Crisis in the ER:

How Can We Improve Emergency Medical Care?

Roundtable before the

U.S. Senate Subcommittee on Bioterrorism and Public Health Preparedness

September 27, 2006

Statement by

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I am Margaret VanAmringe, Vice President for Public Policy and Government Relations at the Joint Commission on Accreditation of Healthcare Organizations. I appreciate the opportunity to submit comments on the current state of emergency and trauma care in U.S. emergency departments (ED). Founded in 1951, the Joint Commission is the nation's oldest and largest standard setting and accrediting body in healthcare. The Joint Commission accredits approximately 15,000 healthcare facilities along the entire spectrum of services. Our mission is to continuously improve the safety and quality of care provided to the public. We are an independent voice that is derived from both the multitude of expert opinion that we bring together on tough issues facing the healthcare system, and from our more than 50 years gathering daily information on quality and safety from the front lines of care delivery.

On behalf of the Joint Commission, I would like to take this opportunity to thank the Senate Subcommittee members for their dedication to improving the quality and safety of emergency care in the U.S. We are especially grateful because we realize the Subcommittee has jurisdiction over a very wide array of public health issues: BioShield, the Centers for Disease Control and Prevention (CDC), immunizations, infectious diseases, pandemic flu, and vaccines. Your specific focus on EDs and emergency care, strongly linked with the aforementioned issues, is both important and germane.

The Joint Commission agrees with the Subcommittee's statement that, "ambulances are on diversion, stretchers line ED hallways, ambulances idle waiting to offload patients, [and] patients leave EDs without being seen." Because the Joint Commission accredits most hospitals, these emergency care issues are of great concern. The Joint Commission recently sponsored an expert roundtable to discuss ED overcrowding. The issues raised in that session, in conjunction with the work we do with providers across the U.S., serves as the basis for our responses to the questions the Subcommittee has posed in its letter of invitation.

Why Are Emergency Departments So Overcrowded?

Bolstered by the *Emergency Medical Treatment and Labor Act of 1986* (EMTALA), the only guaranteed access to medical care in the U.S. is through the ED. All persons who present to the ED must be provided with a medical screening exam and stabilization, and no one can be turned away because of their inability to pay. Whereas EDs were once meant for treating trauma and urgent illness, they are now the "safety net for the safety net." Many

patients wait hours, even days, in the ED because they have no other care option. Others, however, view the ED as a convenient choice to receive same-day service without lengthy appointment waits. ED demand is driven further by an aging, higher acuity patient population, as well as an increasing number of mentally ill patients who have no other care option. EDs also have disproportionately high Medicare and Medicaid patient populations.

Additionally, a growing number of uninsured is overwhelming community health centers and other public "safety net" providers. Community health centers specifically created to provide safety net care to Medicaid-insured or uninsured patients are typically under funded and overwhelmed by demand. Community mental health services are especially lacking and very problematic as the ED is one of the first places that police take disruptive citizens or mentally ill homeless individuals.

Unfortunately, this overall increased demand is coupled with reduced capacity. Hospitals are short of available beds and workers, particularly registered nurses. Rising demand for hospital-based care comes at a time when there are fewer hospitals and still fewer EDs. From 1988 to 1998, the number of EDs decreased by 1,128. This diminution of hospital capacity was a planned "benefit" of managed care and federally administered financial constraints designed to control costs and rid the healthcare system of excess and inefficiency. Another factor driving demand involves high medical liability insurance rates in some states, especially for physician specialists. At the same time, many specialists are in short supply and increasingly unwilling to agree to take on-call duties from hospitals.

Overcrowding is clearly a *systems* problem, not just an emergency department problem. This is even true within the hospital itself. The lack of inpatient beds is the most commonly cited reason for crowding in the ED. When patients are "boarded" in the hallway, they take up treatment space, equipment, and staff time, straining an already overwhelmed unit. Overcrowding may also involve the inability to appropriately triage patients, forcing patients into the ED waiting area while they await ED treatment spaces. Although it is true that emergency departments have the capacity to deliver an array of medical services for acutely ill and injured patients, it is also dependent upon a number of ancillary services such as laboratory, diagnostic imaging, and skilled nursing to make that delivery happen. The failure of any one of these services could bring the ED to a halt – thus supporting the notion

that the ED is not necessarily the cause of the backlog; but rather is the unit most vulnerable to it.

