initiatives to advance the trauma and emergency systems in the 80's, 90's and for five years served on the Board of the Pennsylvania Trauma Systems Foundation, heading a committee on standards for the state-wide trauma system in Pennsylvania. Federally, I was a member of the ad-hoc Committee on Model Trauma Systems & Plan for the Department of Health & Human Services/ Health Resources and Services Administration in 1992, and co-author of a position paper on Trauma Systems that resulted from a committee for the Center for Disease Control's "National Agenda for Injury Control in the 1990's." And lastly, from 2003-2006, I was one of two surgeons to serve on the Committee on the Future of Emergency Care for the Institute of Medicine. As an aside, Congressman Waxman, this is my second visit to your committee. In the late 80's, I testified about the escalation of gun violence and death in our cities and its effects on health. Thank you for the privilege of speaking with you again.

SUMMARY

There is a crisis in delivering emergency care to our population. Emergency care is defined to encompass the full spectrum of services involved in emergency medical care. This includes Emergency Medical Services, hospital-based emergency and trauma care, on-call specialty care, bystander care, and injury prevention and control. While the demands on emergency and trauma care have grown dramatically, the capacity to handle such demands has not kept pace. This problem is universal in the United States and the response, solutions, and willingness to put time and effort to solve this crisis seem miniscule in relation to the crisis itself. Our citizens seem better informed and more worried than our government and its leaders. In fact, the July 2007 Consumer Report identifies the emergency care crisis as the latest challenge facing U.S. consumers today.

In June of 2006, after two and a half years of interdisciplinary study, analysis and debate a group of experts delivered its report on the Future of Emergency Care for the U.S. Health System. This three-volume collection is one of the largest undertakings conducted by the IOM and represents a range of problems almost too big to tackle. For that reason,

the task force was divided into three areas: Hospital Based Emergency Care, Emergency Medical Services, and Emergency Care for Children. Each is a separate, but coordinated report with synchronized goals and recommendations. The contents of this report are sobering, and its recommendations are profound. Similar to its predecessors of 1966 and 1985 (Accidental Death and Disability: the Neglected Disease of Modern Society and Injury in America), the intent was to improve the emergency and trauma system throughout the United States. The hope was that this long overdue report would catalyze a collaborative effort by government, healthcare, taxpayers and citizens to fix a badly broken system. Unfortunately, the response has been, in my estimation, almost nothing. There has been perhaps some transient coverage in the media, several dissemination meetings in various parts of the U.S., but no response has come from our government. Despite efforts by all constituents, little seems likely to be done to begin to manage the biggest crisis in American healthcare.

The report comes in response to an epic crisis in America that is already a decade in the making. Because of other catastrophic events that have struck our country, this crisis has been put "out of sight and out of mind." Yet the weakness, frailty and even failure of the system to function as our country's "safety net" permeates the record of how we responded to these natural and intentional catastrophes. Both 9/11 and Katrina, and even the War in Iraq, serve as snapshots of how poorly prepared, coordinated, staffed and capable emergency and trauma care are to respond to our greatest needs. While government think-tanks and policy effectors struggle with how to design a response for the next disaster, little attention is paid to the substantial data and numerous reports that show what emergency care facilities can be on a day-to-day basis: overloaded and crowded with non-emergencies, diverting ambulances, and boarding critical patients for days to gain access to hospitals. As the basic foundation of the "safety net," emergency care is in need of major resuscitation and an infusion of resources. To expect our emergency and trauma centers to shoulder the load in a disaster of 200, 2000, or more patients under the current conditions is unrealistic . . . and dangerous for us all.

In 2003, the IOM brought an interdisciplinary group together and began to analyze the strengths and weaknesses of emergency care. Early on, it became apparent that the crisis we were being asked to fix was accompanied by some remarkable successes in American medicine—the most notable being the consistent dedication and commitment by professionals who unselfishly give beyond the call, night and day. Other remarkable successes include the development of Emergency Medical Services, the growth of Emergency Medicine as a specialty, and the considerable advances in biomedical research and their applications to emergency care over the past 40 years. *The other success and theme that would become central to creating the vision of the future was (and is) the regional trauma systems.* Perhaps no system in medicine better displays the comprehensive linkage of components, use of national standards and guidelines to provide consistent high-quality care, performance improvement to optimize care, and public dissemination of outcomes and verified accomplishments, as do these regional trauma systems. Despite these successes, all evidence points to a fragmented, overworked, stressed, underpaid, undervalued emergency workforce. This system and its professionals, including trauma surgeons, must cope with 24/7 readiness and an inability to limit access

to non-emergencies and minor injury. This, coupled with the increasing burden of the uninsured and underinsured, drains financial resources away from sustaining, much less improving, the real emergency system. As important, is the increasing lack of hospital-based specialists who are not available or choose not to participate in covering the emergency needs of patients. The reality of emergency care is far from what is portrayed by our television or movies. Real "emergency" is at a breaking point!

As if that is not enough, the exponential increase in demands over the next 20 years that the emergency care system will need to cope with are even more startling. They provide a compelling argument for drastic change. As the Boomers retire, some 73 million people will pass into their seventh decade. This group of individuals will live longer, be more active and demand more health care than any other group of people within a narrow older-age range that have ever occupied the earth. Their need for emergency and trauma care will also increase. If one factors this demographic into the already 114 million emergency department (2004) visits per year, the problem of assuring universal emergency care becomes daunting. One area in the report that is especially challenging is the increasing shortage of surgeons to provide emergency and trauma care. When linked with the manpower studies already documenting a profound shortage of several surgical specialties, this projects a devastating crisis for emergency patients in the near future. General surgery, neurosurgery and orthopedic surgery shoulder a large portion of the emergency and trauma care responsibility. These three specialists are the key to the surgical response for trauma care and more importantly, are the necessary surgical experts to save the life of an injured patient. General surgery, and especially trauma and surgical critical care-trained general surgeons and neurosurgeons, have the greatest shortfall in manpower production.

In two recent surveys of emergency departments nationwide, two-thirds to almost three-quarters of all ED directors or administrators report worrisome shortfalls in specialists, especially surgical specialists. Approximately one-fifth of staff said they would seek care at another hospital because of the lack of a specialist on call. A key message within the IOM report is the need for a broad-based surgical emergency specialist with skills in surgery, critical care, organization, and teamwork. This should be a surgeon who is knowledgeable of the emergency system and an expert working in and with it. The need for this acute care or emergency surgeon is apparent now and vital for any future emergency care system, as are more committed general surgeons, orthopedists and neurosurgeons.

RECOMMENDATIONS

In drafting the recommendations, the need for interdisciplinary collaboration between (and within) medicine, public safety and health, government and payers to fix the crisis is the key to success. In addition, central to the vision for the emergency and trauma care system of the future are three core principles: coordination, regionalization and accountability. Any patient, regardless of geography, environment, age or problem should expect to have a seamless "system" of components that guarantees their care and transport to the most appropriate facility. Professionals within emergency care must be well-trained across the life spectrum, especially for children and emerging special

populations. All components and resources must be coordinated throughout the system to assure concurrent availability of the necessary resources. Similar to the current regional trauma systems in some areas of our country, most hospitals will have key local roles in delivering emergency care, and after stabilization, moving patients to higher-level or special levels of care, if needed. As important, all providers and the system of emergency and trauma care will be accountable for what they do. This will require strong performance improvement and reporting to the public to demonstrate that emergency care is high-quality, safe and a good return on their investment. Each recommendation is aimed at a target group that the IOM felt had the power, authority and financial control to implement the recommendations brought forth.

The vision throughout is to create a regional, coordinated, high quality and safe emergency system that is built on evidence-based practices and meets national standards for all providers and system components. It is a system that works across all the traditional turf lines, whether geopolitical or medico-political. The report calls for changes in how we fund these systems and all emergency care. It calls for immediate action, money to offset losses from uninsured care, funding to establish pilot projects, and urges government to change EMTALA. It recognizes and embraces emergency and trauma care as a unique part of medicine and public safety, which is the key to disaster response and therefore requires a single lead agency in the federal government to coordinate all aspects. In addition, the recommendations call for Congress to immediately initiate a task force on the workforce needs to staff the emergency and trauma care system of the future and to direct CMS (Medicare) and the third-party payers to reexamine the funding for emergency care. Other recommendations call for re-evaluating and changing the current HIPAA regulations that prevent flow of patient care information in an emergency situation. The vision for the 21st Century is built on widespread implementation of information technology, training and education and assurance of core competencies for all providers throughout the system. Of great importance, it directs distinct and dedicated efforts to examine the need for funding scientific investigation in all areas of emergency and trauma research and injury control. This space does not permit a more in-depth explanation of the special needs to assure a well-coordinated, educated, and funded Emergency Medical System and the special needs to care for our young. However, those two reports are just as compelling.

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Mr. CUMMINGS. Dr. Johnson.

STATEMENT OF RAMON W. JOHNSON

Dr. JOHNSON. Mr. Chairman, members of the committee. I want to first start by giving you an idea of my practice environment because I don't work in an inner city or a highly urbanized area. I work in a suburban emergency department that sees approximately 45,000 to 50,000 visits a year. We also function as a satellite children's facility, so approximately 40 percent of our volume are children.

I want to tell you that even in our sleepy suburban community, which I believe is typical of almost every community of America outside of the urban setting, I am in an environment that continues to be understaffed. We are underfunded. We are overworked, overwhelmed, and overcrowded.

I want to address each one of those things for you. First of all, let me give you a story. It was interesting listening to Dr. Schwab talk about his experience. My experience is a little bit more profound than that, because 1 day when I was working in the emergency department, a frantic mother brought in a child who was choking to death and was blue, and I did not have even a single bed available in my emergency department.

I debated for a few seconds, should I just put the child on the floor in order to try and open the airway? I did not have a bed. Fortunately, because of the dedicated staff we work with in our emergency department, the nurses were able to scramble a patient out of a bed and pull the bed over to the middle of the emergency department hallway, where I pulled an apricot pit out of this child's trachea.

It struck me then and there when I looked up, and you are kind of "adrenalinized" at that point—you look up and see about 30 people looking at you, most of them are patients, some of them sitting with their gowns that are kind of open in the back, so it makes for an interesting sight as well.

I am here to tell you that even in my sleepy community of Mission Viejo, CA, a suburban area, there are days when I don't have adequate resources to take care of my patients.

One of the big problems that we are facing, I think, in this country is an explosion in the volume of patients we are seeing. In my area, for example, we have had a tremendous growth in population because of construction, and I understand that we are not the only area of the country that is seeing that kind of explosion. But one of the problems that we are seeing is the lack of infrastructure to help support that explosion in population growth. So as a result, we are confronted with the issue of overwhelmed, overcrowded emergency departments every day.

We also have a situation where we also have patients that are literally living in our emergency department for more than a day at a time. We have psychiatric patients sitting in our emergency department because we cannot get resources to them or there aren't beds in my immediate area to send those patients to.

Most people have this misunderstanding about overcrowding in emergency departments. I would like to dispel that myth once and for all, here in this committee. Overcrowding in emergency depart-

ments is not due to patients who have minor problems coming into the emergency department. It is due to patients who are sick, sitting in beds in my emergency department, when there are no inpatient beds, no capacity in the hospital, to get them upstairs. So I can't get new, incoming patients back into my emergency department.

That means that I have to contact my charge nurse and let her know when I don't have any beds any longer because they are full of inpatients in my department. I have to let her know that ambulances cannot come here. So that means, although we are a cardiac receiving center, we have a cath lab available 24 hours a day to take the sickest cardiac patients in my community, I cannot get them into my hospital emergency department because I don't have a bed for them. So I have a hospital with tremendous capabilities, tremendous talent, tremendous dedication, and I cannot get these patients to my facility to take care of them.

All I ask of you, all I ask of this committee and of the Federal Government, is to help me do what I do best, and that is save lives and take care of patients. I cannot do that unless we have the resources.

I think the Institute of Medicine report laid it out very clearly. We are underfunded, we don't have adequate resources. We are talking about a surge capacity; there is no surge capacity left within our hospital environment. By the way, my hospital is located approximately 30 minutes north of a nuclear power plant, and I can guarantee you if there is anyplace that needs surge capacity, it is my facility. It just does not exist.

Let me summarize by saying the American College of Emergency Physicians has over the last few years brought this to the attention of everyone we could possibly bring it to. We have had a rally on the lawn of the Capitol, had surveys that have been put together, and we have even introduced a bill, the Access to Emergency Medical Services Act of 2007.

I know this is an oversight committee, but the fact of the matter is that we are making every effort to try and come to solutions that will help solve this problem. But, once again, my sleepy community town is, I think, average America. And if we are seeing the same problems that urban and suburban environments are seeing all over this country. We should all be very, very afraid of what is happening. We really need to do something, and do something quickly. Thank you.

Mr. CUMMINGS. Thank you very much, Dr. Johnson.

[The prepared statement of Dr. Johnson follows:]

Statement of

Ramon W. Johnson, M.D., F.A.C.E.P.

Mission Hospital
Mission Viejo, California

American College of Emergency Physicians (ACEP)
Board of Directors

before the

House Committee on Oversight and Government Reform
U.S. House of Representatives

Hearing on

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

Presented
June 22, 2007

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.
>
> 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.
>
> 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.

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

Mr. CUMMINGS. Dr. O'Connor.

STATEMENT OF ROBERT E. O'CONNOR

Dr. O'CONNOR. Thank you very much, Mr. Chairman. I was struck by the opening comments that I heard several of you make, Congressman Davis, Congresswoman Watson, and Congressman Cummings. I agree with everything you said, and I am struck by the uniformity of recognition that our health care system, our emergency health care system, is in a state of disarray.

I look back at my own career. I have been in practice for over 20 years. I have been involved in the medical direction of prehospital care for just about as long; the instruction of prehospital care providers perhaps longer. I wanted to try to tell what my views were about how we have gotten to the place we are at today.

What I have seen throughout my career are tremendous strides in care. We take care of patients with myocardial infarction, heart attack right now, when we used to have no other treatment options other than to provide comfort measures only and not truly offer definitive care. We have made tremendous strides in trauma care, in stroke care, and the list goes on.

However, we are hampered by our ability to provide that care. We have state-of-the-art technology, and yet we are practicing in a non-state-of-the-art environment where patients who are just hapless bystanders witness things that perhaps they should not see in a crowded emergency department environment.

The conditions in an emergency department, we have the tools to provide the best care that we can. The environment is so crowded that it sometimes creates a major obstacle to that. I look back on my career with EMS and prehospital care, it was sparked by funding that goes back really into the 1970's, prompted by the National Academy of Sciences report, "Trauma: The Neglected Disease of Modern Society." Over that time, the initial funding was at quite a high level. In 2007 dollars, it is about $1.5 billion. It was $300 million at the time. That has since dwindled. While a solution to the problem is not to throw money at it, I do think increased funding for EMS would be one possible solution.

The second part is to look at some of the funding agencies that provide care for EMS and to see how best to spend that money. If you look at certain EMS programs, the rural EMS grant program exists to support training and equipment for smaller communities. That has since been eliminated. If you look at the Trauma Systems Planning grant, that has also been eliminated. The EMS for Children [EMS–C] program has to continually fight for funding year in and year out, and it is only through the focused effort of Members of Congress that this program has sustained funding from year to year.

Regarding one of the recommendations from the Institute of Medicine report, it was to establish a lead Federal agency, I have some comments in my written testimony regarding that. There currently exists the Federal Interagency Committee for EMS, which is the ideal body, really, to look at how to establish a lead agency. I think it is essential that we have a lead agency in the Federal Government, one to champion EMS causes.

If you go back to the fall of 2001, September 11th specifically, the public concern over our preparedness for terrorism, mass casualty events resulted in funding for police and fire and other agencies. EMS was notably absent from that funding pool. While I strongly believe that we need to have public safety—strong public safety resources such as police and fire—I also think that EMS is in a unique position where they work at the intersection of public safety plus public health. In fact, EMS is the integration of public safety with emergency health care.

So in closing, I would like to thank everyone for your efforts. We in emergency care take pride in what we do. We, I believe, provide excellent care to patients. We are somewhat hampered by the resources we are given and the demands on our time and effort. If we are given the opportunity to and the resources to improve that care, we will welcome that opportunity. So thank you.

[The prepared statement of Dr. O'Connor follows:]

Testimony
Robert E. O'Connor, MD, MPH
House Committee on Oversight and Government Reform
June 22, 2007

Chairman Waxman, Ranking Member Davis, I would like to thank you for holding this hearing today on the Department of Health and Human Services'(HHS) implementation of the recommendations from the Institutes of Medicine (IOM) recently published series of reports on the future of emergency care in the U.S.

I currently serve as President of Advocates for EMS, a not-for-profit organization founded to educate elected and appointed officials and the public on important issues affecting EMS providers. Our membership is comprised of 31 EMS-related organizations and represents all facets of emergency medical services. In addition, I am the Immediate Past President of the National Association of Emergency Medical Physicians (NAEMSP) and am the incoming Chair of Emergency Medicine at the University of Virginia.

The EMS community has long been concerned about emergency medical services getting lost in the shuffle at the federal level. The IOM recommends a national effort to address the crisis in the nation's emergency and trauma care system through improved coordination, expanded regionalization, and increased transparency and accountability. In its publication titled "Emergency Medical Services at the Crossroads,[1]" the IOM reports that "EMS is widely viewed as an essential public service, but it has not been supported through effective federal and state leadership and sustainable funding strategies.[2]"

For the past 20 years, federal support for EMS has been both scarce and uncoordinated. In fact, following the September 11th attacks, when the country focused its attention on all terrorism preparedness, first responders were described as police, fire, and "other". In conjunction with police and fire, EMS is the primary first responder for medical assistance in the event of a natural or man-made disaster or public health emergency. However, unlike with police, fire and emergency management, there was a lack of coordination at the federal level and no dedicated program to support EMS infrastructure or disaster response. Currently, a number of federal agencies are involved with EMS, though most focus on just one segment of the EMS system.

In 2001, the General Accounting Office (GAO) cited in its report *Emergency Medical Services: Reported needs are Wide-Ranging with a Growing Focus on Lack of Data,* the need to increase coordination among federal agencies as they address the needs of regional, state or local emergency medical services systems.

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[1] Institutes of Medicine of the National Academies, "Future of Emergency Care: Emergency Medical Services at the Crossroads," Washington DC: May 2007.
[2] IOM, page 41.

During the 108th and 109th Congress, the EMS community worked closely with members of both the House and Senate to authorize the Federal Interagency Committee on Emergency Medical Services (FICEMS) that would serve to coordinate the various Federal agencies that are involved in EMS, including HHS, the Department of Homeland Security (DHS) and NHTSA at the Department of Transportation. On August 10, 2005, the FICEMS was signed into law as part of H.R. 3, the Safe, Accountable, Flexible, Efficient, Transportation Equity Act – A Legacy for Users (SAFETEA-LU). The new FICEMS is beginning its work this year.

The new, fully-formed FICEMS is the ideal body to consider the lead agency issue and fully form a consensus on how to best organize and perhaps realign federal support of EMS systems. It will greatly enhance coordination among the federal agencies involved with the state, local, tribal and regional emergency medical services and 9-1-1 systems and help assure that Federal agencies coordinate their EMS-related activities and maximize the best utilization of established funding. In addition, the FICEMS is required to submit an annual report to Congress to help provide members of Congress with information on emerging Federal EMS issues.

HHS Funding Support for EMS Systems Development

Currently, there is very little funding support for EMS at the federal level. The vast majority of funding for EMS comes from the Centers for Medicare and Medicaid Services in the form of below cost reimbursement for ambulance runs. Outside of that funding source, there is very little federal discretionary funding dedicated to the development of EMS systems for daily operations or disaster preparedness.

There used to be a few, small EMS programs at HRSA that were recently eliminated in the appropriations process. A rural EMS grant program existed to support training and equipment for smaller communities and it was eliminated in the FY 2006 Labor HHS appropriations bill. The Trauma Systems Planning grant program had $3 million and was eliminated in that same year. The program was reauthorized this year and we are hopeful that Congress will provide some funding for this vital program. There remains a $20 million EMS for Children program at HRSA that focuses on pediatric emergency medicine.

