Statement of

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Introduction

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

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

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

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

ACEP for years now has been working to raise awareness of the critical condition that exists in delivering high-quality emergency medical care with lawmakers and the public. More recently, these efforts included promoting the findings of a 2003 Government Accountability Office (GAO) report on emergency department crowding; conducting a stakeholder summit in July 2005 to discuss ways in which overcrowding in America's emergency departments could be alleviated; sponsoring a rally on the west lawn of the U.S. Capitol in September 2005 attended by nearly 4,000 emergency physicians to promote the introduction of H.R. 3875, the "Access to Emergency Medical Services Act" (and the subsequent Senate companion legislation, S. 2750); and releasing our first "National Report Card on the State of Emergency Medicine" in January 2006.

ACEP National Report Card on the State of Emergency Medicine

ACEP's "National Report Card on the State of Emergency Medicine" is an assessment of the support each state provides for its emergency medicine systems. Grades were determined using 50 objective and quantifiable criteria to measure the performance of

each state and the District of Columbia. Each state was given an overall grade plus grades in four categories, *Access to Emergency Care, Quality and Patient Safety, Public Health and Injury Prevention, and Medical Liability Reform.*

In addition to the state grades, the report card also assigned a grade to the emergency medicine system of the United 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.

Emergency Department Overcrowding

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

> I am at a level one trauma center, and we are so overcrowded that people are waiting up to 11 hours to be seen, patients are on stretchers lined up against the walls waiting for beds for three or more hours, and we are filled with patients being held for ICU beds. I am only able to see four to six patients in a 6- hour shift because there just are not beds to put the patients in to see them. We go on diversion, but so do the other hospitals in the area.
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> A teenage girl was hit in the mouth playing softball, causing injury to her teeth. She arrived in the emergency department, which was full, at 6 pm and sat in a waiting room, holding a cloth to her face, bleeding for 2 hours. Finally, when a bed opened for her, the doctor saw she had significant dental 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.

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

Every day in emergency departments across America, critically ill patients line the halls, waiting hours – sometimes days – to be transferred to inpatient beds. This causes

gridlock, which means other patients often wait hours to see physicians, and some leave without being seen or against medical advice. Contributing factors to overcrowding include reduced hospital resources; a lack of hospital inpatient beds; a growing elderly population and an overall increase in emergency department utilization; and nationwide shortages of nurses, physicians and hospital support staff.

On-Call Shortage

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

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

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

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

> A 23 year-old male in Texas arrived unconscious with what turned out to be a subdural hematoma. We were at a small hospital with no neurosurgical services. Ten minutes away was a hospital with plenty of neurosurgeons, but that hospital would not accept the patient because the on-call neurosurgeon said he needed him to be at a trauma center with an around-the-clock ability to monitor the patient. All the trauma centers or hospitals larger were on "divert." The patient was FINALLY accepted by a hospital many miles away, with a 90-minute Life flight helicopter transfer. The patient died immediately after surgery there.
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> A 65 year-old male in Washington State came to an emergency department at 4:00 a.m. complaining of abdominal pain. The ultrasound showed a six-centimeter abdominal aortic aneurysm (AAA) and he was

> unstable for CT scanning. We had no vascular surgeon available within 150 miles; a general surgeon was available, but he refused to take the patient out-of-state. We reversed the Coumadin and transferred the patient in three hours to the nearest Level I trauma center, but he died on the operating table. He probably would have had a better outcome without a three-hour delay.

EMTALA

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

When CMS issued its September 2003 EMTALA regulation, uncertainty was created regarding the obligations of on-call physicians who provide emergency care that could potentially increase the shortage of on-call medical specialists available and multiply the number of patients transferred to hospitals able to provide this coverage. Under this new rule, hospitals must continue to provide on-call lists of specialists, but they can also allow specialists to opt-out of being on-call to the emergency department. Specialists can also now be on-call at more than one hospital simultaneously and they can schedule elective surgeries and procedures while on-call. Without an adequate supply of specialists willing to take call, some hospitals may choose not to provide emergency care at all, which would only shift the burden to the already strained hospital emergency departments that remain open.

Reimbursement and Uncompensated Care

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

While emergency physicians stand ready to treat anyone who arrives at their emergency department, uncompensated care can be an extreme burden at hospitals that have a high volume of uninsured patients, which now exceeds 51.3 million Americans and continues

to rise. Hospital emergency departments are the provider of last resort for many people, including undocumented aliens, who have no other access to medical care. As such, emergency departments experience a high-rate of uncompensated care.

Boarding

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

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

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

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

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

- Beds that could be used for emergency department admissions are instead being reserved for scheduled admissions, such as surgical patients who are generally more profitable for hospitals.
- Less than one-third of hospitals that went on ambulance diversion in fiscal year 2001 reported that they had not cancelled any elective procedures to minimize diversion.
- Some hospitals cited the costs and difficulty of recruiting nurses as a major barrier to staffing available inpatient/ICU beds.

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

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

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

Ambulance Diversion

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

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

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

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

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

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

Conclusion

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

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

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

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

Attachment

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

Strategies currently being employed to mitigate emergency department overcrowding:

- Expand emergency department treatment space. According to a Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standard (LD.3.11), hospital leadership should identify all of the processes critical to patient flow through the hospital system from the time the patient arrives, through admitting, patient assessment and treatment and discharge.
- Develop protocols to operate at full capacity. In short, when emergency patients have been admitted, they are transferred to other units within the hospital. This means that the pressure to find space for admitted patients is shared by other parts of the hospital.
- Address variability in patient flow. This involves assessing and analyzing patient arrivals and treatment relative to resources to determine how to enhance the movement of patients through the emergency department treatment process and on to the appropriate inpatient floors.
- Use queuing as an effective tool to manage provider staffing. According to an 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.