Lastly, the emergency department is affected by the number and type of community services that can receive its patients, and the ease at which patient transfer can take place. There must be adequate nursing home, home care, mental health and other community services to receive patients that can be discharged to these other venues, and good service support and collaboration to make these transfers work efficiently.

What Congress Can Do

Complex problems with multiple contributing factors require multi-faceted solutions. Therefore, there is no one magic bullet, or single recommendation that will solve the problem. Many stakeholders have a part to play and a full list of strategies for all players would be quite long. The Congress, of course, can play an important role in addressing certain aspects of the problem.

- First, Congress should continue to address the issue of the uninsured.

Unfortunately, a major source of healthcare for this underserved population is the ED. Thus, in order to properly address the Subcommittee's first inquiry of why EDs are so crowded, the uninsured must be acknowledged as a significant demand on the system.

Nevertheless, and contrary to public perceptions of the uninsured's impact, the most frequent visitors to EDs are Medicaid beneficiaries, followed by Medicare beneficiaries. A major percentage of these patients are visiting the ED because of a severe illness that could have been prevented by proper intervention in the community, either by having a relationship with a primary care physician or by having available community-based services.

- Congress should support and work with states as appropriate to increase the availability of primary care and other community health services, especially for publicly-insured populations. On area that needs particular attention in the community is the creation and funding of more mental health services to meet a range of behavioral health needs.

The current environment around pay-for-performance provides an opportunity for Congress to ensure that appropriate incentives are placed into reimbursement programs that can affect how care is delivered.

- As part of a pay for performance framework, Congress should consider a number of incentives to improve emergency care processes, such as rewarding:

    an institutional culture that drives improvement in ED quality and efficiency; fast-track and intervention programs to help ensure patients are receiving care where it can be most effective and efficiently delivered; healthcare information technology solutions to improve occupancy and capacity monitoring; dedicated personnel for quicker bed turnover and streamlining discharge policies and procedures; the use of hospitalists to provide more inpatient care, and specific provisions for treating psychiatric patients in the ED.

Certain bills introduced in 2005 and 2006, like the *Access to Emergency Medical Services Act* (H.R. 3875 or S. 2750), provide a model for addressing some of the problem and the standards contained within should be vetted with the private sector in order that the standards have broad-based support.

Finally,

- Congress should act on proposals that will lessen litigation and improve the medical liability system.
- Congress should continue to invest in Title VIII programs that are aimed at addressing the critical nurse shortages in this country and consider effective funding programs aimed at growing shortages in other essential hospital staff, such as qualified laboratory personnel.

Federal Options for Enhancing System Coordination and Integration

From a system-wide coordination and integration perspective, Congress should help to alter public perceptions, encouraging all healthcare stakeholders to view ED crowding as a collective problem. Because so many trauma centers and large hospitals report that their emergency departments are operating at or over capacity, it may be difficult or impossible to gain the surge capacity needed to sustain the health care system in a community during a mass casualty event. Community planning for emergency care is essential and should be part of ongoing community and regional efforts. If effectively done on a routine basis, such planning will position the community/region for large-scale disasters.

The Joint Commission has been promoting more community integration and coordination as a means to disaster preparedness. Recent publications have been produced to help guide communities in this regard. For example, the Joint Commission has published:

- ✓ *Are You Prepared? Hospital Emergency Management Guidebook* (2006)
- ✓ *Standing Together: An Emergency Planning Guide for America's Communities* (2005)
- ✓ *Managing Patient Flow: Strategies/Solutions for Addressing Hospital Overcrowding* (2004)

Despite the years of post 9/11 funding, there are still many more efforts which need to be made to ensure that communities are prepared.

- Congress should encourage community-wide real-time healthcare system capacity monitoring systems.
- Congress should also develop concrete expectations for communities that accept emergency preparedness funding, and fund a program of objective evaluation for assessing the effectiveness of these emergency preparedness efforts across all players.

Conclusion

If considered crowded today, EDs promise to become busier in the not too distant future. A large cohort of aging Baby Boomers are beginning to live longer, the ranks of the uninsured continue to grow, and a growing number of providers are less willing to treat Medicaid- and Medicare-covered patients. In short, more and more patients will enter a diminished number of EDs. Increased demand will be met with reduced capacity. It is the Joint Commission's contention that neither patients nor healthcare providers are well served by the current emergency care system in the U.S. The central question is how emergency care services can be restructured to actively encourage providers to implement new policies. Redesigning the emergency care system will be a long-term endeavor, one that addresses larger/national social and economic issues.