Historically, HHS used to provide significantly more resources for EMS. As stated in the recent IOM reports, in 1973, Congress enacted the EMS Systems Act, which created a new grant program to develop regional EMS systems which at the time did not exist. In total, more than $300 million was appropriated at HRSA for EMS planning, operations, expansion, improvement and research. This is equivalent to over $1.5 billion in today's dollars. In 1981, under the Reagan Administration, the Omnibus Budget Reconciliation Act eliminated this categorical funding for EMS to states and folded the funding into what is now the Preventive Health and Health Services Block Grant at the Centers for Disease Control and Prevention where states 16 states spend approximately $8 million of the total $99 million block grant on EMS. I should note that the last three Administration budget requests have proposed elimination of this block grant program, but the Congress has restored this funding in the final appropriations bill.

Clearly more dedicated federal funding support for EMS is needed within HHS to support EMS systems development for daily operations and emergency preparedness; especially by the historical standard of 26 years ago when there was an emphasis on these critical public health needs.

One of the IOM recommendations to address surge capacity, training and protection of hospitals and staff is for Congress to significantly increase total disaster preparedness funding for hospital emergency preparedness in the following areas:

- Strengthen and sustain trauma care systems;
- Enhancing ED, trauma centers and inpatient surge capacity;
- Enhancing the availability of decontamination showers, standby ICU capacity; negative pressure rooms and appropriate personal protective equipment; and
- Conducting international collaborative research on the civilian consequences of conventional weapons (CW) terrorism.

In addition, the IOM recommended that all institutions responsible for the training continuing education and credentialing and certification of professionals involved in emergency incorporate disaster preparedness training into their curricula and competency criteria.

According to reports issued by the Department of Homeland Security, EMS providers continue to receive less than four percent of approximately $3.7 billion in funding available to first responders in FY 2002, 2003 and 2004 from programs where EMS is eligible to receive first responder grant funding. In addition, EMS receives about five percent of the $450 million Hospital Bioterrorism Preparedness grant funding. Congress needs to make improved disaster response training and equipment for EMS providers a priority. The FY 2007 Department of Homeland Security Appropriations Report requested another report by the Department examining EMS first responder grant funding levels. The report was due on January 23rd of this year. However, the Department has yet to issue the report. The EMS community is eager to review the report.

History of the Medicare Ambulance Fee Schedule

On April 1, 2002, the Centers for Medicare and Medicaid Services (CMS) implemented a fee schedule for the Medicare reimbursement of ambulance services. Under the new fee schedule, ambulance service providers are no longer able to bill any portion of their services at the previous "reasonable charge" rate. The new reimbursement system has resulted in significantly lower reimbursement rates for many ambulance providers nationwide.

Congress took temporary action to help struggling ambulance providers in the Medicare Modernization Act of 2003 (MMA). The MMA language provided desperately needed relief to a majority of the ambulance service providers receiving the largest payment reductions under the Medicare ambulance fee schedule and to ambulance service

providers who serve very rural communities. From 2004-2009, ambulance providers and suppliers may be paid the greater of (1) the national fee schedule, or (2) a blend of the national fee schedule and a regional fee schedule established by CMS. The MMA also included a number of temporary reimbursement increases to further support ambulance providers, including a temporary increase for ground transports, long trip adjustments, and a "super rural bonus." Most of these relief provisions expired in 2006 and none of the relief provisions have adequately addressed the enormous impact the fee schedule is already having on patient access to ambulance services.

Recent reports from government and industry confirm that the average reimbursement levels of the single largest payer of ambulance services, Medicare, are below the average cost of providing the service.

The GAO recently submitted a report to Congress showing negative Medicare margins for many ambulance service providers. The report stated that the average Medicare payments for ambulance services are six percent (6%) below the average cost per transport.[3] As part of the Medicare Modernization Act (MMA) of 2003, Congress requested that the GAO to study the "cost, access, supply and quality of ambulance services under the Medicare program." The average cost per transport reported by the GAO in 2004 was $415 per transport.[4]

Findings of National Studies

Collectively, the GAO, AAA and IOM reports found:

- **Ambulance providers are paid substantially below their average costs to provide medical transportation services to patients covered under Medicare.**
  - GAO = Medicare payments in 2004 were 6% below average cost per transport. Payments were below costs in all three service areas: six percent (6%) for transports in urban areas, one percent (1%) for transports in rural areas and seventeen percent (17%) for transports in "super rural" areas.[5]
  - AAA = Medicare payments in 2004 were 8% below average cost per transport.[6]
- **Medicare's share of transports is greater than Medicare's share of payments.**
  - GAO = Medicare patients represent 40% of total transports while comprising only 31% of total revenue.[7]

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[3] Government Accountability Office, "Ambulance Providers: Costs and Expected Medicare Margins Vary Greatly," GAO-07-383, Washington DC: May 23, 2007, page 24.
[4] GAO, page 24.
[5] GAO, page 24.
[6] AAA, page 26.
[7] GAO, page 11.

- AAA = Medicare patients are the largest share of total transports for ambulance providers, with 44% of total transports, while comprising only 41% of total revenue.[8]

- **Ambulance services provide more uncompensated care than any other major healthcare provider group, including hospitals and doctors.**
  - AAA = The average uncompensated care burden for America's ambulance providers ranges from 10.8% to 16.5% of all ambulance care. By comparison, U.S. hospitals report an average of 5.6% in uncompensated care, while physicians report an average of 4.3%.[9]
- **Medicare reimbursement does not adequately fund the cost of readiness.**
  - IOM = EMS costs include the direct costs of each emergency response, as well as the readiness costs associated with maintaining the capability to respond quickly, 24-hours a day, 7-days a week—costs that are not adequately reimbursed by Medicare.[10]"

Payment Shortfall is Estimated to be Even Greater Than Reported

The AAA estimates that the Medicare payment shortfall is even greater than reported based on the factors below:

- **Volunteer Labor Understates GAO Cost.** The GAO included volunteer ambulance services in the analysis, defined as providers with more than 20 percent of labor from volunteers. The presence of significant volunteer labor understates the estimated average cost of ambulance transports, especially since volunteer labor is prevalent in rural areas.

- **Impact of Uncompensated Care Adds about 3% to the Shortfall.** Neither the GAO nor the AAA estimates includes Medicare's share of uncompensated care. Based on the Medicare bad debt burdens of other health care providers, actual Medicare margins are estimated to be roughly 3 percentage points lower than those shown by the GAO.

- **Need for Capital Reserves Adds about 5% to the Shortfall.** Both the GAO and AAA estimates assume zero margins which are necessary for providers to reinvest in the service's infrastructure, such as finance capital improvements in technology, communications systems, equipment and facilities. Both reports also assume zero reserves for responding to natural disasters or terrorist attacks.

The Impact of Below-Cost Reimbursement

It is critical that the rates of the single largest payer, Medicare, are high enough to cover the costs of an efficient, full-cost, high-quality provider.

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[8] AAA, page 35.
[9] AAA, page 50.
[10] IOM, page 7.

- **EMTs and Paramedics earn almost 30% lower wages than comparably trained personnel working in hospitals and nearly 50% less than other public safety roles.** A comparison of wages published by the U.S. Bureau of Labor Statistics[11] among healthcare workers with similar educational requirements, the average annual wage of EMT/Paramedics in 2006 was $29,390, while the average annual wage of Licensed Practical and Licensed Vocational Nurses in 2006 was $37,530, a 27.7% difference. Similar analysis shows ambulance personnel earn nearly 50% less than police officers and firefighters.
- **Many communities are forced to rely on unpaid staff.** Ambulance providers are unusual due to their substantial use of volunteers. In 2004, two-fifths of the ambulance industry relied substantially on volunteer staff.[12] Chronic below-cost reimbursement, especially in rural and super-rural areas is widely viewed in the industry as a major reason that ambulance providers rely heavily upon unpaid staff.
- **Below-cost reimbursement threatens service quality.** According to the IOM, "overall, the new fee schedule significantly reduces Medicare payments to EMS providers. . . As a result, local EMS systems may now need greater subsidization from local governments or may be forced to reduce costs through personnel cuts, reductions in capital expenditures, or other means.[13]" Furthermore, chronic below-cost reimbursement erodes service delivery over time including increased burn-out of personnel, use of older vehicles and equipment, more expensive maintenance, and inability to reinvest in new technology, lifesaving drugs and emerging medical treatments.

An emergency medical services system serves as the safety net for the local health care system and individuals who call 9-1-1 for an emergency medical services transport when all other sources of help are exhausted. A comprehensive, coordinated emergency medical services system that has adequate resources for staffing, training and equipment is essential to assure prompt, quality care to persons experiencing medical crisis.

On behalf of the pre-hospital and hospital-based emergency care associations and providers we look forward to working with you as you consider this issue further.

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[11] U.S. Department of Labor, Bureau of Labor Statistics, "Occupational Employment and Wages," May 2006: Washington DC.
[12] GAO, page 10.
[13] IOM, page 47.

Mr. CUMMINGS. I want to thank all of you for your testimony. We will go into questioning now, and we will stick by the strict 5-minute rule.

I would like to ask a question of all three witnesses. Since back in 2002 the Congress has appropriated some $2.7 billion to the Department of Health and Human Services to improve the ability of communities to respond to emergencies that cause mass casualties. According to an analysis prepared for this committee by the Congressional Research Service, critics have charged the program over the years with lacking sufficient focus to adequately direct funds in meaningful directions, and with failing to assure that emergency health care services will be available consistently across jurisdictions.

Have the billions of dollars spent by the Department to enhance—that's HHS—to enhance surge capacity for bioterror attacks and other mass casualty events made any difference in your daily practice? Dr. Schwab, we will start with you.

Dr. SCHWAB. Thank you, Mr. Chairman.

It's an interesting thing, if you look at the IOM report and some of the data we looked at, of all those billions and billions of dollars. If I can track this back, only 4 percent ever went actually into the States to look at EMS or look at preparedness.

In response to your question has any of this money affected myself or our trauma center or the emergency department, the answer is categorically no. I don't think we could track a dime into the actual practice at the bedside for making our patient's lives better.

Dr. JOHNSON. I would have to also say no, Mr. Chairman. I sit on our advisory committee for HRSA funding for trauma preparedness in California, and I can tell you that while my hospital bought a tent, it doesn't help my day-to-day ability to take care of patients in the emergency department who are sitting there waiting for a bed upstairs.

Mr. CUMMINGS. Dr. O'Connor.

Dr. O'CONNOR. Of the money you cited of the bioterrorism program, less than 5 percent has gone to EMS during that time period.

Mr. CUMMINGS. Dr. Schwab, you describe the situation has steadily worsened over many years. The crisis has been extensively documented in academic studies, the news media and even the Department's own reports. From your perspective what, if anything, has HHS done to address the problem?

Dr. SCHWAB. I think one of the most important things that I think they have done is they have listened. I wish I could say they have reacted. On the other hand, I have been in this business now for 30 years. Twice during that 30 years I have seen Federal legislation that was directed specifically at emergency, EMS and trauma, and then within a few years I have seen actually that appropriation go away, which means that we had money, we used it effectively, it went away, and we can't make the sustained type of efforts.

I was very heavily involved in the late 1980's and 1990's with HHS in designing the model trauma plan. That was 3 years' funding that was subsequently taken away through appropriations, and

that whole effort failed, and honestly, all of our work really went up in smoke at that time.

So I think there is a complexity here that in order for the government agencies to respond, they have to have money in order to do it.

Mr. CUMMINGS. A lot of people say that money is not necessarily always the answer. You hear that a lot up here. I have often argued that the most important thing is the effective and efficient use of money. And so I think that all of you have talked about money, and I am just wondering, what do you all see? If you could wave your magic wand and you had the money, what would be the most effective and efficient use of it? I will start with you, Dr. Johnson, then go back.

Dr. JOHNSON. First, Mr. Chairman, I would like to say for at least my situation, unless my hospital wants to build more beds with that money, it doesn't really help my situation. More money doesn't help me personally in the emergency department.

What it may do, though, is allow me to get my orthopedic surgeon to come in, because they won't come in to take care of patients who are underfunded. So it may entice them to come in and get my patients out of the emergency department a lot faster.

So unless my hospital wants to build more beds, it doesn't really help me. I will say there is no question in my mind that there are many nurses, for example, who I can't hire for my institution because the cost of living where I live is too high, and the salaries are too low. So if I had that pot of money, the first thing I would do is buy myself about 10 more nurses to be on staff every day because that would certainly help me take care of my patients in a more efficient way.

So, given that money, I would take care of that.

Mr. CUMMINGS. Dr. O'Conner.

Dr. O'CONNER. I think the best way to answer your question, the best way to spend money is to use it in a way where it is leveraged, where it amplifies the amount of money that we are spending. I think if you look at emergency care, systems of regionalization, a demonstration project in that area might be one such means to do that, to look at research so that findings in efficiency and effectiveness of care can be translated across the entire U.S. population, to look at a means of establishing best practices, whether it is through a demonstration program as well.

But I would encourage, in terms of spending money—I mean, money, if there isn't enough, I think in terms of efficiently using it and safeguarding the taxpayers or the fiduciary responsibility—I think to look at the way to leverage the amount of money that is spent in terms of benefits to healthcare would be the way to go.

Mr. CUMMINGS. Dr. Schwab, I just want to go back to something earlier. You talked about the trauma system and how that might be helpful to what we are dealing with. Can you elaborate a little bit more on that?

Dr. SCHWAB. Yes, thank you.

Let me go back again, because I think it is important, because the staff has supplied you all with these references and our written comments constantly refer to the IOM report. The IOM Committee on the Future of Emergency Care worked for a year trying to find

something that worked for a tactical solution, not a strategic solution. And my colleagues to my left actually have already given you some of the successes, but the real success in organizing regional care and delivering one form of emergency care to life-threatened patients was trauma, trauma systems. This has been a three-decade effort led by the American College of Surgeons but endorsed by enabling legislation in some 40 States to create regional centers in which all patients whose life and limbs are threatened are brought to those centers where emergency physicians and trauma surgeons are waiting. They are effective, they are efficacious, and they are cost-effective.

And that is not me saying that or the IOM, but, in fact, the peer review literature. The most recent literature on that topic is in the New England Journal of Medicine. It was a national study. Some of the States were included in this study; some were not.

In the entire national study population it asked the question, "what advantage to the patient whose life is threatened does a trauma system give?" And it was a 25 percent reduction in mortality.

Now, we thought in the IOM that if we could use the trauma system model as a blueprint and apply those components, efficient and effective regionalized—not fragmented—care that is accountable, and apply it to the emergency care system overall, it would be a wonderful tactic to do. And going back to Dr. O'Conner's comments, there is a strong recommendation in the IOM to provide money immediately to set up pilot projects to study the impact of a regionalized emergency care system.

So I think the tactical solution is there in print. It is proven in the field of emergency care, and I think it is doable. And if you asked me what I would do with the money, Mr. Chairman, I would take it and I would fund those projects, those pilot projects, but I would make them accountable for what they are doing; and I would require them to report what they've done—not just to our government agencies, but to you.

Mr. CUMMINGS. Let me ask one more question, and you all may answer this, too.

CMS has proposed a rule that would cut hundreds of millions of Federal Medicaid dollars from securing supplemental payment to hospitals and provide significant amounts of uncompensated emergency and trauma care. The purpose of these payments is to help these hospitals offset the financial losses they incur by providing those services.

Last month, Congress enacted a 1-year moratorium prohibiting CMS from implementing this rule. In this public notice about the rule, CMS officials say, "we anticipate the rule's effect on actual patient services to be minimal." Do you agree with that?

Dr. SCHWAB. I don't agree with that; and I have to tell you, this was a real shocker to all of us. This was a shocker to me; 40 to 50 percent of all the patients that my emergency medical colleagues and I touch have their reimbursement essentially administered under CMS. To in any way give those patients less ability to pay us to cover our costs, many times not even cover our costs, to me is absurd.

What is interesting about this is that CMS should be standing up for the consumer, the patient. And this month in Consumer Reports the back page is entirely dedicated to the consumer in what it calls the greatest crisis in the most threatening part of healthcare, emergency care, and it tells a consumer how to get through an emergency department visit. For us to think that we are going to lose more funding is absolutely absurd at this time.

Mr. CUMMINGS. Dr. Johnson.

Dr. JOHNSON. From what I understand, Mr. Chairman, it has been reported that hospitals lose more money on Medicare patients that come through the emergency department than some other groups of patients. Fifty percent of hospitals report being in the red when they admit patients through the ED that are covered by Medicare. So I do think that CMS, if it can increase funding for those patients, it would actually assist in getting those patients into the hospital more effectively.

Mr. CUMMINGS. Dr. O'Conner.

Dr. O'CONNER. In terms of speaking to the hospital impact of those cuts, as it stands now Medicare's share of transports is greater than the share of payments. Medicare patients represent 40 percent of the total transports, while comprising only 31 percent of the revenue; and to have that money further cut would increase that gap accordingly. Providers pay substantially below their average costs even to provide routine transport. In fact, one other aspect of this is that in general, pre-hospital care providers are reimbursed for transport only, not for the care or specific care that is provided. So I think those cuts would have a dramatic and deleterious impact.

Mr. CUMMINGS. Thank you.

Mr. Davis.

Mr. DAVIS OF VIRGINIA. Thank you. And thank you very much for what you do.

My son had a broken jaw in a Swarthmore-Haverford game. He broke his jaw in a baseball game; and, of course, he had to wait to get a physician that would do it because of tort costs. But we took him to an emergency department, and I had my first experience with Pennsylvania's rules.

Let me ask you, in terms of magnitude, I am going to get an order of magnitude here in terms of the problems and how we can solve it here. Tort laws play a role, there is no question about that, in emergency rooms, mandated emergency care. We are serving people in many cases who are either here illegally or are uninsured and can reimburse nothing who play a role in this and are squeezing out other people who can appropriately pay.

We have certificates of need, limited beds, and try to allocate them in an appropriate fashion; and yet one of the problems I hear is that we don't have enough beds in some areas. But if they could get to appropriate certifications you could create more beds which would be able to alleviate moving people from emergency rooms to hospital beds.

Federal reimbursability, which of course the private sector also pegs reimbursability now in some cases to Medicare, being very, very low, so even if you get a patient, the reimbursability of that doesn't always cover the cost. And when you add in the uninsured

and everything else, it creates a huge problem; and the ability to attract and retain good people, whether doctors, where we still have a shortage, or nurses.

As you rank all of these, all of them have a Federal component. What do we do? How important is each one or are some of them really red herrings or are they all important in terms of trying to get an understanding or our arms around this problem?

I'll start with you, Dr. Schwab.

Dr. SCHWAB. You are just picking on me because your son was playing in Pennsylvania. [Laughter.]

Let me say this. They are excellent questions. Each on its own we could spend a fair amount of time, and I think you have to dissect and drill down and look at how it affects emergency care. I want to start with the first one you mentioned, if I could, sir, and that is tort reform.

One of the things in the last 10 years, including the major crisis in Pennsylvania trauma centers just a few years ago that Governor Rendell handled beautifully for us, was blamed on malpractice. If one tries to ascribe that tort reform will solve the crisis in emergency care, I would say that it is not fair. That is a much bigger issue. However, where it affects us is that there is no consideration of our malpractice risk, our malpractice premiums, for delivering care to an emergency patient versus that patient in which you have established a doctor-patient relationship.

And what is interesting about that, again, in the report, if you look at it, the majority of the patients are life threatened, many of which cannot speak for themselves, comas, hit in the head, having a heart attack or stroke. We can't get information about them. We have no information about them, yet we are required to treat within a matter of seconds.

I knew nothing about this man whose chest I had to open. I didn't know his allergies. I didn't know his medicines. I didn't know anything. I didn't know if he had diabetes. I didn't know anything. But I had to do something, as do my colleagues sitting next to me.

But what is interesting is my malpractice is exactly the same. I get no benefit for doing that. I get no recourse from that, and I am at extremely high risk if one goes ahead and tracks malpractice complaints into emergency care. They are very high.

So I haven't answered your question comprehensively, but at least your first topic, what we say in the IOM report is that there needs to be a study done immediately to look at some way of relieving the physicians and nurses that are applying or giving emergency care. And by that, we defined and said we should define what an emergency episode is and in that episode we should go ahead and look at how the government may excuse us from some of the malpractice burden we carry if we truly are delivering life-saving care.

Mr. DAVIS OF VIRGINIA. Everybody thinks reimbursements are low, and that drives a lot of this as well, the uninsured. I appreciate your answer.

Dr. Johnson.

Dr. JOHNSON. Some things CMS can do to help alleviate some of the problems. They are a very powerful organization because they hold the purse strings, and hospitals do whatever they can to try

to get ahold of those funds. I think CMS can use its purchasing power to get hospitals to probably move patients upstairs by creating financial incentives to reduce crowding. If hospitals achieve high efficiency and get patients out of the ED in an efficient way, CMS can be rewarded by CMS for doing that; and if they are not, they can also raise a big stink, so to speak, to be penalized for not moving patients out of the ED.

For example, we have observation codes that CMS could expand upon to provide additional funding. We can now put patients into areas of the hospital where we can observe them and not require full hospital admission. That actually might save money in the long run for the system.

Finally, I do think you probably are aware that there are many different types of patients that hospitals can put into beds upstairs. Some of those are nice elective surgeries where it is certainly predictable how long they will be in the hospital and how much it is going to cost them, and it seems CMS is more than happy to pay a certain fee for those patients. But when you have an emergency department patient who is very ill, the hospital cannot collect enough money to cover their costs. So if CMS were to expand and prioritize emergency department patients over those nice elective, predictable patients, that actually might get patients into beds a lot more efficiently and open up emergency department beds.

Mr. DAVIS OF VIRGINIA. Let me talk to you on the tort side, because Dr. Schwab makes a case. You probably know less about your patients than anybody else when they come in. You have to make life-saving decisions based on limited information, and if it is the wrong decision you are going to see it in court and you are going to have to revisit that decision. Is the standard pretty tough for emergency room? What has been your experience?

Dr. JOHNSON. To be perfectly honest, there is a tremendous amount of defensive type of medicine that is practiced in the emergency department. There are many things that we do knowing full well that we are just covering the bases, so to speak, and probably not as important in the care of the patient. If I had some relief, some liability protection, I think that I could also practice in a more efficient way, absolutely.

Mr. DAVIS OF VIRGINIA. Thank you.

Dr. O'Conner.

Dr. O'CONNER. In terms of liability protection, many of the services are protected to the level of gross negligence. Maybe one such model is to look at emergency care in its total as a means to overcome this problem.

In terms of your question, there are staffing issues; there are hospital issues.

Mr. DAVIS OF VIRGINIA. Gross negligence is a much higher standard of negligence to show. It would give you some relief in not having to do some of these defensive mechanisms. Is there a consensus on that? That is an easier standard for you to operate under, at least.

Dr. O'CONNER. It is, yes. Also, I never would have thought that EMS pre-hospital work would be impacted by things such as nursing home placement, things on the other end of healthcare.

In looking at the magazine cover that is now 6 years old, Crisis in the ER, and it really is a crisis in the healthcare system. I think our current admission and discharge process from the in-patient setting is broken. And it is reflected by the overcrowding stories that we have heard, it is reflected by ambulances that have to be diverted, thereby creating a problem in a second hospital that they divert to. Ambulance diversions are particularly problematic because they tend to cause a rapid downward spiral of the entire system in the region.

So I think, in answer to your question, it is not a simple thing to answer. I think that, as a first step, we may want to try to understand the problem a little bit better.

Mr. CUMMINGS. Mr. Yarmuth.

Mr. YARMUTH. Thank you, Mr. Chairman.

I want to get at that topic a little more extensively. I am trying to get my arms around—and I know it is hard to generalize across the entire country in all sorts of different communities—to what extent this is a total patient capacity problem and, therefore, more of a method of dispersion problem, as opposed to just an emergency room capacity problem. Dr. Schwab, do you want to start?

Dr. SCHWAB. Thank you.

Let me just say the difficulty here is—if I can just have you think about a large geopolitical area. So you have a metropolitan service area, suburban area and a rural area. There are a certain number of hospital EMS units, emergency departments that render care for their citizens. There is no doubt that there is a disbursement or a fragmentation problem. And again in the report, we identified that and said one of the things that could really help deficiencies is if we design this regional emergency care system that includes all components of that care system, from the rural ambulance care up in the mountains versus the ones in the city, all talking electronically and in real time so that we can take people to where there are open beds. Thus the term regionalization.

But then there is also a problem in that we have to look at how those hospitals that are getting patients—and especially if the patient needs specialized care, cardiac, neurologic, trauma obstetrical or pediatric—that those centers that function as the regional emergency care centers are in fact enabled through proper funding and proper resources to maximize their efficiency and be able to move patients through.

Dr. O'Conner just mentioned he never thought that the nursing home would affect the EMS. I can tell you every day we have now continuously dedicated very high-level nursing and administrators who are helping to get people out to skilled nursing facilities, rehabilitation so we can take more people in. It is all connected, Congressman.

But I think what you have to look at is, again, how you might design this regionalized system which would help us disperse people better, but not lose sight that not all hospitals can deliver all types of care.

Mr. YARMUTH. To what extent—and maybe Dr. O'Conner can address this—to what extent do you believe that the competitive aspect of institutions exacerbates this problem?

I know in my community we have several very highly competitive hospital entities who most not-for-profit now, but we know that means in the healthcare business mostly nontaxpaying don't make profits. I am curious as to whether you have done an analysis of how big a problem that is in this context.

Dr. O'CONNER. I can give you some examples.

Locally, we established a—again I won't name the locale—pre-hospital, 12-lead program to identify patients with heart attack, with acute myocardial infarction in the pre-hospital setting, so they can go to a place where they can receive angioplasty if necessary. But we found tremendous resistance from some of the smaller hospitals which perceived a potential competitive disadvantage of taking care of all patients, including heart attack patients.

I went back to them with data that showed how many patients this involved. It was a small number and I pointed out they were the type of patients that were being transferred out anyway. And the hospitals understood this, so they were more accepting.

We started the program, and it has been very successful. I say this because if you can educate the administration of these other hospitals, they will realize that it is not really a competitive disadvantage. In fact, what you are doing is saving a secondary transfer or taking patients who are too sick for that hospital or require services that cannot be rendered by that hospital to a more appropriate facility.

Mr. YARMUTH. One quick question, and anybody can answer.

We talked about this regional approach, and I understand that would be very important here. To your knowledge, is any region or any community in the country doing a good job at this? Are there any models we can look at to try to roll out across the country?

Dr. SCHWAB. Well, I don't want to play to your chairman, but the model that occurs in the State of Maryland is an excellent model to look at. As far as trauma systems go, the model in San Diego. And as far as models in emergency medical services [EMS] coordination, the greater Pittsburgh regional area is well-known.

To go back to the question, how would you use your money, what we need to do is formally study those systems and see what the best practices are, again, for efficacy, efficiency, and effectiveness, and make sure that that is not just our feeling but in fact we can prove that to the country and to our citizens.

Mr. CUMMINGS. Thank you very much.

Mr. Issa.

Mr. ISSA. Thank you, Mr. Chairman.

Dr. Johnson, welcome. I apologize that I no longer represent Mission Viejo, but redistricting was not kind to me in my loss of Orange County.

Governor Schwarzenegger has proposed in your home State, in our home State, a broad, sweeping universal coverage initiative that requires that employers either take fiscal responsibility for their employees or pay a 4 percent fee that would go into a pool to help fund those activities which are necessary as a result of their failure. And emergency rooms, obviously, become the first choice of people who have no formal health coverage.

In Orange County if, in fact, we were able to accomplish that through private means to ensure that every individual had either

State coverage, if they were unemployed or indigent in some other way, or company coverage, back door, front door, depending whether or not an employer provided that care or paid the 4 percent, how much would that change what you see at the emergency room in yours and neighboring hospitals?

Dr. JOHNSON. That is an excellent question. Let me answer that by saying, since 1993, the number of patients visiting the emergency department has arisen to 115 million visits a year, and most of those visits are patients who are insured. They are insured. So it is not a question of not having funding and going to the emergency department because it is a place of last resort. It is a question of not having access to primary care capabilities within the community; and, as a result, the emergency department becomes the facility where they are forced to go because they can't get in to see their physician. Or, worse, they go to see their physician who decides you must go to the emergency department. In that regard, whether there is a universal coverage in California or not, it probably would not change the situtation in our particular environment of Mission Viejo.

Mr. ISSA. So how do we reverse that? I realize it is a wealthy community in the center of the greater LA, Orange County, San Diego megalopolis. So if it can be fixed, and a suburban well-to-do neighborhood would seem to be the easiest place to fix it, how do we make those changes to get people to the front door of an urgent care center or to the front door of routine medical treatment through a normal relationship and not at your emergency room door?

Dr. JOHNSON. Well, once again, given the reality that most of the patients who actually come to the emergency department are absolutely sick and actually need to be there, we actually see a very small volume of patients who have minor problems that really do not need to be in the emergency department. Unless we are willing to build another hospital in Mission Viejo, CA, we are not going to solve the problem.

Mr. ISSA. When you say "sick," do you mean life-threatening, immediate injury, or——

Dr. JOHNSON. Life-threatening admission.

Mr. ISSA. And what percentage did you say that was?

Dr. JOHNSON. Between 20 and 30 percent of the patients who present to the emergency department there of Mission Viejo require admission.

Mr. ISSA. Twenty percent.

Dr. JOHNSON. Twenty to thirty percent.

Mr. ISSA. What about the 80 percent?

Dr. JOHNSON. I would say the remaining 70 percent, at least half of those patients require being seen in the emergency department and probably receive care within 2 hours.

Mr. ISSA. What did we do in our society that created this huge rise?

Dr. JOHNSON. Lack of primary care access is driving a lot of it. I think patients are waiting until they are sick before they seek healthcare.

Mr. ISSA. So they are insured, well-to-do, in a suburban neighborhood; and they are not going to primary care because there is no access.

Dr. JOHNSON. Correct. If you call your physician and say you need an appointment to be seen because I have a cough and they say I will see you 3 weeks from now, that doesn't work. Then you wait a week until you have pneumonia and then go to the emergency department.

Mr. ISSA. I guess I will ask one more time, because this is an area I want to shed light on. It is your neighborhood that I missed. Because if anything can be fixed, it can be fixed in southern Orange County because means are there. You are saying we need more doctors so doctors don't say come in 3 weeks. What really will change that? Do we need urgent care? Do we need community clinics? Tell me what we need in one of the richest geographic areas in the country that we don't have and why.

Dr. JOHNSON. There is no doubt the entire healthcare system is broken. I think all those things are possible solutions. I do think we can expand our emergency department capabilities to add more observation capability, for example, and keep patients out of the inpatient service but require some prolonged level of care, perhaps in between the inpatient service and the ER.

Mr. ISSA. The day before yesterday I was with Michael Moore, the maker of "Sicko;" and the group I was with, I was the only person that wanted to preserve the private care system. Everybody else in that room, from Mr. Conyers on down, they wanted to have a single-payer, government-driven system. And I have to ask you, do you know of a single-payer, government-led system that would fix this? And what is that model, if one exists?

Dr. JOHNSON. I think any model that we create in the United States of America will be unique to this particular country. I don't think we can look to other models to be the only model that is available. I think we will have to try to find our own model that will work for most of our citizens.

Mr. ISSA. Anybody else want to weigh in on that?

Dr. SCHWAB. If you'll think of Philadelphia as Orange County.

Mr. ISSA. I love Philadelphia. You had a great convention for us there, and I was there just a few weeks ago. Except for the heat, the humidity, if you are on the 19th floor and you look out, it does look like San Diego.

Dr. SCHWAB. In short, I don't think one solution fits all.

I will go back again to the IOM report. We looked at this. And specifically what we said with no doubt, including one of our recommendations, is we have to increase access to primary care in all aspects of the population. Because, according to the analysis, if you look at those 114 million ED visits, a huge percentage of those, maybe not where Dr. Johnson practices, are for non-life-threatening emergency chronic care conditions for people who can find care in no other area. And in Philadelphia, in our hospital, that is a huge part of our emergency medical faculties' burden.

Mr. ISSA. Thank you, Mr. Chairman, for the indulgence.

Mr. CUMMINGS. No problem.

Let me just say this. As I listen to the testimony, it is frightening. When you think about an area like, for example, where you op-

erate Dr. Johnson, to have the kind of problems that you just stated is amazing. Then I guess it quadruples in an area where you are from, Dr. Schwab. Is that a fair statement?

Dr. SCHWAB. Yes, it is.

Mr. CUMMINGS. Mr. Cooper.

Mr. COOPER. Thank you, Mr. Chairman.

John Maynard Keynes once said that we are all the slaves of some defunct economist. I would like to suggest that we may be somewhat the slaves of the major Federal intervention in this area in the last several decades, the EMTALA law. When you see graphs like the ones we have been presented with where patient demand is going up, up, up and the number of emergency rooms and emergency capacity is going down, down, down, there is a fundamental problem. Because any regular economic system when demand goes up, supply goes up. So, thinking strategically for a moment, I think that what we really need here is a recognition of the role that money plays.

Mr. Issa questioned why in a rich community there is a shortage of primary care. Well, it is pretty well-known, at least at the elite medical schools, no one wants to be a primary care doctor, because being a primary care doctor pays much less than being a specialist and the work is often more difficult and carries other risks.

You get what you pay for, and you don't get what you don't pay for. You also don't get what you mandate without funding. And if we had a third panel of hospital administrators, the people who actually allocate resources between the grass roots and 60,000 feet, I think most of them will tell you, whether a nonprofit or for-profit hospital, that the ER business is a very bad business to be in.

That is why new-fangled hospitals, specialty hospitals oftentimes don't even include an ER. And that is why, in a celebrated case that I am surprised hasn't been mentioned, in a Texas specialty hospital they had to call 911 from the hospital because they had no emergency capacity within the hospital.

So it seems to me that if you look at programs like Medicare or Medicaid, the truth is they really don't pay enough for the services received, and they haven't for years. And everybody knows that, but we don't do anything about it. And a couple billion dollars here or there isn't going to solve the problem because the problem is so immense, you know, these specialty problems, because bioterrorism or things like that are fashionable at the moment, they are little more than Band-Aids for the needs that you have.

When the government wants to tackle the problem, it can. None of you are old enough to remember the old Hill-Burton hospitals that were built pretty much nationwide after World War II because we needed more hospital capacity.

Well, today, we need more ER capacity. And especially that surge capacity that many of you have alluded to is extremely expensive. Because, by definition, surge capacity is not used a good bit of the time; and you have to pay for all these resources to be on hand when they are not used.

But think of this analogy. With fire protection, it costs you more the farther you live from a good fire department. We may be reaching the time where health insurance will cost you more the farther you live, the less able your local ER is. Because I think Dr. Schwab

mentioned a 25 percent risk or increase in mortality if you don't receive proper emergency care.

Dr. SCHWAB. Proper trauma care.

Mr. COOPER. So these are serious issues that will take far more than this committee's resources to deal with.

I would like to suggest that fundamentally it is an economic problem; and yet physicians, others who are not trained to think in those terms—but solving them I think will take an economic solution.

So I have used up my time, Mr. Chairman, but it is more of a statement than a question, anyway.

Mr. CUMMINGS. You actually have about a minute, because the timer malfunctioned.

Mr. COOPER. Timer malfunction. Well, I would welcome any response that you all have. I just say it is more of a statement than a question.

Dr. O'CONNER. If I may very briefly, I think your comments are right on target. We are in many ways—I am very comfortable with EMTALA, because I treat any patient who comes in. I have to say that is the way I like it. I look at the curves in the reports.

Mr. COOPER. EMTALA has two parts, the requirement that you see everyone and then also no pay for some.

Dr. O'CONNER. Yes. I was going to say when EMTALA was first enacted, I was talking to a leader in the health insurance field who said I am not paying for a medical exam. There is no reason I have to. That has, of course, softened somewhat. I was struck by that stance.

I think if you look at the number of visits in emergency care, in many ways, we are victims of our own success. A patient can get a very elaborate work-up in a very brief period of time. A similar work-up as an outpatient would take days to weeks. So I think that is part of the explanation for demand. Even if we had something along the lines of universal health coverage, demand would still be quite high. That would be my opinion.

Mr. CUMMINGS. Mr. Murphy.

Mr. MURPHY. Thank you very much, Mr. Chairman.

Thank you all for being here today.

I spent 4 years as the chairman of the Public Health Committee in the State of Connecticut; and part of the reason that I sought a seat here in Congress was that it was pretty apparent that this wasn't going to be a 50-State strategy, that there needed to be a central solution to the issue of overcrowding in the ER.

I want to ask the three of you sort of an unfairly simple question. It strikes me, as we are talking about potential solutions here, that there are sort of three areas in which you can focus your efforts.

First, you can focus your efforts on trying to prevent people from getting to the ER in the first place, either through greater access to primary care or through trying to broaden those who have insurance.

Second, you can focus on the ER itself, greater resources there, greater coordination between sites.

And, third, as Dr. Johnson noted, you can expand the ability to move patients out of the ER. You can broaden and expand the ca-

pability of hospital inpatient services, i.e., sort of open up the potential to move patients out more quickly.

I guess it would be helpful for me at the very least to get a sense of how you might prioritize those three approaches. If we had to focus in one place first, second and third, preventing people from getting there, making the process itself in the ER more efficient or, third, trying to open up capacity to get people out of the ER, how might you recommend us approaching that? Or is there a fourth that I am missing?

Dr. JOHNSON. I would certainly recommend the final recommendation which would be to open the capacity by ending the boarding of admitted patients in the emergency department. By ending boarding and opening beds in the emergency room, all of a sudden you solve the problem of ambulance diversion. You basically allow patients to be seen in the ED. If they have no access to primary care, we are more than happy to take care of them there. Most emergency departments have figured out that if patients have minor problems they can wait in the waiting room for who knows how long or be seen in another area where minor care cases can be seen efficiently. But once you at least have bed capacity in the emergency department you can do what you are there to do, which is to save lives; and getting those boarded patients out should be the No. 1 priority, I believe.

Dr. O'CONNER. I would agree that the third priority is the key of increased capacity. Because, without it, it doesn't allow for improved efficiencies within the department.

I think a lot of the inefficiencies that occur in the emergency department now are directly attributable to patient boarding hours, where staff will take care of patients who are normally in the inpatient setting.

As far as keeping patients who don't belong there out, I think just by waiting times and the crowding issue, we sort of do that already. We have looked locally at some of our EMS transports, and patients with seemingly minor complaints such as a headache "self-triage" with higher acuity if they call EMS. Or if they come to the emergency department, as opposed to an urgent outpatient clinic, they tend to be sicker, tend to have a more serious illness than if not.

Mr. MURPHY. Let me ask one last question, and that is the issue of psych patients. One of the greatest capacity issues for inpatient beds in Connecticut is our lack of inpatient psych beds, adult psych beds in particular. How much of a problem right now is the lack of capacity on the back end to get psych patients, both juvenile and adult, out of the ER and into a more community based system of care or an inpatient system of care?

Dr. JOHNSON. A single word: Huge. In my department, for example, one to two patients a day that come into my department are psychiatric patients. Even after we have done all the medical screening, they can potentially sit in my emergency department for a period of time from hours to literally up to 24 hours and supposedly get admitted into my hospital if there is bed capacity. But they have actually lived in my emergency department for a couple of days before we can get psychiatric personnel to come out and evaluate them to find a bed to place them in.

Sometimes there may not be a bed to place them; and, as a result, they will have to stay in the emergency room if they are a true high risk before we can actually stabilize them or have an evaluation of them to be seen or to be sent home or to another institution.

So psych patients are a huge problem. I would love to talk to you after the hearing on ways we might be able to solve that, but this is a huge problem confronting emergency rooms all over the country now.

Mr. CUMMINGS. Thank you.

Let me ask a question quick. If you had to relate our emergency systems using hospital terms like "intensive care" or "a critical condition"—you know the various terms you all use—how would you all describe it?

Dr. SCHWAB. I would say it is life-threatening or resuscitating on a day-to-day basis, and it is going to die if we don't fix it. I don't know if that is hospital terms or not.

Mr. CUMMINGS. It sounds pretty hospital terms to me, but it sounds almost like funeral home terms, too.

Dr. SCHWAB. Let me just go on and say I meant what I said before. If it wasn't for the dedication of the nurses, the paramedics and the physicians that struggle with this on a day-to-day basis, this system would have broken already; and that was the conclusion the Institute of Medicine's report.

Mr. CUMMINGS. Dr. Johnson.

Dr. JOHNSON. Mr. Chairman, I believe that you are looking at the proverbial canary in the mine right now. You are looking at him face to face. Because I am here to tell you that when I take my last breath in that emergency department it will be when the system completely falls apart, and I am on my last breath right now. So we are the canaries, the emergency physicians and the nurses and the personnel. I have had some of my best nurses leave my department, which is I believe one of the best departments in California, to go to other areas of the hospital like the cath lab where they can get paid the same salary for half the work.

Dr. O'CONNER. In terms of what is acceptable to the staff, situations that used to be considered bad days, tough days at work are now routine; and the threshold to which some of the days rise is appalling.

Mr. CUMMINGS. Mr. Sarbanes.

Mr. SARBANES. Thank you, Mr. Chairman.

I had the privilege for almost 20 years to represent as my prime clientele community hospitals in Maryland and the region, probably 25, 30 hospitals over the course of that time. So this problem is one that I am very familiar with from all sides, and it is almost impossible to overstate it. You are trying your best here to do it in ways that will get our attention, which I think you have, but hopefully a broader attention.

Dr. Schwab, you said "the patient may die" when asked to assess this system using those kinds of terms; and, Dr. Johnson, you said that the system—you are holding on before the system completely falls apart. What does that look like? What does this system look like when it dies, when it completely falls apart? What is the prospect down the road that we can look back later to the testimony

in this hearing and say, well, this is not a surprise to anybody. I mean, we predicted this would happen.

This is the fundamental human problem of if A, then B, and if B, then C, but for some reason we can't get it together to have a minimal amount of foresight. So what does it look like when the system dies?

Dr. SCHWAB. Let me tell you about my Wednesday afternoon, which is a pretty typical day. What you probably don't know is that we are the most frequently closed trauma center in the State of Pennsylvania. We are closed nine times more than any other trauma center in the State because of volume. So I see this doomsday picture you are asking me to give. I see it momentarily.

Because what happens is we close, ambulances are diverted, ambulances go to other centers, some are not trauma centers, there are no surgeons waiting. And ultimately what happens, I think, if we can ever prove it and would dare to prove it, is patients die. If the emergency system falls apart, rather than that being episodic throughout a day, it is going to be continuous; and it will be some kind of terrible movie that I don't want to ever think about.

But it is happening now in our largest cities and even some of our suburban areas. It happens. People are diverted. And there is now an excellent study to show that people, other patients don't do well with diversion. They die while they are being diverted.

There are also now studies, one of which is now coming out of the University of Pennsylvania, which shows that if simultaneously on an overload condition everybody is busy, you are doing major trauma cases and yet another cardiac code comes in, there is data to show that those patients don't do as well either. Why? Because everybody is busy.

Think of O'Hare International Airport on Friday afternoon, a terrible thunderstorm and all flights are canceled, what it is like. It is mayhem.

Mr. SARBANES. You conjure up an image in my mind where, ultimately, diversion is straight to the morgue. That you are going from one hospital to one hospital to one hospital and you can't get in; and eventually, you know, you just pass it by and you go straight to the morgue. That is what I am hearing here.

Dr. JOHNSON. In your scenario, what would probably happen is that a patient would stay in the ambulance until they reached a point where they would die, and then the ambulance would have the ability to upgrade the patient to a "code" status and go to the nearest facility, regardless what the status would be, whether they are open or closed. So patients eventually do have a finite period of time which they can ride around in the ambulance.

I will tell you what will happen in your scenario. It will be a very slow, incremental collapse of the system, beginning with the loss of subspecialty capability. So neurosurgeons, orthopedic surgeons, hand specialists, they will eventually be gone from those facilities. And what would happen is you would lose them in your rural areas, for those who have that specialty backup already, and then you will lose them from your suburban areas and consolidate them in fewer and fewer facilities, leaving more and more facilities without any subspecialty backup. Which means if you come in with something other than what I can handle as an emergency physi-

cian, if you require plastic surgery or if you need a hole drilled into your skull to relieve pressure from blood building inside your head, that would not happen and you would, of course, then die in my facility because I would not be able to transfer you anywhere and I would not have the specialty backup in order to take care of you.

So that is how it would happen. The lack of subspecialty services would mean that patients would die at the institutions they were at.

We would foresee increasing ambulance diversion to the point where you would have some facilities that would have ambulance diversions continually. I know in my area there is a rule in the Los Angeles area that if you are on diversion for so many hours you have to be off an hour before you can go back on. So it would be on diversion, off diversion, on diversion, off division.

Mr. SARBANES. You are describing an emergency diversion system, not an emergency care system. I appreciate you being candid about this. Let's talk about a solution.

I am out of time. Thank you, Mr. Chairman.

Mr. CUMMINGS. Thank you, Mr. Sarbanes.

There are a lot of people dying, aren't there? I am basing it on what you all just said. There are people dying that don't have to die.

Dr. SCHWAB. That's correct.

Dr. JOHNSON. Yes.

Mr. CUMMINGS. Ms. Norton.

Ms. NORTON. Thank you, Mr. Chairman.

This is an important hearing. I am here not only as a member of this committee but as a member of Homeland Security Committee. I am here also as a representative of a big city in the post-9/11 period, one might say of a big city in the post-9/11 period where you have to think about EMS. And there is a lot of thinking about it, but I don't think enough thinking about what the Federal Government's responsibility is to EMS ambulance services.

Taking a point you make, Dr. O'Conner, in your testimony about the funding of EMS ambulance services. Looking to more than 30 years ago, 1973, this was a clear priority because we funded $300 million to advance EMS services nationwide, is that correct?

Dr. O'CONNER. Yes. That was in 1973.

Ms. NORTON. Now, in real terms, you show a kind of priority. In real terms 1973, that amount of money would be $1.5 billion today.

Now, let's look at what you are coping with now. The block grant program, the whole thing has been block granted. That happened in 1981. What we are seeing is the devolution of this whole mission. As I understand it, the block grant program provides these EMS services to only 16 States and only $8 million. We are talking now the equivalent of $1.5 billion 30 years ago. $8 million out of $9 million that we appropriated, but only $8 million of it for EMS services.

Now, as I understand it, the Bush administration wants to eliminate the block grant altogether. Now that would mean the $8 million would be gone, would it not?

Dr. O'CONNER. Yes, it would.

Ms. NORTON. In 2006, the committee notes that the Bush administration zeroed out the small community ambulance development

and trauma EMS programs that was once run by HHS. We are awfully concerned here about isolated rural communities, and without community ambulance service I don't need to tell experts like yourselves what the effect of that would be. Now the only HHS program that I could find that still supports EMS services at the Federal level is the EMS for children, called the EMSC program, is that not correct?

Dr. JOHNSON. That is correct.

Ms. NORTON. Now the signature issue for this administration is homeland security. We are talking about emergency services. This gets to be very serious. In the last three budgets, we could not find—what we did find was the administration had proposed to zero out even EMSC programs, is that not correct?

Dr. JOHNSON. That's correct.

Ms. NORTON. We talk about a nonexistent program. Can you explain how over 30 years we have gone from a priority for EMS services through the Federal Government to essentially the decline and fall of such services? I mean, how could that happen? Have States been clear about the importance of these services?

In post-9/11, Dr. O'Conner, you are from Virginia, close to where we had the worse trauma, second only, of course, to New York, how could this disconnect continue to get to this point?

Dr. O'CONNER. There has been a slow decline over 30 years. The initial money started up what we now know as pre-hospital care and EMS. That was largely successful. In fact, it was money that most would argue was extremely well spent. It allowed the establishment of State EMS offices and really created the medical care that we know today as pre-hospital EMS care.

What has happened since then is there has been a transition of funding to different areas that has resulted in it becoming a very easy target to zero out EMS programs. I would just hope that the administration would reconsider some of these decisions.

Ms. NORTON. So if it wanted to eliminate something and you were receiving the money, was this considered more a State issue and not a Federal issue, do you think, so the money could be stolen from here as opposed to other places?

Dr. O'CONNER. I think some of it has to do with the fragmentation of EMS. There is not a single go-to lead agency that can oversee where the money goes.

Ms. NORTON. Would folding it into the block grant—was that the beginning of the end of the program?

Dr. O'CONNER. In retrospect, yes. I didn't know that at the time.

Ms. NORTON. Do you think that this program should be a stand-alone program?

Dr. O'CONNER. I think that all of emergency care would fair better as a stand-alone program. This is not just about EMS. It is about everything we do in unscheduled care for emergency problems. I think if the sum total of emergency care were a stand-alone agency, it would help for sure.

Dr. SCHWAB. If you are asking me about EMS alone, I think, once again, my comments have always been to look at the emergency care system comprehensively, a lead agency or a coordinating body with the authority of responsibility and continuous appropriations to help us solve these problems.

Ms. NORTON. And you think EMS would receive the proper priority within emergency care?

Dr. SCHWAB. I absolutely do. In the IOM report, we actually call for that. One of the three reports is about emergency medical services, and we need to fund them adequately to do their job.

Mr. CUMMINGS. The gentlelady's time is up.

Let me say as we summarize and we move onto our next panel, the gentlelady, when she opened her questioning, she talked about homeland security. And I was just curious, if we had a Madrid-level bombing today in D.C., for example, what would happen? Would we be able to take care of folks?

Dr. SCHWAB. America has always been good, Congressman, at rising to the occasion, no matter what it was. So would we be able to take care of them? The answer would be, we would. The question is, who would suffer? Because we have to put all of our resources taking care of those that are involved with that type of bombing. Where would we divert our ambulances, where would the children go, and where would the routine myocardial infarction, heart attack, stroke victim go while we were overwhelmed with that?

Mr. CUMMINGS. So there is no capacity, really, no extra capacity.

Dr. SCHWAB. There is no extra capacity. That is very clear. It is frightening because, because of our emergency departments being overloaded with routine patients and trauma patients and whatnot, it occurs on a day-to-day basis already. So adding on a disaster like that would just overwhelm the system.

Mr. CUMMINGS. Dr. Johnson.

Dr. JOHNSON. I would echo that as well, Mr. Chairman. I think that in the beginning when the Federal Government created moneys to be used for bioterrorism protection, what it didn't do was figure out if we would be much more at risk of a routine bombing. As we started down the road of buying tents and preparing for pandemic flu, we have yet to deal with the day-to-day environment of not having enough trauma surgeons, not having enough resources in our everyday emergency department that is already overwhelmed.

Dr. O'CONNER. At this time of day in every emergency department in the United States there is no capacity, so a Madrid-level bombing would completely overwhelm the system.

Mr. CUMMINGS. Thank you all very much. Your testimony has been chilling. It is very, very helpful. Thank you very much.

We'll call our next set of witnesses: Dr. Kevin Yeskey and Dr. Walter Koroshetz.

As you all come forward, I just want the committee to know the committee also invited Dr. Leslie Norwalk, the Acting Administrator of the Center for Medicare and Medicaid Services for EMS to testify on behalf of her agency. She has declined to appear citing schedule conflicts. She also has declined to send any other CMS official to represent her agency.

This is highly unfortunate and, frankly, inexplicable and inexcusable. The programs administered by CMS play a major role in the financing of our healthcare system, including medical care and emergency care. Indeed, all patients admitted to a hospital through the ER, over three-fifths are covered by Medicare or Medicaid. Because lack of adequate financing is one of the factors contributing

to the Nation's emergency care prices, the testimony of CMS is critical to a full assessment of the Department of Human Health and Human Services' response to the emergency care crisis.

Our staff was informed that Ms. Norwalk's schedule did not permit her to attend. However, CMS has 4,328 full-time employees. It is difficult for us to understand why she could not be with us today. So the Office of the Assistant Secretary for Preparedness and Response, which is represented here today, has only 222 full-time equivalent employees. This is just 5 percent of CMS's staff capacity.

Chairman Waxman shared these concerns with Ms. Norwalk in a letter sent earlier this week. I ask unanimous consent a copy of that letter be included in the record at this point. Without objection, so ordered.

[The information referred to follows:]

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June 14, 2007

The Honorable Leslie Norwalk
Acting Administrator
Centers for Medicare & Medicaid Services
200 Independence Ave., SW
Washington, DC 20201

Dear Ms. Norwalk:

The Committee on Oversight and Government Reform hereby requests your testimony at a hearing on **Friday, June 22, 2007 at 10:00 a.m. in Room 2154, Rayburn House Office Building.**

The hearing will examine the response of the Department of Health and Human Services to the nation's emergency care crisis. We ask that you provide testimony on actions taken by CMS to address this crisis.

The Committee on Oversight and Government Reform is the principal oversight committee in the House of Representatives, with broad investigative jurisdiction as set forth in House Rule X. Information for witnesses appearing before the Committee is contained in the enclosed Witness Information Sheet.

If you have any questions, please contact Art Kellermann of the Committee staff at (202) 225-5056. We look forward to your testimony.

Sincerely,

Henry A. Waxman
Chairman

Enclosure

cc: Tom Davis
Ranking Minority Member

Mr. CUMMINGS. This afternoon the committee will send a letter to Ms. Norwalk posing a set of questions regarding her agency's response to the emergency care crisis. We look forward to complete and truthful responses to these questions by the close of business on Friday, June 29th. I ask unanimous consent that those responses be included in the record as well. No objection, so ordered.

[The information referred to follows:]

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House of Representatives

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

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June 22, 2007

The Honorable Leslie Norwalk
Acting Administrator
Centers for Medicare & Medicaid Services
200 Independence Ave., SW
Washington, DC 20201

Dear Ms. Norwalk:

This morning the Committee is holding a hearing on the response of the Department of Health and Human Services to the nation's emergency care crisis. Last Thursday, June 14, the Committee invited you to provide testimony on actions taken by CMS to address this crisis. Your staff has informed us, however, that you are unable to attend or send a representative on your agency's behalf.

The programs administered by CMS play a major role in the financing of the nation's emergency and trauma care system. Of the 115 million emergency room visits in 2005, over 40% were covered by Medicare, Medicaid, or SCHIP. Obviously, an understanding of your agency's views is essential to an assessment of the Department's response to the emergency care crisis. I therefore request that you supply answers to the following questions:

1) What actions, if any, has CMS taken to address the boarding of admitted patients in emergency rooms at hospitals receiving Medicare or Medicaid funds? If CMS has taken no action to address this issue, please supply your rationale for such inaction.

2) What actions, if any, has CMS taken to address the diversion of ambulances from emergency rooms at hospitals receiving Medicare or Medicaid funds? If CMS has taken no action to address this issue, please supply your rationale for such inaction.

3) What actions, if any, has CMS taken to address the decrease in coverage by on-call specialists at hospitals receiving Medicare or Medicaid funds? If CMS has taken no action to address this issue, please supply your rationale for such inaction.

4) What actions, if any, has CMS taken to address the adverse health consequences of emergency room crowding, the boarding of admitted patients in ERs, and the diversion of ambulances on Medicare and Medicaid beneficiaries? If CMS has taken no action to address this issue, please supply your rationale for such inaction.

5) CMS has issued a final rule that would limit Medicaid payments to government providers, including safety net hospitals that furnish emergency care and level 1 trauma services. (72 Fed. Reg. 29748 (May 29, 2007)). In developing this proposal, did CMS seek the opinion, formal or informal, of the Office of the Assistant Secretary for Preparedness and Response (OASPR) as to whether the proposed rule would have an adverse effect on the nation's disaster preparedness? If not, please explain why CMS did not seek the OASPR's opinion on this matter. If so, please provide a copy of any document received from the OASPR relating to its opinion on this matter.

6) CMS has issued a proposed rule to eliminate federal Medicaid matching payments for the costs of Graduate Medical Education (GME), including the costs of residents who staff emergency rooms and trauma centers. (72 Fed. Reg. 28931 (May 23, 2007)). In developing this proposal, did CMS seek the opinion, formal or informal, of OASPR as to whether the proposed rule would have an adverse effect on the nation's disaster preparedness? If not, please explain why CMS did not seek the OASPR's opinion on this matter. If so, please provide a copy of any document received from the OASPR relating to its opinion on this matter.

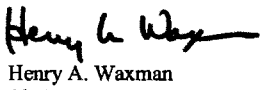
7) In its June 2006 report, *The Future of Emergency Care*, the Institute of Medicine (IOM) recommended that "CMS should convene a working group that includes experts in emergency care, inpatient critical care, hospital operations management, nursing and other relevant disciplines to develop boarding and diversion standards, as well as guidelines, measures, and incentives for implementation, monitoring and enforcement of these standards." What actions, if any, has CMS taken to implement this recommendation? If CMS has taken no action to implement this recommendation, please supply your rationale for such inaction.

8) In its June 2006 report, IOM recommended that CMS "remove the current restrictions on the medical conditions that are eligible for separate clinical decision unit (CDU) payment." What actions, if any, has CMS taken to implement this recommendation? If CMS has taken no action to implement this recommendation, please supply your rationale for such inaction.

9) A recent GAO study concludes that Medicare payments for EMS services are 6% below the average cost of an ambulance transport, and 17% below cost in super-rural areas. (U.S. Government Accountability Office, *Ambulance Providers: Costs and Expected Medicare Margins Vary Greatly* (May 2007) (GAO-07-383)). What actions, if any, does CMS intend to take to address the GAO findings?

Please submit your responses by Friday, June 29, 2007. If you have any questions regarding this inquiry, please contact Art Kellermann at 225-5056.

Sincerely,



Henry A. Waxman
Chairman

cc: Tom Davis
Ranking Minority Member

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

JUN 29 2007

The Honorable Henry Waxman
Chairman
Committee on Oversight and Government Reform
House of Representatives
Washington, DC 20515-6143

Dear Mr. Chairman:

Thank you for the opportunity to respond to your June 22 letter regarding the Centers for Medicare & Medicaid Services' (CMS) response to the Nation's emergency care crisis. We realize these responses are not a substitute for testimony before the Committee, but I hope they will provide insight into CMS' actions in support of our Nation's emergency care providers. We provided answers on June 22 to draft questions sent by the Committee on June 19. Today, we are following up with responses to the questions we received on June 22.

CMS recognizes the significant role our programs play in financing emergency services, as well as the challenges facing our Nation's emergency departments, trauma centers, and medical first responders. We also appreciate the insight provided by the Institute of Medicine's (IOM) series of reports: *"Emergency Medical Services at the Crossroads."* The careful deliberations that informed the reports and their recommendations are a testament to the hard work and dedication of IOM's Committee on the Future of Emergency Care in the United States Health System.

However, we realize that success in this arena cannot be achieved by our agency alone. Although Medicare and Medicaid beneficiaries account for the largest number of inpatients admitted through emergency departments, private pay patients account for the largest volume of emergency department visits overall. Thus, we are committed to moving toward a collaborative, value-driven process so that change in our Nation's emergency care system can be realized.

Finally, we look forward to working with you and your colleagues in our continuing efforts to promote better access to primary care and improved quality of care throughout the health care system. If you have any questions, you may contact me or work with Elizabeth Hall, the Director of the CMS Office of Legislation at (202) 690-5960. Thank you for your consideration.

Sincerely,

Leslie V. Norwalk, Esq.
Acting Administrator

Enclosure

1) What actions, if any, has CMS taken to address the boarding of admitted patients in emergency rooms at hospitals receiving Medicare or Medicaid funds? If CMS has taken no action to address this issue, please supply your rationale for such inaction.

Emergency department (ED) boarding—the practice of holding admitted patients in hallways and other ED areas until inpatient beds become available—is the product of a complex interplay of multiple contributing factors. Ultimately, these factors affect input, throughput, and output of patients throughout their care and flow through the hospital. While CMS finances care for a significant share of the patient population seeking emergency services, it would be neither possible or appropriate for CMS to direct the day-to-day operations of how hospitals manage their workflow.

Consequently, CMS has leveraged its influence by using its strategic and programmatic initiatives to address some of the underlying causes of ED boarding, to support hospital operations more globally, and to develop incentives to achieve improved clinical outcomes. These incentives are focused on the three broad areas of input, throughput, and output of emergency patients, with particular impact on patients requiring admission to the hospital..

I. INPUT

To the extent that CMS can improve access to primary care services, increase healthy behavior and the use of prevention services, and improve chronic disease management, one would expect less demand on emergency services for acute exacerbation of chronic illnesses that lead to hospitalizations as well as make up the preponderance of Medicare admissions via the emergency department. Examples of initiatives to reduce emergency department usage and acute care hospitalizations were provided in our prior response and are reiterated here.

a) <u>Disease Management and Chronic Care Management:</u>

Medicare inpatient admissions through the emergency department are overwhelmingly chronic in nature. Because of this, CMS has sought to implement disease management and chronic care management programs in order to reduce admissions that are often preventable. CMS has two major initiatives underway to further enhance support for chronically ill Medicare beneficiaries, which may have a favorable impact on emergency department services: the Medicare Health Support Program and the Care Management for High Cost Beneficiaries Demonstration. Both programs are intended to help increase adherence to evidence-based care, reduce unnecessary hospital stays and emergency department visits, and help participants avoid costly and debilitating complications.

Section 721 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) authorized the development and testing of voluntary chronic care improvement programs, now called Medicare Health Support (MHS). MHS programs are designed to help reduce health risks, improve quality of life, and provide savings to Medicare. Phase I is a pilot phase that will run for three years. Phase I, which is currently underway, is operating in six geographic areas across the country and serves about 120,000 beneficiaries who are enrolled in traditional fee-for-service (FFS) Medicare and who have heart failure and/or complex diabetes

among their chronic conditions. Depending upon the success of Phase I, the statute calls for a Phase II expansion of MHS programs or program components.

The Care Management for High Cost Beneficiaries (CMHCB) Demonstration is a 3-year project that tests provider-based care management services as a way to improve quality of care and reduce costs for FFS beneficiaries who have one or more chronic diseases and generally incur high Medicare costs. The CMHCB project is operating in several areas around the country, through six different organizations, and serves approximately 25,000 Medicare beneficiaries who are enrolled in traditional FFS Medicare.

Participants in both the MHS Program and the CMHCB Demonstration have access to Case Managers, who help the beneficiary to self-assess his or her health status, and to determine the most suitable treatment modality, thus potentially avoiding costly and inappropriate hospitalizations and emergency treatment.

One CMHCB site is testing the concept of "on-demand" physician home visits. Providing these patients with direct and timely access to a doctor 24 hours a day, seven days a week, allows for the intensive management of chronic conditions and patient monitoring in times of crisis that would otherwise require expensive emergency department visits and/or hospitalization.

Both the MHS Program and CMHCB Demonstration illustrate CMS' continuing commitment to pursuing innovative and beneficiary-centered solutions to the growing concern surrounding emergency department care.

b) <u>Prevention Initiatives:</u>

- *Promotion of Preventive Benefits*: This year, as part of the "A Healthier US Starts Here" initiative, the U.S. Department of Health and Human Services (HHS) and CMS joined with local officials and other partners to raise awareness of the importance of preventing chronic disease and conditions, promote Medicare's preventive benefits, and provide information on how beneficiaries can take action to maintain and improve their health. Medicare began covering preventive services in 1981 with pneumococcal vaccinations, and many other screening and preventive benefits have been added to the program since that time. CMS is committed to promoting the appropriate use of Medicare's preventive benefits. Current preventive benefits include: bone mass measurement, cardiovascular disease screening, cervical cancer screening, colorectal cancer screening, breast cancer screening, prostate cancer screening, diabetes screening, diabetes self-management, glaucoma screening, adult immunizations, medical nutrition therapy for beneficiaries with diabetes or renal disease, smoking cessation counseling, and a one-time "Welcome to Medicare" physical exam (including referral for an abdominal aortic aneurysm ultrasound). CMS has done, and continues to do, extensive outreach to health care professionals to help increase awareness of preventive services covered by Medicare and provide coverage and billing information needed to effectively bill Medicare for preventive services provided to Medicare patients. This outreach includes communication through CMS provider listservs, professional associations at the national and local levels, and Medicare claims processing contractors, in addition to distribution

of materials at health professional conferences. A complete list of CMS educational materials developed to promote preventive services can be viewed at http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp. As these efforts succeed, CMS expects to see reductions of acute exacerbations of chronic illness requiring emergency intervention and hospitalization.

- *Tracking Long-Term-Care (LTC) Immunizations*: Another example of CMS' focus on increasing utilization of covered preventive benefits is the tracking of pneumococcal and influenza immunizations in nursing homes. Tracking patients admitted to the LTC arena for appropriate and timely immunizations can prevent hospitalization. Additionally, CMS ensures through the survey process that residents who have not already received these vaccinations are given the opportunity to receive or decline them.

- *Prescription Drug Coverage Under Part D:*. One of the most significant advances in the Medicare program since its inception in 1965 is the addition of prescription drug coverage. Roughly 38 million Medicare beneficiaries have prescription coverage, to date. The latest Medicare Rx Education Network Survey (September 2006) shows that 1 in 5 seniors in stand-alone drug plans report no longer skipping or reducing needed medications. Sixty-seven percent feel better off now than before Part D, and 80% of seniors are satisfied with the program. Thus, we are moving Medicare towards providing drug usage for prevention and maintenance rather than "rescue" therapy delivered in ED and hospital settings.

c) **State Initiatives:**

- *Rhode Island Connect CARRE Program*: The State of Rhode Island seeks to control program costs and improve the quality of care for disabled and elderly adults in its fee-for-service Medicaid program through the Connect CARRE Program. The target population includes a culturally diverse and economically disadvantaged group of disabled and chronically ill Medicaid beneficiaries age 22 and older with congestive heart failure, chronic obstructive pulmonary disease, sickle cell anemia, asthma, diabetes, and depression. The target population also includes Medicaid beneficiaries who are frequent users of acute care services, who reside in a community setting but lack social and community supports, or who are at risk for recurrent adverse medical events, frequent hospitalizations, and emergency department visits. The program assures that each participant has a medical home, a plan of care that responds to the individual's unique service needs, the skills necessary to manage and monitor chronic conditions, and the ability to recognize situations that require medical intervention. Utilization data and performance measures indicate that the program has reduced unnecessary hospitalizations; improved access to providers, services and care in the community; and enhanced the quality of life for participants. For calendar year 2003, acute hospitalizations cost $1,000,000 less for a subgroup of 45 Connect CARRE enrollees than a control group of 45 recipients who were eligible but refused enrollment.

- *Washington State's Screening, Brief Intervention, Referral and Treatment (WASBIRT) Program*: Individuals with substance abuse problems have had difficulty gaining access

to needed services in the State of Washington. Under the Washington State Screening, Brief Intervention, Referral and Treatment (WASBIRT) program, chemical dependency professionals placed in the State's busiest hospital emergency departments screen individuals suspected of having a substance abuse problem and refer them for treatment, if necessary. This approach is based on the premise that clients with substance abuse problems are most likely to be motivated to seek treatment in moments of crisis. By initiating substance abuse interventions in the emergency department, the State hopes to reduce subsequent emergency department utilization, medical costs, criminal behavior, disability, and death of patients with alcohol or other drug problems. An in-depth evaluation of the WASBIRT program will be conducted in 2007. Preliminary surveys show that screened patients' use of alcohol and drugs has declined, abstinence has increased, and brief chemical dependency and alcohol treatment has resulted in significant declines in use of alcohol.

- *West Virginia's Medical Home Model*: A key concept in the Deficit Reduction Act (DRA) reform package implemented by West Virginia in 2006 involves the creation of a "medical home" for Medicaid beneficiaries in the state. Beneficiaries establish a relationship with a primary care provider and contract with that provider to be responsible for their own good health habits and proper utilization of the health care system. One of the twelve specific clauses in the contract commits the patient to use the hospital emergency department only in true emergencies. It is expected that this agreement, together with the improved patient compliance required by other clauses in the agreement, will significantly reduce the number of unnecessary emergency department visits.

- *Nevada's FQHC Expansion*: The Nevada legislature is reviewing a plan to allocate ten million dollars to expand the capacity of its Federally Qualified Health Centers (FQHCs) to relieve overcrowding of the State's emergency departments due to the influx of patients who would be better handled in a clinic setting. Many patients in Nevada emergency departments come in for complications of diseases like asthma and diabetes that would probably never occur if the patients were connected to a primary care provider and receiving appropriate care for their disease. Nevada's proposed expansion of FQHC capacity and expansion of its Medicaid Program eligibility to create primary care capacity would relieve pressure on the State's emergency departments.

d) Grants for Non-Emergency Service Providers:

Section 6043 of the DRA provides $50,000,000 over four years in grant funding to States to establish non-emergency service providers and provider networks, particularly for those in rural and underserved areas and those in partnership with local community hospitals. These facilities are designed to assist people to receive non-emergency care outside of an emergency department and would be a resource to deter the inappropriate use of emergency departments. The grants are designed to help establish working arrangements between emergency departments and the alternative providers to direct patients to the appropriate care setting. Alternative facilities can provide treatment to individuals who, after an emergency medical screening, have been

determined to have a non-emergency condition. CMS is in the process of developing guidance for States to apply for grant funding, which will be released shortly.

e) **Increased Reimbursement for Evaluation and Management Codes:**

Beginning in 2007, Medicare payments to physicians for many evaluation and management (E/M) services have increased significantly. These increases are a result of the statutorily mandated 5-year review of the work relative value units (RVUs) under the physician fee schedule that was conducted last year. Work RVUs for E/M services reflect the time and effort physicians spend with patients in evaluating their condition and advising and assisting them in managing their health. The work RVUs for a hospital visit requiring moderately complex decision-making increased 31 percent and by 29 percent for a similar level office visit. These E/M codes are in the top ten most frequently billed physicians' services. The increase in payment to physicians for spending time to manage the care of patients will help to provide better access to primary care services, and ensure more efficient use of health care resources and better outcomes for patients.

f) **Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens:**

Under Section 1011 of the MMA, the Secretary of Health and Human Services must directly pay hospitals, physicians, providers of ambulance services, and Indian Health Service and Tribal organizations, for their otherwise unreimbursed costs of providing services required by Section 1867 of the Social Security Act (EMTALA) to certain individuals. These individuals include undocumented aliens, aliens paroled into the United States at a U.S. port of entry for the purpose of receiving such services, and Mexican citizens permitted temporary entry to the United States with a laser visa.

Section 1011 authorizes $250 million per year for fiscal years (FY) 2005 through 2008. Two-thirds ($167 million) is allotted to all 50 States and the District of Columbia, based upon their relative percentages of the total number of undocumented aliens. The remaining one-third ($83 million) is allotted to the six States with the largest number of undocumented alien apprehensions (currently, AZ, CA, FL, NM, NY, TX). Unspent funds under the program roll over each year and are available until expended.

The effective date of the Section 1011 program is for payment requests (i.e., claims) with dates-of-service on or after May 10, 2005. While this effective date resulted in payments for less than the full 2005 fiscal year, the entire $250 million was made available for dates-of-service May 10, through September 30, 2005. Almost 16,000 health care providers have enrolled in the Section 1011 program. To date, six quarterly payments have been made, amounting to approximately $250 million. Data also indicate continually increasing utilization of the program.

g) **Other Initiatives:**

In addition, through its demonstration authority, CMS has implemented a number of other program initiatives that could reduce demand for acute and critical emergency care services

through better chronic care management. The following demonstration projects are either in development or underway.

- *Medicare Medical Home Demonstration (Section 204 of the Tax Relief and Health Care Act of 2006 (TRHCA))*: This demonstration in up to 8 states provides targeted, accessible, continuous and coordinated family-centered care to Medicare beneficiaries who are deemed to be high need (that is, with multiple chronic or prolonged illnesses that require regular medical monitoring, advising or treatment.)

- *Medicare Health Care Quality Demonstration (MMA Section 646)*: This will be a five-year demonstration program under which projects enhance quality by improving patient safety, and reducing variations in utilization by appropriate use of evidence-based care and best practice guidelines, encouraging shared decision making, and using culturally and ethically appropriate care. Eligible entities include physician groups, integrated health systems, or regional coalitions of the same.

- *Medicare Care Management Performance Demonstration (MMA Section 649)*: Modeled on the "Bridges of Excellence" program, this is a three-year pay-for-performance demonstration with physicians to promote the adoption and use of health information technology to improve the quality of patient care for chronically ill Medicare patients. Doctors who meet or exceed performance standards established by CMS in clinical delivery systems and patient outcomes will receive bonus payments for managing the care of eligible Medicare beneficiaries. In contrast to the Physician Group Practice Demonstration, this demonstration, which is currently under development, is focused on small and medium-sized physician practices. The demonstration will be implemented in California, Arkansas, Massachusetts and Utah, with the support of the Quality Improvement Organizations (QIOs) in those states.

- *Physician Group Practice (PGP) Demonstration*: This program rewards physicians for improving the quality and efficiency of health care services delivered to Medicare fee-for-service beneficiaries. Under this demonstration, 10 participating physician groups continue to be paid on a fee-for-service basis and are eligible for performance payments derived from savings from the implementation of care management strategies designed to anticipate patient needs, prevent chronic disease complications and avoidable hospitalizations, and improve quality of care.

II. THROUGHPUT

Although throughput is primarily a function of internal hospital operations and management, and should remain so, CMS has clarified a number of policies to allow hospitals increased flexibility to improve patient flow. These include actions taken by CMS in response to interim recommendations of the Emergency Medical Treatment and Labor Act (EMTALA) Technical Advisory Group (TAG), as well as other initiatives, as described below.

a) **Provider Agreement Regulations and Conditions of Participation:**

- *Provider Agreement Regulations:* CMS responded to testimony and public comments received by the EMTALA TAG by revising the hospital Inpatient Prospective Payment System (IPPS) final rule in 2006 to include changes in the provider agreement regulations implementing EMTALA. This revision stipulated that a hospital that has specialized capabilities is required to accept appropriate transfers of patients, regardless of whether the hospital has a dedicated emergency department. This clarification was intended to improve timeliness of necessary and appropriate transfers by assuring that hospitals with specialized capabilities, including specialty hospitals, are aware of their obligation to accept transfer requests.

- *Conditions of Participation*: CMS has utilized the Conditions of Participation (CoPs) that health care organizations must meet in order to participate in the Medicare and Medicaid programs to facilitate the flow and throughput of inpatients. These minimum health and safety standards are the foundation for improving quality and protecting the health and safety of beneficiaries. In addition to specific standards to which CMS holds the hospital for the provision of emergency services, the general CoP provisions provide guidance for the safe provision of care and services as the patient enters into the hospital system.

  Established within the requirements for participation in the Medicare program are avenues to assure that traffic flow of the patient will include the provision of care in a safe setting. Patients are expected to be assessed in a timely manner by staff, with sufficient staff available to meet the patients' needs. Ensuring sufficient numbers of staff is the responsibility of the hospital's governing body. Administrative and medical staff must share the responsibility for managing the patient flow process in admission decisions, transfer and discharge decisions, along with the scheduling of patient tests and patient interventions.

  While the requirements do not specifically prohibit the boarding of patients in hallways, wherever their care is provided, all requirements must still be met. The existing requirements stipulate that care must be furnished in a safe environment, including compliance with standards for infection control practices as well as those for fire safety and evacuation routes. Patients are to be treated with dignity and the confidentiality of medical treatment must be assured. The patient's plan of care in a therapeutic environment is monitored though the assessment of the nursing process.

  In November 2006, CMS published a final rule revising the hospital Conditions of Participation. We addressed concerns about the burden and restrictiveness of several of our requirements. We extended the authority to conduct the history and physical examination required for each patient to other qualified individuals (besides physicians) in accordance with state law, and lengthened the timeframe for conducting the examination to 30 days prior to, or 24 hours after, admission. We also expanded the individuals qualified to conduct post-anesthesia evaluations, as well as to authenticate verbal orders. Finally, we revised the requirements governing the securing of drugs and

biologicals to achieve a more appropriate balance between enhancing efficient access to promote patient safety and avoiding unauthorized access.

b) Financing Initiatives:

- *Emergency Department Visit Payment Refinements*: Since the inception of the hospital Outpatient Prospective Payment System (OPPS), hospitals have reported emergency department visits according to their own internal hospital guidelines based on five levels of CPT codes, depending upon the resource intensity of the visits, with level 1 visits requiring the fewest and level 5 visits requiring the greatest facility resources. However, hospitals were paid for these visits at only three payment levels. In calendar year (CY) 2006, payments ranged from $74 for level 1 and 2 visits, to $129 for level 3 visits, to $225 for level 4 and 5 visits. In the CY 2007 hospital OPPS final rule (71 FR 68134), CMS finalized a policy that reimburses emergency department visits at five payment levels instead of the prior three in an effort to more accurately tie payments to the intensity of the hospital resources utilized, with higher payment, in particular, for the most resource-intensive emergency department visits. Accordingly, for CY 2007, these payment rates are $50, $83, $130, $210, and $325 for levels 1 through 5 visits, respectively. CMS believes that this refined payment methodology will provide more accurate payments for hospital emergency department visits, particularly for the most resource intensive emergency department visits provided by hospitals to outpatients.

- *Trauma Activation:* Since the inception of the hospital OPPS, hospitals have been paid at one payment level for outpatient critical care services lasting at least 30 minutes, into which hospital payment for a trauma response, if provided, was packaged. In response to public comments on the CY 2007 OPPS proposed rule and to a recommendation of the Advisory Panel on Ambulatory Payment Classification Groups, CMS finalized a policy in the CY 2007 hospital OPPS final rule (71 FR 68134) that would provide an additional separate payment for trauma activation in association with critical care services, to recognize the significant hospital resources associated with a trauma response for Medicare beneficiaries treated as hospital outpatients.

  As noted in the final rule, CMS' claims analyses revealed that the typical hospital cost for the provision of a trauma response in association with critical care services was about twice the cost of critical care services without a trauma response. Therefore, under the CY 2007 OPPS, when a hospital trauma center reports a charge for trauma activation in accordance with established guidelines regarding prehospital notification based on triage information, and provides an appropriate trauma team response associated with critical care services, the hospital will receive a second separate payment in addition to their payment for critical care services. CMS believes that this differential OPPS payment for critical care services with and without trauma activation will improve the accuracy of OPPS payments relative to the required hospital resources, to ensure that trauma centers are paid appropriately for the costs associated with their preparedness and delivery of outpatient emergency trauma services to Medicare beneficiaries.

- *Inpatient Psychiatric Facility Adjustment*: Inpatient psychiatric facilities are paid under a per diem payment system, known as the Inpatient Psychiatric Facility Prospective Payment System (IPF PPS). The IPF PPS includes an adjustment to recognize the higher cost of psychiatric facilities with emergency departments, including psychiatric units in hospitals with emergency departments. In so doing, the IPF PPS provides an approximately 12 percent positive adjustment for the first day of care for facilities with qualified emergency departments (e.g., they are open 24 hours a day, seven days a week) in order to recognize the higher costs incurred in the early days of a psychiatric stay.

- *Redistribution of Residency Slots*. Medicare pays hospitals that train residents in approved programs additional graduate medical education (GME) payments. Hospitals are paid for GME based on the number of residents they train up to a hospital-specific cap. Section 422 of the MMA required the Secretary to redistribute "unused" residency slots (many hospitals were historically training fewer residents than their caps) to other teaching hospitals. An additional 2,500 slots were redistributed under this provision to hospitals nationwide. In recognition of the need for more emergency medicine physicians, CMS specifically gave priority to hospitals that were beginning to train residents in emergency medicine. This will help to address the shortage identified by the IOM.

c) **EMTALA TAG Initiatives:**

Section 945 of the MMA required the Secretary to establish a Technical Advisory Group (TAG) to provide the Secretary with advice concerning issues related to EMTALA regulations and implementation. The members of the EMTALA TAG include the Administrator of CMS, the Inspector General of HHS, hospital representatives and physicians representing various specialties, patient representatives, and representatives of organizations involved in EMTALA enforcement.

The EMTALA TAG is expected to complete its work and offer final recommendations later this year. However, several interim recommendations have already been proposed by the TAG and adopted by CMS, including the application of EMTALA requirements to hospitals without dedicated emergency departments, as described above. This clarification was finalized in the FY 2007 hospital inpatient prospective payment system final rule (71 FR 48097), which extends the requirements of EMTALA concerning acceptance of appropriate transfers to hospitals that have specialized capabilities but are without dedicated emergency departments.

In addition, CMS recently clarified that a hospital or critical access hospital may use remote telecommunications technology to obtain a consultation from another physician without violating EMTALA. Specifically, a Survey and Certification letter dated June 21, 2007, states that the treating physician in a hospital's or critical access hospital's dedicated emergency department who is conducting a medical screening examination and/or providing stabilizing treatment of an individual as required by EMTALA may, without violating EMTALA, consult on the individual's case with a physician who is not present in the dedicated emergency department by means of any telecommunications medium that the physicians choose to use.

Another on-going focus of discussion by the EMTALA TAG is the extent to which EMTALA requirements would apply in disaster situations, and the circumstances under which some provisions might appropriately be waived. CMS looks forward to the EMTALA TAG's final recommendations on this and other issues, and will carefully consider whether regulatory changes or legislative proposals may be warranted.

d) Quality Measurement:

CMS is actively engaged in hospital quality measurement endeavors. A number of existing quality measures relate to the timeliness of emergency care for particular conditions. Additional quality measurement development is underway to more broadly measure emergency department throughput. When implemented, the use of these standards will help measure and promote improvement in patient throughput at the facility level. The development and use of quality measures are more fully described in the response to Question #4.

III. OUTPUT

Once patients are hospitalized, their lengths of stay can be reduced -- and consequently bed availability increased -- through improved options for home, community, skilled nursing facility (SNF), and hospice care. In addition, as more procedural care is moved into the outpatient setting, more in-patient beds can be available for emergency patients admitted through the emergency department, which by and large tend to be chronic care admissions.

a) Initiatives Through the Use of Section 1115 Waivers That Facilitate Community-Based Care:

CMS continues to work with States to expand health care coverage to low-income uninsured populations under demonstration projects. A major element of these demonstration programs is encouraging the provision of care in the most appropriate setting. Many of the individuals covered under these demonstrations are the parents of Medicaid or SCHIP-eligible children who would otherwise lack health care coverage.

Major health care coverage expansions as in Massachusetts, a state with a CMS-approved demonstration that is nearing universal coverage, are helping to eradicate the "old culture" of low-income Americans receiving non-emergency services in the emergency department. As the number of uninsured individuals decreases, there is a parallel movement towards the most appropriate settings to deliver the care that low-income people need. Specifically, in the case of Massachusetts, CMS was able to work with the State to ensure that the demonstration provided additional health insurance coverage, while at the same time offering the necessary financial stability to hospitals that provide emergency services.

Massachusetts, Oregon, Vermont, Oklahoma, and other states are moving towards private coverage models. In doing so, they build upon the strengths of the employer-based model, rather than addressing the issue of the uninsured by expanding public coverage programs. Private coverage models, in which financial accountability for providing quality care is placed front-and-

center, also encourage efficiencies and, therefore, encourage care in appropriate settings with an emphasis on prevention.

CMS has also worked with States to develop demonstrations that appropriately align incentives for consumers with settings that emphasize prevention and an ongoing relationship with a primary care provider. One straightforward way to incentivize individuals to be aware of the costs of medical care is through the pricing of the service. Therefore, appropriate financial incentives are another tool States are testing as a motivator to encourage timely care in the most appropriate setting. Under Utah's demonstration, higher-income people are charged $30 for emergency department visits, compared to $5 for outpatient office visits. Other States are considering different mechanisms to guide individuals to appropriate settings. Indiana is currently working with CMS on an account-based model that is expected to offer $500 of first-dollar coverage for preventive services to uninsured adults to encourage the use of these services. This prevention-focused approach would be tied to a charge as high as $25 for use of the emergency department, providing additional incentives to think about the costs of care and where care is most appropriately received.

In addition to covering more people, moving towards private coverage models, and making consumers aware of the costs of medical care – all of which can help create a health care system that focuses more on prevention and higher-quality health outcomes – CMS encourages States to develop program enhancements through demonstration projects. Iowa, for instance, offers under its demonstration project a 24-Hour Nurse Hotline. Operational since late 2006, the hotline is staffed by nurses from the University of Iowa's Hospitals and Clinics. Within the first three months of operation, the Nurse Hotline received nearly 3,000 calls. It assists in directing individuals toward the most appropriate care setting, thereby decreasing inappropriate use of the emergency department.

b) Section 5001(c) of the Deficit Reduction Act (DRA):

Section 5001(c) of the DRA implemented a quality adjustment in the DRG payment for certain hospital acquired infections. Effective for discharges on or after October 1, 2008, the DRG to be assigned shall be the DRG group that does not result in a higher payment based on the presence of a secondary diagnosis code. The secondary diagnosis code must describe a condition that could have reasonably been prevented through the application of evidence-based guidelines. By implementing Congressional intent to incentivize hospitals to eliminate preventable complications, hospital stays are shortened, improving hospital throughput.

Finally, the initiatives discussed above should also serve as a model for private insurers. Even though Medicare and Medicaid beneficiaries account for the highest number of inpatients admitted through the emergency department nationwide, private pay patients still account for the largest volume of emergency department visits. It is important that none of these initiatives be viewed in isolation. Rather, the changes CMS has already implemented as well as our future plans are part of a broad, strategic plan to leverage our position in the market as well as our role as a public health agency to address the emergency care crisis.

2) What actions, if any, has CMS taken to address the diversion of ambulances from emergency rooms at hospitals receiving Medicare or Medicaid funds? If CMS has taken no action to address this issue, please supply your rationale for such inaction.

As with boarding of inpatients in emergency departments, ambulance diversion is a symptom of larger healthcare delivery issues facing the emergency care system. The types of initiatives listed in response to Question #1, focusing on the drivers behind emergency department crowding, would similarly reduce the necessity for ambulance diversion. In addition, CMS has specifically addressed issues related to ambulance capacity, from clarifying hospital responsibilities to adjusting ambulance payments, as described below.

a) EMTALA Clarification for Hospitals:

CMS heard complaints from EMS providers that some hospitals were refusing to take responsibility, often for lengthy periods, for patients transported by ambulance to the emergency department, requiring the ambulance crew to remain with the patient, thereby reducing EMS capability to respond to other emergency calls. CMS issued Survey and Certification memoranda on July 13, 2006 and April 27, 2007 reiterating that a hospital with a dedicated emergency department has an EMTALA obligation that begins when an individual arrives on the hospital's property, and that "parking" of patients with the ambulance crew was not acceptable. On the other hand, CMS also recognized that there might be extraordinary circumstances where emergency department staff are so busy with other emergent cases that it could be reasonable for them to ask EMS providers to briefly monitor a less urgent patient. CMS sees the emergence of such conflicts between EMS providers and hospitals as evidence of the rapid growth in demand for both types of services that has occurred in recent years.

b) Ambulance Payment:

In its 2006 report, *Emergency Medical Services at the Crossroads*, the IOM recommended that CMS consider the inclusion of readiness costs in Medicare payment for ambulances, and permitting reimbursement for EMS services rendered without transport. Recognizing the increased cost to ambulance services to be able to respond to emergency 911 and equivalent calls, the ambulance fee schedule already differentiates payment for emergency response from other routine ambulance transports. Ambulance costs include the direct costs of each emergency response, as well as the readiness costs associated with maintaining the capability to respond quickly, 24 hours a day, seven days a week. Medicare's ambulance fee schedule payment structure (which recognizes seven levels of service) was devised by a Negotiated Rulemaking Committee representing all aspects of the ambulance industry. When defining "emergency response" and setting payment levels for emergency level services, the Negotiated Rulemaking Committee recognized the cost of readiness and built it into the payment structure of the fee schedule.

With respect to payment for EMS services without an ambulance transport, it is important to note that Medicare coverage of ambulance services is limited by statute. The Medicare ambulance benefit is defined in Section 1861(s)(7) of the Social Security Act, which states that ambulance services are covered "when the use of other methods of transportation is contraindicated by the

individual's condition." CMS interprets this language as limiting the benefit to instances when an actual transport occurs, as well as a determination that the services are medically necessary and other forms of transport would be medically contraindicated. Thus, services rendered without actual transport of the patient (for example, EMS services furnished at an accident scene with no subsequent transport) are not covered under the statutory parameters of the ambulance benefit.

Further details on ambulance payment are addressed in Question #9.

3) What actions, if any, has CMS taken to address the decrease in coverage by on-call specialists at hospitals receiving Medicare or Medicaid funds? If CMS has taken no action to address this issue, please supply your rationale for such inaction.

We believe this question is best viewed in relation to the "on-call" requirement under EMTALA. In 2003, based on numerous comments that CMS' previous EMTALA guidance was overly prescriptive and that hospitals should not be required to maintain any particular level of on-call coverage, CMS adopted regulations providing more general guidance on this issue. Under those regulations, which are currently in effect (see 42 CFR 489.24(j)), each hospital is required to maintain an "on-call" list of physicians in a manner that "best meets the needs" of patients receiving services required under EMTALA, in accordance with the resources available to the hospital, including the availability of on-call physicians. However, some hospital representatives subsequently expressed concern that this more general requirement is *insufficiently* prescriptive, thereby exacerbating rather than improving the problem of insufficient on-call coverage. In response, CMS has sought comments and suggestions from the EMTALA TAG.

The EMTALA TAG has recognized that the shortage of on-call coverage is complex with multifaceted causes ranging from changes in workforce, lifestyle, and delivery models, to name just a few. They also recognize that CMS lacks the statutory authority to require physicians to provide on-call services. To better address a range of possible approaches to the problem, the TAG established a subcommittee devoted solely to on-call issues, including (among other considerations) options for regionalization of on-call services. The TAG is expected to issue its final recommendations this fall. In the meantime, it is continuing its deliberations on this issue, including substantive input from experts across the country. The TAG has also acknowledged that factors beyond EMTALA affect on-call availability and established another subcommittee to consider larger healthcare system issues, ranging from reimbursement, to liability environment, to workforce, to capacity, to disparities in care.

CMS believes any further substantive action on this issue should await the TAG's final report. The Secretary will then evaluate the TAG's recommendations and will consider any regulatory changes or legislative proposals, as appropriate.

In the meantime, CMS has moved forward with other relevant initiatives. For example, on June 22, 2007, CMS issued instructions to the State survey agencies to clarify that telecommunications technology may be used by physicians treating emergency cases as a means to consult with specialists, including ones who are not on-call at the hospital, without violating EMTALA. Furthermore, specialists who are on-call do not have to appear in person, unless the treating physician requests this. This clarification facilitates broader and more efficient access to specialty services.

4) What actions, if any, has CMS taken to address the adverse health consequences of emergency room crowding, the boarding of admitted patients in ERs, and the diversion of ambulances on Medicare and Medicaid beneficiaries? If CMS has taken no action to address this issue, please supply your rationale for such inaction.

Evidence on the collective impact of ED overcrowding, boarding and diversion on health outcomes is largely anecdotal to date, with studies only now emerging as to the specific adverse outcomes related to increased lengths of stay, medical errors, morbidity and mortality, and other factors. Due to the complex interplay of individual contributing factors that vary by hospital, community and region, at this time we believe solutions to these problems are best addressed by a local approach rather than in a top-down manner from CMS.

While generally not mandating particular solutions to these and other health quality challenges, CMS does, however, require hospitals to be proactive and to employ systemic approaches to improving quality of care and patient safety. And regardless of whether a hospital is experiencing ED overcrowding, patient boarding, or diversion of ambulances, the hospital still has obligations related to quality of care, outlined by the Medicare Conditions of Participation (CoPs).

Adverse health occurrences in hospitals are dealt with through CMS' survey and certification enforcement process and the application of CoPs when specific complaints arise. Additionally, through its QIO program, CMS provides technical assistance to healthcare facilities and organizations to improve quality of care. Finally, CMS has a number of quality initiatives in this area, which are described below.

a) Conditions of Participation (CoPs):

CMS requires, through the Conditions of Participation, that hospitals develop, implement and maintain a hospital-wide, data-driven quality assessment and performance improvement program. Hospitals are expected to measure, analyze and track internal quality indicators, including adverse patient events, and other aspects of performance related to process of care, hospital services and operations. Hospitals are required to set priorities for performance improvement activities that focus on high-risk, high-volume or problem-prone areas and affect health outcomes, patient safety and quality of care. A hospital must conduct annual performance projects proportionate in number to the scope and complexity of services it offers. It would be reasonable and desirable for a hospital, as one of its quality improvement projects, to focus on the factors that increase emergency room crowding, boarding and ambulance diversion, and to undertake initiatives to address those factors within the hospital's control. CMS does not, however, mandate specific hospital quality improvement projects or methodologies, since hospitals must have the flexibility to tailor their efforts to their specific circumstances.

b) Survey and Certification Enforcement Process:

Apart from CMS' special quality initiatives, its routine survey and certification activities provide a critical foundation in ensuring that hospitals, including their emergency departments, comply with the health and safety standards established in the Conditions of Participation. Through its

complaint investigation activities, CMS surveys the compliance of both accredited and non-accredited hospitals. Through the survey process, deficiencies are identified and hospitals are required to develop and implement systematic plans to correct the identified problems and, ultimately, to provide better care for patients.

c) **Quality Initiatives:**

- *HCAHPS Survey:* Section 5001(a) of the Deficit Reduction Act of 2005 (DRA) required the Secretary to expand the set of quality measures collected in the inpatient hospital setting, including Hospital CAHPS (HCAHPS) measures. The HCAHPS survey provides a standardized instrument and data collection methodology for measuring patients' perspectives on hospital care. The survey is designed to produce comparable data on the patient's perspective on care that allows objective and meaningful comparisons between hospitals on domains that are important to consumers. Survey results are publicly reported, which is designed to create incentives for hospitals to improve their quality of care and enhance public accountability by increasing the transparency of the quality of hospital care. The survey includes measures on the hospital environment and a patient's experience at the hospital as well as care from doctors and nurses. The perspectives of admitted patients will be included as part of this survey and public reporting initiative. Given the large subset of patients admitted through the emergency department, their satisfaction, often colored by long wait times and throughput, will create an opportunity for hospitals to improve patient flow.

- *Value Based Purchasing Initiatives*: CMS is also working to implement Section 5001(b) of the DRA, which authorized CMS to develop a value-based purchasing plan for Medicare hospital services beginning in FY 2009. This report will be submitted to Congress shortly and reflects extensive research on value-based purchasing in the hospital setting. The plan would utilize financial incentives and public reporting to reward both improvement and attainment on quality measures. The plan would be gradually implemented during FY 2010-2011 and would initially measure efficiency, outcomes, emergency care, care coordination, and structural and patient safety.

- *Public Reporting of Quality Measures:* Another way CMS has sought to leverage its position as a primary payer of services furnished to inpatients admitted through the emergency department is by improving the quality of care furnished to Medicare beneficiaries through public reporting of quality data. Public reporting not only provides information to the public, but is an important stimulus for hospitals to improve quality. Hospitals currently report on 22 measures, which are publicly available on the Hospital Compare website for nearly all hospitals.

  Several of the measures pertain to care in hospital emergency departments and thus are indicators of quality of care in that setting. Insofar as hospital emergency department crowding may have a general impact on the quality of care rendered in emergency departments, it could be expected that the Hospital Compare measures pertaining to the emergency department may be impacted. Further, three of the Hospital Compare measures relate directly to the timeliness of care in the hospital emergency department.

These include timing of antibiotic administration for patients admitted for pneumonia, timing of percutaneous coronary intervention for a heart attack, and timing of thrombolytic therapy for a heart attack.

CMS has also embarked on a project to develop quality measures specifically directed at the timely and efficient provision of hospital emergency department care. Examples of measures that could result from this project include overall patient time in the emergency department for admitted patients and for discharged patients; percentage of emergency department patients who left without being seen by a physician; emergency department patient turnaround time for particular conditions and services; and timeliness of administration of pain medications.

Hospital Compare utilizes consensus endorsed measures, thereby representing broad consensus among stakeholders in the healthcare system. At this time there are no consensus measures available for implementation that have been adopted or endorsed by national consensus organizations that relate to throughput in hospital emergency departments.

- *Hospital Quality of Care:* Medicare's Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program has been providing differential payments to hospitals that publicly report their performance on a defined set of inpatient care performance measures since FY 2004. The measures are designed to create incentives for better care, focusing specifically on some conditions that are often treated in an emergency department prior to the patient being admitted, such as acute myocardial infarction, heart failure, and pneumonia.

  Since its inception, the RHQDAPU program has been expanded to provide consumers with quality of care information that will enable them to make more informed decisions about their healthcare and encourage hospitals to improve the quality of inpatient care. The hospital quality of care information gathered through the initiative is available to consumers on the Hospital Compare website. Hospitals that do not report the required set of quality measures receive a reduced payment update.

d) <u>Quality Improvement Organizations</u>:

The Quality Improvement Organizations have considerable responsibilities in quality improvement with providers nationally. Currently, QIOs work with nursing homes, home health agencies, hospitals, and physician offices. The following are clinical activities that QIOs are working on with providers to reduce patients' need for hospitalization:

- Preventing readmission to the hospital through appropriate care by home health agencies,
- Influenza and Pneumococcal vaccinations,
- Management of pressure ulcers,
- Management of depression,
- Improving primary care physicians' use of care management, measuring clinical care, and providing preventive care.

CMS has also charged the QIOs with implementing a number of initiatives to provide health information technology (HIT) services across the continuum of provider settings. Fewer emergency room visits and hospitalizations are key benefits that will result from care management and HIT implementation. Through the Doctor's Office Quality Information Technology (DOQ-IT) initiative, over 4,000 practices representing 13,200 physicians across the U.S. have taken a baseline survey as the first step in adopting and implementing electronic health records (EHRs). Also, on April 11, 2007, CMS launched DOQ-IT University (DOQ-IT U), a nationally available, first-of-its-kind, free e-learning system to support HIT in physicians' offices (accessible at http://elearning.qualitynet.org).

The Care Management Module provides a web-based learning opportunity for all physicians. Modules will focus on adopting and implementing HIT in the physician's office setting, improving the physician/patient relationship and dialogue, overall strategies for motivating patients to engage in their care, optimizing decision-making by providing choice of individual tests/therapies based on specific guidelines, costs and therapeutic value, preventing errors through averting errors of omission, improving care processes such as providing better care documentation, enhancing preventive care, and improving understanding of drug interactions and use in the elderly.

This systemic approach to care management will help to prevent emergency room visits and hospitalizations. Care management modules will also include disease-specific tools and templates to engage patients in their own care (including for diabetes, coronary artery disease, hypertension, and congestive heart failure, as well as preventive care)

5) CMS has issued a final rule that would limit Medicaid payments to government providers, including safety net hospitals that furnish emergency care and level 1 trauma services. (72 Fed. Reg. 29748 (May 29, 2007)). In developing this proposal, did CMS seek the opinion, formal or informal, of the Office of the Assistant Secretary for Preparedness and Response (OASPR) as to whether the proposed rule would have an adverse effect on the nation's disaster preparedness? If not, please explain why CMS did not seek the OASPR's opinion on this matter. If so, please provide a copy of any document received from the OASPR relating to its opinion on this matter.

In developing the proposed Medicaid Payment Reform Proposal as well as the final rule, published on May 29, 2007, CMS used standard clearance and review processes including the review of components of the Department of Health and Human Services (DHHS). However, CMS did not specifically request input from OASPR because that Office is not likely to have expertise in Medicaid financing arrangements, which is the subject of the rule.

In general, this rule should not negatively impact safety net providers. As noted in our response to previous questions from the Committee on this issue (using Grady Memorial Hospital as an example), providers are unfairly bearing the burden of financing the non-federal share of the Medicaid program. Our rule would, in fact, benefit these providers.

To the extent that a provider is not governmentally operated, this rule does not impact Medicaid payments made to them by the State. It would, however, offer further protection against States requiring non-governmental providers to assist in the funding of the Medicaid program as well as clearly stating that the provider must retain all of the Medicaid payments it receives.

To the extent that a provider is governmentally operated, the rule stipulates that the provider is entitled to receive Medicaid payments up to their full cost of providing services to Medicaid eligible individuals.

6) CMS has issued a proposed rule to eliminate federal Medicaid matching payments for the costs of Graduate Medical Education (GME), including the costs of residents who staff emergency rooms and trauma centers. (72 Fed. Reg. 28931 (May 23, 2007)). In developing this proposal, did CMS seek the opinion, formal or informal, of OASPR as to whether the proposed rule would have an adverse effect on the nation's disaster preparedness? If not, please explain why CMS did not seek the OASPR's opinion on this matter. If so, please provide a copy of any document received from the OASPR relating to its opinion on this matter.

In developing the proposed Graduate Medical Education (GME) rule published on May 23, 2007, CMS used standard clearance and review processes including the review of components of the Department of Health and Human Services (DHHS). However, CMS did not specifically request input from OASPR because the rule did not directly address payments to "safety net hospitals" nor did it target Medicaid payments for emergency departments or trauma centers.

The proposed GME rule specifies that states may not make medical education payments under their Medicaid State plans because Congress has not authorized GME as a reimbursable service under Title XIX as they directly have under Title XVIII. The proposed rule indicates that States are able to recognize increased costs associated with providing services in teaching hospitals by increasing the rates paid for those services. In addition, States would also be able to include the Medicare adjustment known as indirect medical education (IME) when calculating the Medicaid upper payment limit applicable to Medicaid rates. The Medicare IME adjustment is the payment Medicare uses in its reimbursement system to recognize the increased service costs in teaching hospitals.

In addition, limitations regarding graduate medical education payments should not adversely impact the nation's disaster preparedness as the Medicaid program is a federal-state partnership to provide medical benefits and services to low-income citizens of the United States.

7) In its June 2006 report, *The Future of Emergency Care*, the Institute of Medicine (IOM) recommended that "CMS should convene a working group that includes experts in emergency care, inpatient critical care, hospital operations management, nursing and other relevant disciplines to develop boarding and diversion standards, as well as guidelines, measures, and incentives for implementation, monitoring and enforcement of these standards." What actions, if any, has CMS taken to implement this recommendation? If CMS has taken no action to implement this recommendation, please supply your rationale for such inaction.

We recognize that the strain and stresses of the emergency care system go beyond what CMS alone can address. To assure a comprehensive, coordinated approach to provide CMS with direction for current and future initiatives, CMS' first steps in response to the IOM report were:

- Participation in an HHS-wide workgroup
- Presentation at the IOM's Capstone Workshop
- Participation in the Federal Interagency Committee on Emergency Medical Services (FICEMS)
- Continued participation in EMTALA TAG

a) HHS-wide workgroup:

Soon after the IOM reports were released, HHS convened an internal senior staff level workgroup to examine the three reports, discuss the 22 recommendations directed at HHS, evaluate initiatives and suggest a strategy to move forward. We appreciate the IOM's careful analysis of the problems relating to emergency care, and we are continuing, together with the rest of the Department, to evaluate the recommendations of their reports. In particular, the Office of the Assistant Secretary for Preparedness and Response (ASPR) is developing a coordinated response to the IOM report. CMS has been an active member of the HHS-wide workgroup since its inception along with representatives of the NIH, AHRQ, CDC, FDA, ASH, and HRSA. This workgroup has been beneficial in providing a forum for evaluation of the emergency care crisis from a global HHS viewpoint rather than examination of the CMS role in isolation.

b) IOM's Capstone Workshop:

In December 2006, CMS provided testimony at the IOM's Capstone Workshop in Washington D.C., which provided a forum to engage public and stakeholder groups in a national discussion of issues identified in the three IOM reports, outlining some of CMS' initial responses to the IOM reports in conjunction with other HHS agencies.

c) FICEMS:

CMS has been an active member of the Federal Interagency Committee on Emergency Medical Services (FICEMS) since its inception in December 2006. FICEMS was established by the Safe, Accountable, Flexible, Efficient Transportation Equity Act: A Legacy for Users (42 U.S.C 300d-4). FICEMS is charged with coordinating Federal Emergency Medical Services (EMS) efforts for the purposes of identifying State and local EMS needs, recommending new or

expanded programs for improving EMS at all levels, and streamlining the process through which Federal agencies support EMS. The Secretary of Transportation, the Secretary of Health and Human Services, and the Secretary of Homeland Security, acting through the Under Secretary for Emergency Preparedness and Response has established a Federal Interagency Committee on Emergency Medical Services. The Committee is in the process of developing recommendations that are pertinent to the IOM report. Again through active participation in such workgroups, CMS can assure its efforts are consistent and coordinated with the federal community at large.

d) EMTALA TAG:

CMS has had formal representation on the Emergency Medical Treatment and Labor Act (EMTALA) technical advisory group (TAG) established by the Medicare Modernization Act. The 19-member TAG was created to review issues related to EMTALA regulations, provide advice and recommendations to the Secretary regarding those regulations, solicit comments and recommendations regarding the implementation of regulations, and disseminate information regarding the application of such regulations. Following release of the IOM reports, the TAG requested formal testimony from the IOM to better understand their concerns and suggestions. This Fall 2007, the TAG will be issuing recommendations for changes in statute, regulations, or policy related to EMTALA.

Active involvement in such forums and Department-wide workgroups are an essential precursor to establishing any internal CMS working group. CMS will continue to work with HHS' Office of the Assistant Secretary for Preparedness and Response and with other appropriate agencies to address boarding and diversion concerns. This will foster a department-wide approach to the nation's emergency care issues. Moreover, as noted in responses 1 - 4, even in the absence of a formal internal working group, CMS has already taken action on numerous initiatives designed to improve emergency department crowding.

8) In its June 2006 report, IOM recommends that CMS "remove the current restrictions on the medical conditions that are eligible for separate clinical decision unit (CPU) payment." What actions, if any, has CMS taken to implement this recommendation? If CMS has taken no action to implement this recommendation, please supply your rationale for such inaction.

Under the hospital Outpatient Prospective Payment System (OPPS), Medicare provides payment for observation care. Such care is described as a well-defined set of specific, clinically appropriate services that include ongoing short-term treatment, assessment, and reassessment of patients before a decision can be made regarding whether they will require further treatment as hospital inpatients or if they can be discharged from the hospital. Observation status is commonly assigned to patients with unexpectedly prolonged recovery after surgery, and to patients who present to the emergency department and require a significant period of treatment or monitoring before a decision is made concerning their next placement. "Clinical decision units" may be developed by hospitals specifically for observation of patients with certain medical conditions, in order to improve the efficiency and quality of care for those patients.

The OPPS provides payment for all medically reasonable and necessary observation services. In the majority of cases (approximately 70 percent of occurrences), payment for observation is bundled into the payment for other separately paid services provided to patients, including surgical procedures, emergency department visits, and diagnostic tests. This bundling of payment is consistent with the OPPS principle of prospective payment for clinically similar groups of services. The observation care is inextricably linked to these other services, and its costs are considered in establishing the OPPS payment rates for these services. For three medical conditions, specifically asthma, congestive heart failure, and chest pain, the OPPS provides separate payment for observation care based upon the observation care costs determined from hospital claims data for patients with these conditions. For separate payment to be provided, a variety of criteria must be met, including a minimum of eight hours of observation care. Hospitals may determine the most appropriate approaches to providing observation care in their facilities, including developing clinical decision units, because bundled or separate payment for this care for all clinical conditions is provided under the OPPS.

The Advisory Panel on Ambulatory Payment Classification Groups (APC Panel), which advises CMS on the OPPS, has an active Observation and Visit Subcommittee that studies observation issues. The APC Panel has made recent recommendations to provide separate payment for observation for additional diagnoses, specifically syncope and dehydration, and to evaluate other clinical conditions for which separate payment for observation care could be appropriate.

The June 2006 IOM Report encourages hospitals to apply tools to improve the flow of patients through emergency departments, including developing clinical decision units. CMS encourages the current efforts by hospitals to streamline their care for patients receiving emergency services, including those patients for whom a period of observation care is necessary before a decision about patient admission or safe discharge from the hospital can be made. CMS is currently considering the recommendations of the APC Panel and examining all of the current OPPS payment policies for observation services, which are presently provided to Medicare beneficiaries with many different clinical conditions, to assess whether any changes to those

policies would provide more appropriate payment to hospitals for observation care. This assessment includes evaluating whether different packaged and separate observation payment policies should continue to be associated with observation care for specific clinical conditions. Any changes to the current observation payment policies would be proposed through the annual OPPS rulemaking cycle.

9) A recent GAO study concludes that Medicare payments for EMS services are 6% below the average cost of an ambulance transport, and 17% below cost in super-rural areas. (U.S. Government Accountability Office, *Ambulance Providers: Costs and Expected Medicare Margins Vary Greatly* (May 2007) (GAO-07-383)). What actions, if any, does CMS intend to take to address the GAO findings?

On April 1, 2002, CMS implemented the Medicare ambulance fee schedule in a budget neutral manner, with a 5-year transition period. The relative values in the fee schedule were established through a negotiated rulemaking process, as required by the statute. During the transition to the national fee schedule, the Medicare Modernization Act (MMA) added several temporary payment provisions to address the cost of ambulance services including a substantial add-on for ambulance trips originating in "super rural" areas (expiration date December 31, 2009) as well as an additional payment for long rural trips (expiration date December 31, 2008) and a regional adjustment for ambulance companies located in areas that would not have received as great a benefit under the national ambulance fee schedule's original transition formula (expiration date December 31, 2009). A provision supplementing payments for rural and urban ambulance trips by 2% and 1%, respectively, expired on December 31, 2006. We note that the Government Accountability Office (GAO) used predominately 2004 data to compile its May 2007 report ("*Ambulance Providers: Costs and Expected Medicare Margins Vary Greatly*" (GAO-07-383)), which was prior to the implementation of the MMA provisions.

CMS greatly appreciates the attention GAO paid to this issue and we welcome its recommendation for continued scrutiny. Specifically, GAO recommended that CMS monitor utilization of ambulance transports to ensure that Medicare payments are adequate to provide for beneficiary access, particularly in "super rural" areas. As stated in the Agency's comments on the GAO report, CMS is committed to continuing to monitor payment under the fee schedule and to make adjustments, as needed, to ensure that payment rates reflect the realities of ambulance services provided to Medicare beneficiaries. CMS also noted that the implementation of Rural Urban Commuting Areas (RUCAs), in conjunction with the 2000 decennial census population data, will allow us to recognize levels of rurality in every zip code across the country.

Mr. CUMMINGS. Thank you very much, doctors. Would you please stand.

[Witnesses sworn.]

Mr. CUMMINGS. We will first hear from Dr. Kevin Yeskey, the Director of the Office of Preparedness and Emergency Operations and Acting Deputy Assistant Secretary in the Office of the Assistant Secretary for Preparedness and Response at HHS.

STATEMENTS OF KEVIN YESKEY, M.D., DIRECTOR, OFFICE OF PREPAREDNESS AND EMERGENCY OPERATIONS, ACTING DEPUTY ASSISTANT SECRETARY, OFFICE OF THE ASSISTANT SECRETARY FOR PREPAREDNESS AND RESPONSE, DEPARTMENT OF HEALTH AND HUMAN SERVICES; AND WALTER KOROSHETZ, M.D., DEPUTY DIRECTOR, NATIONAL INSTITUTE OF NEUROLOGICAL DISEASES AND STROKE, NATIONAL INSTITUTES OF HEALTH, DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF KEVIN YESKEY

Dr. YESKEY. Thank you, Mr. Chairman, members of the committee, for the invitation to speak to you today on such an important topic, one in which the Office of the Assistant Secretary of Preparedness and Response is extremely interested and engaged.

I am Kevin Yeskey, a Board-certified emergency medicine physician, a former U.S. Public Health Service Officer and the Director of the Office of Preparedness and Emergency Operations within the Office of the Assistant Secretary for Preparedness and Response at the Department of Health and Human Services.

The Office of the Assistant Secretary for Preparedness and Response is relatively new, being created by the Pandemic and All-Hazards Preparedness Act passed in December 2006 establishing a lead Federal official for public health and medical preparedness and response within HHS. The Assistant Secretary for Preparedness and Response [ASPR], serves as the principal advisor to the Secretary of Health and Human Services on matters related to Federal public health and medical preparedness and response activities to national disasters.

Additionally, the responsibility of the ASPR include: one, leading the Federal public health and medical response to acts of terrorism, natural disasters, and other public health and medical emergencies; two, developing and implementing national policies and plans related to public health and medical preparedness and response; three, overseeing the advanced research and development and procurement of qualified medical countermeasures; four, providing leadership in international programs, initiatives and policies that deal with public health and medical emergency preparedness and response.

In short, the ASPR is responsible for ensuring a one-department approach to public health and medical preparedness and response, and leading and coordinating the relevant activities of the HHS operating divisions. As a result of many changes, including the passage of the Pandemic and All-Hazards Preparedness Act, the Office of the Assistant Secretary for Preparedness and Response is forward-leaning and results-driven. In just a short time since the en-

actment of the Pandemic Act, it has created the Biomedical Advanced Research and Development Authority; has completed the transfer of two programs, the National Disaster Medical System from the Department of Homeland Security and the Hospital Preparedness Program from the Health Resources and Services Administration; and has announced a National Biodefense Science Board. Again, all this has been completed since January 2007.

We are also committed to the use of evidence-based processes and scientifically founded benchmarks and objective standards called for in the law under the National Health Security Strategy. By utilizing this approach, OASPR will assure consistency in the preparedness efforts across our Nation, ensure greater accountability of local, State and Federal entities, and provide for a foundation for improved coordination.

The IOM "Future of Emergency Care" report represents an objective assessment of the status of our Nation's overall emergency care, as we have already heard. Recognizing the importance of these reports, HHS convened an internal work group to examine the 22 recommendations that were specifically directed at HHS.

We evaluated the initiatives, and the working group suggested a strategy to address those concerns. The working group was comprised of senior-level representatives from the relevant operating divisions and staff divisions of the Department, to include the National Institutes of Health, the Centers for Disease Control and Prevention, the Center for Medicare and Medicaid Services, the Food and Drug Administration, the Agency for Health Care Research and Quality, the Health Resources Services Administration, the Assistant Secretary for Health, and the ASPR.

The working group met regularly in 2006 and 2007, and the ASPR and I were briefed about the working group's progress. In evaluating the recommendations, the working group concluded there were three consistent items. One was the creation of a lead agency for emergency care within HHS to encourage efforts directed at daily emergency care issues, while also supporting the Federal Interagency Committee on Emergency Medical Services. The second was a unity of effort within HHS to promote clinical and systems-based research; and, finally, to further promote greater regionalized approaches to delivering daily emergency care.

The Institute of Medicine also held regional workshops to discuss these findings and recommendations and to encourage an open dialog with involved parties. The final capstone workshop conducted here in the National Capital included the participation of the ASPR.

As already noted, we have undertaken initial steps to better understand the IOM report recommendations, and we have initiated steps within HHS to implement them. ASPR is also creating an administrative element within the Office of the Assistant Secretary for Preparedness and Response that will promote coordination and unity of effort across the Department's emergency care activities.

In closing, OASPR will continue to provide leadership in this area, fostering a departmentwide approach to the Nation's emergency care issues.

Again, thank you for the invitation to speak today.

Mr. CUMMINGS. Thank you very much, doctor.

[The prepared statement of Dr. Yeskey follows:]

Testimony
Committee on Oversight and Government Reform
United States House of Representatives

Advancing Emergency Preparedness and Emergency Care in our Nation

Statement of
Kevin Yeskey, M.D.
Deputy Assistant Secretary
Office of Preparedness and Emergency Operations
Office of the Assistant Secretary for Preparedness and Response
U.S. Department of Health and Human Services

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Thank you, Chairman Waxman and Members of the Committee for the invitation to speak to you today on such an important topic and one in which the Office of the Assistant Secretary of Preparedness and Response is extremely interested and engaged. I am Kevin Yeskey, a Board Certified emergency medicine physician, prior Public Health U.S. Public Health Service officer and, as of May 27th , the Director of the Office of Preparedness and Response in the Office of the Assistant Secretary for Preparedness and Response (OASPR) at the U.S. Department of Health and Human Services (HHS).

As outlined within the Pandemic and All-Hazards Preparedness Act (PAHPA), our office's primary role is the federal lead for public health and medical disaster preparedness and response; therefore, the majority of my comments on the Institute of Medicine (IOM) report will concentrate in this area. I will make my remarks as brief as possible, for I look forward to your questions and discussing how HHS and ASPR can work with you to advance emergency preparedness and emergency care for our nation.

ASPR and the Pandemic and All Hazards Preparedness Act: A Nation Prepared

This is a challenging and an exciting time for the Office of the Assistant Secretary of Preparedness and Response. In December of 2006, the Pandemic and All-Hazards Preparedness Act was enacted, which created a lead federal official for public health and medical emergency preparedness and response within the HHS named the " The Assistant Secretary for Preparedness and Response (ASPR), currently RADM Craig Vanderwagen, a family physician with significant prior experience with the Indian Health Service, service in Iraq, and the HHS senior officer in the HHS responses during the 2005 Hurricane season and the Tsunami , serves as the lead official for Emergency Support Function #8, the Public Health and Medical Annex under the National Response Plan.. In addition, the Assistant Secretary of Preparedness and Response serves as the principal advisor to the Secretary of the Department of Health and Human Services on federal public health and medical preparedness and response issues,

oversees advanced research, development, and procurement of medical countermeasures and provides logistical support for medical and public health aspects of federal responses to public health emergencies. This extensive law also assigned to the ASPR lead and/or coordination roles over multiple HHS programs including: the Strategic National Stockpile, the Cities Readiness Initiative, the Medical Reserve Corps, the Emergency System for Advance Registration of Volunteer Health Professionals, the Hospital Preparedness Program and the National Disaster Medical System. I would like to briefly discuss two of these last two programs

Transferred to the Office of the Assistant Secretary of Preparedness and Response on January 1st of this year, the National Disaster Medical System is a coordinated effort by HHS and the Departments of Defense, Homeland Security, and Veterans Affairs, working in collaboration with states and other appropriate public and private entities to assist state and local authorities in dealing with the public health and medical impacts of public health emergencies and providing support to the military and the Department of Veterans Affairs medical systems in caring for casualties evacuated back to the U.S. from armed conflicts. The National Disaster Medical System, consisting of medical providers mainly from Emergency Medical Services, emergency departments and hospitals, stand ready to respond to public health or medical emergencies across the nation. The teams under this system include: the Disaster Medical Assistance Teams (DMAT), the Disaster Mortuary Operational Response Teams (DMORT), the National Medical Response Teams (NMRT), the Veterinary Medical Assistance Teams (VMATs), the National Nurse Response Teams (NNRT), and the National Pharmacy Response Teams (NPRTs). The mission of NDMS is three-three-three-fold: 1) providing medical support to a disaster area in the form of teams, supplies, and equipment; 2) moving patients from a disaster site to unaffected areas of the nation;, and 3) provision of definitive medical care at participating hospitals in unaffected areas.

The Health Resources and Services Administration (HRSA) Hospital Preparedness Program was also transferred to the OASPR as a result of the PAHPA. Since 2002 this program has distributed approximately $2.6 billion through cooperative agreements to

states to improve hospital emergency preparedness capabilities and capacity. Each state receives a base amount, plus an amount based on its proportional share of the national population. States must allocate at least 75 percent of its funds to hospitals or other health care entities and then distribute the funds to hospitals, with a small portion going to other entities such as community health centers, emergency medical services, and poison control centers. While the focus of the program had been bioterrorism preparedness, a shift has been made to all-hazards preparedness based on local and state hazard and vulnerability assessments. New to the program this year, as directed by PAHPA, is a competitive program that will enhance local healthcare system regional partnerships and collaborations, an area mentioned within the IOM Reports. The goal is to transcend day-to-day competitive interactions of hospitals and to foster collaboration to ensure that casualties of a mass casualty incident receive high quality care at the most appropriate facility capable of providing that care. To facilitate this collaboration, eligibility requirements require inclusion of a trauma center and a regional jurisdiction, be that county, city, or state. All applicants for this program will be required to demonstrate integration into their respective State's plans, as demonstrated by a letter of support from the State health office.

It should also be mentioned that the Office of the Assistant Secretary of Preparedness and Response, under PAHPA, has become more forward leaning, action-oriented and results driven. Since the beginning of 2007, OASPR has created the Biomedical Advanced Research and Development Agency, completed the transfer and review of the National Disaster Medical System (NDMS) and the announcement of the National Biodefense Science Board. We have also committed to the use of evidence-based processes and scientifically founded benchmarks and objective standards called for in the law under the National Health Security Strategy. By utilizing this approach, the OASPR will ensure consistency in the preparedness efforts across our nation, ensure greater accountability of local, state and federal entities, and provide a foundation for improved coordination.

HHS Responds to the IOM Reports

The reports -- "Hospital-Based Emergency Care", "Emergency Care for Children", and "Emergency Medical Services" -- represent an objective assessment of the status of our nation's overall emergency care system. In addition to issuing these three reports, the Institute of Medicine held regional workshops to discuss the findings and recommendations, encouraging an open discussion on this issue. We commend the IOM for holding the workshops and support the dialogue. The ASPR was a panel member and participated in the final capstone workshop here in the nation's capital.

Recognizing the importance of the IOM "Future of Emergency Care" reports, soon after the release, HHS convened an internal senior staff level workgroup to examine the three reports, discuss the 22 recommendations directed at HHS, evaluate initiatives, and suggest a strategy to move forward.

This workgroup met regularly since 2006. The workgroup includes representatives from Operating Divisions (OPDIVs) and Staff Divisions (STAFFDIVs) throughout the department including the National Institutes of Health (NIH), Centers for Disease Control and Prevention (CDC), Centers for Medicare and Medicaid Services, Food and Drug Administration (FDA), Assistant Secretary for Health (ASH), Agency for Healthcare Research and Quality (AHRQ) and Health Resources and Services Administration. The workgroup found that all three reports made valuable recommendations.

In evaluating the recommendations, the workgroup concluded there were three consistent themes that were noted: 1) creation of a lead agency for emergency care within HHS to encourage efforts directed at daily Emergency Care issues, while also supporting the Federal Interagency Commission on EMS, 2) unity of effort with AHRQ, FDA, CDC and the NIH to promote clinical- and systems- based emergency care research, and 3) assistance from HRSA, CMS, and the ASH's office, to further promote greater regionalized approaches to delivering daily emergency care.

The Way Ahead

ASPR has already undertaken initial steps to better understand the IOM report recommendations and has begun working within the department to discuss ways to proceed. Additionally, ASPR is creating an administrative element within the Office that will coordinate the HHS's emergency care activities. The ASPR will continue to provide leadership in this area, fostering a department-wide approach to the nation's emergency care issues.

This concludes my testimony. Thank you.

Mr. CUMMINGS. Dr. Koroshetz.

STATEMENT OF WALTER J. KOROSHETZ

Dr. KOROSHETZ. Thanks very much. It is a pleasure to talk to you about the NIH efforts in emergency research.

The emergency conditions that threaten patients with risk of their life and risk of their quality of health are exceedingly important to the NIH, and much of our effort goes into trying to find better treatment for these patients, and I would ask you to think about our efforts in terms of a pyramid where at the bottom we have the basic research issues that then go up higher into the translational research issues where what we discover from the basic can be applied to disease process. And at the final top of that pyramid is the effort to get this out to patients and actually try on patients to see if it really helps them.

I would say that this has been the motive of research at NIH, and it has actually, I think, led to significant improvements in the care of emergency patients. I would say that at the current time the difficulties you heard in the first panel, they are impediments not only to patient care, but also to research on this high end of the pyramid where it is much more difficult now to be able to translate these new discoveries into better care in that environment where people are so hard pressed. It's very hard to ask them to do research on top of taking care of patients.

So I would just emphasize what you heard this morning is affecting the research in emergency care as well as the patient care.

In response to the IOM report, the NIH put together a Trans-NIH Emergency Medicine Task Force comprised of representatives from over 23 institutes. We are now involved in doing a targeted internal review of our research portfolios and trying to get at the key questions that need to be addressed to improve emergency care of patients, what are the real big questions that need to be answered.

Doctors also met with leaders of emergency medicine and asked them to come up with the same type of analysis, what are the big questions that need to be solved in this area to improve patient care. Because it is very multidisciplinary, these problems—some of which are very high-level neurologic problems, cardiac problems. It requires coordination throughout the NIH, and after the NIH there has been a much greater emphasis on doing this kind of coordination through the Office of Portfolio Analysis and Strategic Initiatives. So I think we can come up with a trans-NIH approach to these problems that arise from our internal review and from discussions with the outside experts. As mentioned before, the NIH has participated with the major groups at HHS.

In terms of just a couple of examples of what came out of our institute, the Neurologic Institute, lots of things that are real emergencies that need to be taken care of quickly like strokes, head injury, and we have, for instance, set up networks of emergency physicians to try to do trials and get new treatments in the emergency scenario out to patients quickly. We have stroke centers throughout the country where emergency medicine has to be the lead organization. We are trying to train emergency physicians in these centers to become experts in stroke care delivery.

And even in the Washington area, the NIH Intramural Program has gone into emergency rooms in different hospitals and offered stroke and imaging expertise in the emergency setting. The NHLBI has had similar efforts with the Resuscitation Outcomes Consortium, the Heart Attack Alert Program, and NIGMS with research and training programs in trauma.

So, in summary, I think that the NIH is very successful at coming up with new discoveries that will impact the care of emergency patients. Our bottleneck may be at the point of testing in the environment, which, as you heard today, is somewhat chaotic, and we are certainly interested in working with the Department and the Assistant Secretary of Preparedness and Response to improve delivery.

Mr. CUMMINGS. Thank you very much.

[The prepared statement of Dr. Koroshetz follows:]

Testimony
Before the Committee on Oversight and Government Reform
United States House of Representatives

NIH Emergency Care Research

Statement of
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Deputy Director
National Institute of Neurological Disorders and Stroke
National Institutes of Health
U.S. Department of Health and Human Services

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Mr. Chairman and Members of the Committee, I am Dr. Walter Koroshetz, an internist, neurologist/neurointensivist, and, since January of this year, the Deputy Director of the National Institute of Neurological Disorders and Stroke (NINDS) at the National Institutes of Health (NIH), an agency of the Department of Health and Human Services (HHS). I am also a member of the Trans-NIH Emergency Medicine Task Force. This group is developing a coordinated NIH response to the relevant concerns raised by the Institute of Medicine (IOM) Report on the Future of Emergency Care in the United States Health System. Prior to coming to NIH, I directed the emergency neurology, stroke, and neurointensive care services at Massachusetts General Hospital and Harvard Medical School. I also worked over a 17- year period with the emergency medicine societies in the Brain Attack Coalition to improve emergency care of stroke victims.

The mission of the NIH, in emergency care as in other areas of medicine, is to make biomedical discoveries that improve health and save lives. Essential to emergency medicine is the emphasis on ultra-rapid diagnosis and treatment to save the critically ill emergency patient. NIH research continues to push for discoveries that will improve the outcomes for patients with these life, or quality of life, threatening conditions in which time to treatment is so critical. In this discussion it is important to see this mission as separate, though linked by the site of care, to the problem of supplying optimal medical care for the wide spectrum of conditions that bring millions of Americans to emergency departments across the country.

It is also important to note the vital contribution of basic biomedical research to emergency medical care. Basic biomedical research yields critical insights into the fundamental

mechanisms of cell response to injury, and into pathways of cell recovery and regeneration. While not classified as emergency medical research *per se*, these and other avenues of basic research provide the foundation for the translational and clinical research I will be highlighting today.

STROKE AND OTHER NEUROLOGICAL EMERGENCIES

The stroke story, which I know best, illustrates how NIH research plays a critical role in developing new emergency interventions and working with emergency medicine to improve treatment. It is replicated in many areas of emergency medicine, including treatment of acute coronary syndromes, cardiac arrest, trauma, burns, sepsis, and toxic exposures, to name just a few.

About a decade ago, an NINDS clinical trial revolutionized acute stroke treatment by demonstrating that the clot-busting drug tPA (tissue plasminogen activator), administered within a critical time window to carefully diagnosed patients, improved the outcome from stroke. This was the first proven treatment for stroke, and it was the culmination of many advances from basic biomedical research that were then tested for years in animal models, followed by careful pilot studies in patients. Its success has opened entirely new areas of patient care and research on emergency care of stroke and other neurological disorders in academia and industry. Building on this first acute stroke treatment, the Brain Attack Coalition, which includes government, voluntary, and professional societies, has energized the public and the medical community to regard stroke as a treatable emergency. The Coalition developed guidelines for certifying primary stroke centers, and there are now more than 250 stroke centers across the United States.

No doubt, these advances in stroke care added to the complexity of emergency medicine because they introduced an entire new set of responsibilities into the responses provided by already strained emergency departments.

To further improve emergency care of stroke victims, the NINDS instituted a competitive process to establish Specialized Programs of Translational Research in Acute Stroke (SPOTRIAS) centers across the country. To qualify for this national network of research centers, institutions must demonstrate a strong commitment to the rapid treatment of acute stroke patients and an active collaboration between emergency medical services, emergency physicians, neurologists, and radiologists. Promising interventions developed at SPOTRIAS centers, such as the use of ultrasound to enhance the clot busting effectiveness of tPA, are now in clinical trials. SPOTRIAS centers, which are at large academic medical centers, are now reaching out with telestroke programs to address the need of all hospitals, no matter their size or location, to have rapid access to on-call stroke specialists necessary to carry out treatments such as tPA safely. Access to specialists was one of the issues that the IOM report highlighted, and we are exploring whether telemedicine can supply a solution. SPOTRIAS sites are also committed to training emergency medicine physicians in clinical neurological research.

Stroke, brain trauma, spinal cord injury, continuous seizures, and other neurological events together constitute 5 to 10% of all medical emergencies, and the NIH continues its research programs to develop better interventions. Ongoing emergency neuro-clinical trials, for example, focus on whether patient outcome can be improved by cooling children with head injury; on ultra- rapid administration of magnesium sulfate by paramedics in the field to stroke

patients; and on removal of clots that block blood flow to the brain in stroke. To expedite the development of emergency interventions, the NINDS recently developed the Neurological Emergency Treatment Trials (NETT) network. The NETT is led by experts in emergency medicine who are designing a system of testing new therapies for neurologic emergencies. The first NETT clinical trial is testing the use of the drug midazolam for emergency treatment of continuous seizures, such as those that chemical nerve agents from a terrorist attack might provoke.

The NETT/midazolam trial is part of the CounterACT (Countermeasures Against Chemical Threats) program. CounterACT is a major effort, from basic research to clinical trials, through which the NIH is working together with other agencies, including the Department of Defense, to address potential terrorist chemical challenges. As this Committee has heard in the past, the NIH, through the leadership of its National Institute of Allergy and Infectious Diseases, is also developing emergency countermeasures and diagnostics for nuclear and biological terrorist agents, as well as for emerging infectious diseases that may pose a public health threat.

NIH EMERGENCY CARE RESEARCH

I have used a few examples from neurologic emergencies to illustrate how NIH research lays a scientific foundation for improving emergency care. As the IOM report noted, emergency care research is a very broad field of inquiry, involving many disciplines and cross-cutting themes. The Trans-NIH Emergency Medicine Task Force reflects this range, with 23 NIH Institutes and Centers participating.

To understand the scope and nature of NIH supported research and training that underpin emergency care, the NIH is conducting a targeted internal review of its current research portfolio as it relates to the key scientific questions that need to be addressed to improve emergency medical care. This will include research in pediatric emergency care, pre-hospital acute care, and research training opportunities. A few other examples illustrate NIH activities:

- The National Heart, Lung, and Blood Institute's (NHLBI) National Heart Attack Alert Program Coordinating Committee addresses multiple aspects of emergency medical service (EMS) care for acute cardiac syndromes.
- NHLBI's Resuscitation Outcomes Consortium (ROC) conducts collaborative clinical trials of new treatments for cardiac arrest and severe traumatic injury. Along with EMS agencies, ROC will involve public safety agencies, regional hospitals, community healthcare institutions, and medical centers in 11 regions in the United States and Canada and as many as 15,000 patients over a 3-year period.
- The research and training programs in Trauma, Burn, Perioperative Injury, and Wound Healing of the National Institute of General Medical Sciences improve understanding of the biological processes invoked after traumatic or burn injury; bring basic scientific observations and principles into the clinical arena; and foster interactions and communications within institutions and throughout the trauma community by outreach efforts that promote trauma, burn, perioperative injury, and wound healing research at the institutional level.

The IOM report emphasized the importance of research into the efficacy, safety and health outcomes of treatments for infants, children, and adolescents. The NIH supports many

projects focused on the needs of pediatric populations. The National Institute of Child Health and Human Development, for example, supports the Pediatric Pharmacology Research Units (PPRU) Network, whose overall goal is the safe and effective use of drugs in children. PPRU activities include studies on the action, absorption, and elimination of drugs in children, pre- and post-marketing clinical trials in children, and an advisory body to industry, regulatory agencies, health professionals, and the public on the appropriate use of drugs in pediatric populations. NIH will pay special attention to pediatric issues as it reviews its current portfolio for gaps and opportunities in research.

In consultation with experts, we will continue to identify emergency care research issues and explore ways to address barriers to conducting emergency care research. The NIH will also explore opportunities for leveraging existing and developing new partnerships that can promote research and training in this area, both within NIH and in the academic and privately funded research community.

Finally, the IOM raised several key issues about overcrowding of emergency and trauma centers, the fragmentation of emergency medical services, unmet needs for access to specialists, and the challenges of preparation for major disasters. Although the structural issues in U.S. health care system do not fall within the purview of the NIH, the same problems that complicate the quality and timeliness of emergency care also hamper research in this important clinical care setting. The NIH will continue to work with HHS's Office of the Assistant Secretary for Preparedness and Response and with other appropriate agencies to improve the treatment of patients with medical/ surgical emergencies.

Thank you for providing me with the opportunity to present this information to you. I will be happy to answer any questions you may have.

Mr. CUMMINGS. Mr. Sarbanes.

Mr. SARBANES. Thank you, Mr. Chairman.

Dr. Yeskey, I am interested in knowing more about this $2.7 billion of resources that has been committed since 2002 to the Hospital Preparedness Program, and I guess what is remarkable is the testimony we heard from the prior panel was pretty uniform in saying they don't really see much evidence of impact from expenditures to that program.

That is consistent with my own experience when I worked with community hospitals post-9/11, and certainly post-2002 when these dollars became available, where, for the most part, absent the occasional grant opportunity, they were not able to perceive any kind of coordinated effort to improve disaster preparedness at their level.

And I understand the program is now within your jurisdiction or oversight, and I wonder if you could speak to why it is that so much money has been spent on this, and yet in the field, the practitioners who are on the front lines don't have a perception that it has made any kind of a measurable impact on improvement.

Dr. YESKEY. The program, in its transfer coming over, needs to be enhanced in its ability to assess the impact that it has had. We know we can do a better job of assessing both the weaknesses of the program thus far, as well as some of the successes, and there have been some successes. The program initially was set up to provide hospital preparedness for the bioterrorist scenarios rather than the day-to-day surge capacity issues that we heard about today.

But there have been successes. Hospitals have developed command-and-control systems that enable them to integrate better into a community's response plans with EMS, law enforcement. They have developed interoperable communications so they can help in a systems way route patients in an event so they have a better way of getting the patients to the care they need. Those are just a few examples of that.

I think we need to look a little bit harder at how we can improve how moneys are being spent using more effective performance measures, being able to describe what exactly we want hospitals to do and to measure that. The money we give in a hospital preparedness program goes to the States. It doesn't go directly to the hospitals, it goes to the States, and they distribute that money to their hospitals and health care facilities rather than going to the hospitals directly.

We do have this year, in this upcoming grant program, a competitive piece as directed by the Pandemic and All-Hazards Preparedness Act where money can go for the development of regional coalitions of hospitals, and that money will go directly to those coalitions rather than to the State; however, those coalitions need to be integrated into an overall state plan. And we hear that from the States from time to time, that they want to make sure that they understand what their coalitions are doing so fits into the overall State preparedness plan.

Mr. SARBANES. So it sounds from the get-go they needed more accountability as the money was being passed down the line, which ultimately that accountability comes back to those who are origi-

nating the grants and the money that is flowing. So that is the Federal Government's responsibility, if it is going to dispense $3 billion, to make sure as it is meted out, it is being done in a judicious way.

Let me ask you really quickly before time runs out, we heard a lot of testimony about what some viewed as a tactical response to the emergency care situation. I view, perhaps, it as being strategic as well, and that is to set up these regional networks of response, emergency care, and I was glad of the mention of what has been accomplished in Maryland, which I think is a model with the MIEMS model and Maryland Shock Trauma Institute and so forth.

I assume you see great possibilities in that approach, and that many of these dollars would be directed toward trying to facilitate that kind of thinking and modeling.

Dr. YESKEY. We support regional—coalitions. Regional models of emergency care.

Mr. SARBANES. Thank you, Mr. Chairman.

Mr. CUMMINGS. Thank you very much, Mr. Sarbanes.

Dr. Koroshetz, in the IOM report on emergency care, the committee recommended, "The Secretary of the Department of Health and Human Services should conduct a study to examine the gaps in opportunities in emergency and trauma care research and recommend a strategy for the optimal organization funding of the research effort."

I am very glad to learn from your testimony this morning that the Department has organized a Trans-NIH Emergency Medicine Task Force. When can we expect the task force's recommendations?

Dr. KOROSHETZ. My understanding is that we are currently in the process of doing the internal review and the fingerprinting of the research that is going on now, and that should be done by the end of this year, along with the consultation with the outside groups about where they see the gaps matching up with our assessment. And so we think the beginning of next year we would have the final report.

Mr. CUMMINGS. Now, let me tell you this, that Mr. Waxman and this committee, we are going to hold you to that, so when you get back to your shop, and there is something different, would you let us know that? And I hope staff will make that a part of our questions, because one of the things that we are trying to do is that we found a lot of times is we will get answers, people tell us they are going to do things, and the next thing you know, time passes by and it is 2 years later, a whole new group of Congressmen, a whole new committee, and it sort of slips under the rug. This is something that we cannot afford to let happen. So we are going to hold you to that.

Dr. KOROSHETZ. I understand.

Mr. CUMMINGS. Dr. Koroshetz, in your written testimony you state, "The structural issues in the U.S. health care system do not fall within the purview of NIH."

If that's true, then where should the doctors like those on the first panel turn for the research they need to help them improve the organization and delivery of emergency care?

Dr. KOROSHETZ. Well, I think we would say that the NIH is going to be most effective at determining what is the best therapy

for a patient and actually improving what that therapy is. But the issues that you heard about this morning are so complicated with regard to the finances, the regional organizations, specialist involvement, that going into those areas would really detract of our mission of making these therapies available.

I would caveat that by saying that certainly we will put an emphasis onto bringing the therapy to market and trying to break down the bulwarks that prevent therapy from coming to market, but it is probably something we can't do alone, that we need to do with people who are interested. The Brain Attack Coalition is a nice example. So we came up with a new stroke therapy, but it requires a great deal of new work being done in emergency departments to deliver that therapy, and you heard how strained they are.

We started a coalition with emergency physicians, EMS providers——

Mr. CUMMINGS. Let me ask you this. I just want to make sure we are able to end this hearing so we don't have to hold you up for another 2 hours or hour and a half. Let me ask you this: Would the Agency for Health Care Research and Quality [AHRQ] have jurisdiction over this, be helpful with this?

Dr. KOROSHETZ. I think in the past that they have looked at delivery of health care and outcomes related to how care is delivered.

Mr. CUMMINGS. So you would recommend that?

Dr. KOROSHETZ. I think from the standpoint of the questions about those which relate to what is the best therapy versus how it is actually proportioned, I think that the AHRQ, it may be more in their ballpark in terms of how things are delivered.

Mr. CUMMINGS. You realize that AHRQ, their budget is more than $300 million, or a little more than 1 percent of your agency's budget. Do you know that?

Dr. KOROSHETZ. Yeah.

Mr. CUMMINGS. Let me leave you with this. I heard you talk about getting therapies, I guess, into practice. One of the things that, if we listen to the testimony today, we heard was those therapies are nice, they are important, but they are not getting to people in many instances because people are dying.

Dr. KOROSHETZ. Because of the overcrowding issue.

Mr. CUMMINGS. Yes. I was just sitting here thinking anybody in this room could possibly, God forbid, have a heart attack right now, and although we may have all the research, we have done all the things we are supposed to do, given money to NIH, and then because of overcrowding, they will die. Even the gentleman, Dr. Johnson I think it was, from one of the more affluent areas, people in his district are dying.

And so it just seems to me that we can do better. And it is a shame and very upsetting that CMS did not appear here today. I think that that is one of—when you have close to 4,250 employees, and you can't find 1 person, and it is your responsibility to address this issue, and you don't show up, you are a no-show, that is a major, major problem. This committee is determined to get Dr. Norwalk here and to figure out what is CMS doing about this problem.

Ladies and gentlemen, I move that the Members have 5 days to submit questions and comments. With that, the hearing stands adjourned. Thank you very much.

[Whereupon, at 12:38 p.m., the committee was adjourned.]

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