

Newsweek - May 11, 2007

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How to Stop the Bleeding

Emergency-room health care is in a state of emergency. What the best minds in the medical community prescribe to begin to treat the crisis.

By Arian Campo-Flores
Newsweek

May 8, 2007 - When the Institute of Medicine, a nonprofit arm of the National Academy of Sciences, published three massive reports on the state of emergency care in the U.S. last June, Dr. Arthur Kellerman imagined they might serve as a call to action. The well-regarded studies—conducted over the course of three years by a committee of about 40 medical and policy professionals, including him—presented a dismal picture of overburdened, understaffed and underfunded emergency rooms. Yet despite a big rollout for the reports, including press conferences and congressional briefings, barely anyone seemed to notice. “It was disappointing,” says Kellerman. “I was hoping that report would be viewed with as much concern, even alarm, as the committee had when it generated it.”

The public may have grown inured to sirens warning about the emergency-room crisis, but the situation is more distressing than ever. Among the Institute of Medicine (IOM) committee’s findings: a worrisome dearth of on-call specialists like neurosurgeons; poor coordination between ambulance squads and hospitals; and a woeful lack of preparedness for major disasters such as pandemic flu or a terrorist attack. While emergency department visits nationwide grew by 26 percent from 1993 to 2003, according to the IOM study, the number of hospital beds dropped by 17 percent and the number of ERs dropped by 9 percent. The authors also found a troubling increase in the practice of “boarding”—storing patients for hours or even days in the ER while they wait to be admitted to the hospital. In a survey of 90 ERs across the country on a typical Monday evening, 73 percent reported that they were boarding two or more patients. Then there’s the issue of “diversion”—the rerouting of ambulances as hospitals reach the saturation point. One study found that a half-million ambulances were diverted in 2003—an average of one per minute. “It’s a system that’s just hanging together, and it’s on the verge of collapse,” says Dr. Brent Eastman, chief medical officer at Scripps Health in San Diego, and an IOM committee member. “This is one of the most profound crises that American medicine has ever faced.”

So what can be done? With a health-care system as complex as the U.S.'s, no single, sweeping solution exists. But the IOM reports offered numerous recommendations to tackle the problems piecemeal. For starters, there's the basic issue of funding. The uninsured population is now estimated to exceed 45 million, and many among their number resort to the ER for their health-care needs. As a result, hospitals often get stuck with the bill. Though some safety-net providers qualify for additional Medicaid and Medicare money, it's usually not nearly enough. Hence the IOM's suggestion that Congress dedicates additional funding to those institutions that offer large amounts of uncompensated care (that idea has yet to gain traction on Capitol Hill). Some advocate a more ambitious agenda: universal health care coverage. "If we had that, we wouldn't be fooling around with all these complicated formulas all the time," says Richard Knapp of the American Association of Medical Colleges, which represents the nation's teaching hospitals. Yet that's a long shot politically, and would take years to accomplish.

Other ideas in the IOM reports appear more feasible. The authors, for instance, proposed that Congress create a lead agency for emergency care in the Department of Health and Human Services (HHS). Currently, that responsibility is spread out over numerous agencies—a situation, the committee says, that hampers decision-making and limits accountability. Another IOM suggestion seeks to remedy fragmentation among service providers, from ambulances to community hospitals to ERs. In most of the country, these entities don't have especially good communication with one another. A paramedic transporting a patient with a particular condition often has no idea where the most relevant treatment options or specialists are available at that moment. That information gap not only generates inefficiency, but it can cost the patient precious minutes. To address the problem, the IOM committee recommended the creation of regional trauma care systems—like one in Maryland—that can function as a sort of air-traffic control for patients, doctors and hospitals.

Officials at HHS, the main agency with responsibility for emergency care, say they've studied the IOM reports. "We're in the process of looking at how we can implement some of those recommendations," says Dr. Kevin Yeskey, director of HHS's Office of Preparedness and Emergency Operations. The agency has created a working group of representatives from all of HHS's operating divisions, such as the Centers for Disease Control and Prevention and the Centers for Medicare & Medicaid Services. That group is looking closely at three IOM ideas in particular: the establishment of a lead agency for emergency care, the creation of regional trauma-care systems and the funding of additional emergency-care research.

Another area HHS is devoting attention to: disaster preparedness. With ERs stretched to the limit, many worry about the ability of hospitals to handle catastrophic events, like a bioterrorism attack, that produce mass casualties. So the agency is addressing things like “surge capacity”—the ability of the emergency-care system to mobilize additional resources and personnel quickly to deal with a sudden influx of patients. HHS funding for hospital preparedness—things like protective equipment and decontamination showers—has increased from \$135 million in 2002 to \$470 million this fiscal year. The best defense, though, remains a solid, well-coordinated emergency and trauma care system. “Better daily emergency care will result in better medical care in response to disasters,” says Dr. David Marcozzi, a senior medical adviser at HHS’s Office of the Assistant Secretary for Preparedness and Response.

Many members of Congress argue that much more needs to be done. Democratic Rep. Henry Waxman, chair of the House Committee on Oversight and Government Reform, says he’s been trying to draw attention to the woeful state of emergency care since the 9/11 terrorist attacks. Now that Democrats have taken over Congress, he’s ramping up scrutiny of the administration in this area. Around mid-June—the one-year anniversary of the release of the IOM study—he plans to hold an oversight committee hearing to examine, as he terms it, “the federal government’s failure to address the crisis in emergency care.” Other congressional committees plan to take up the issue as well. The House Committee on Homeland Security has two hearings planned for later this year—one to focus on surge capacity, the other to address the Emergency Medical Services system. And the House Committee on Ways and Means—whose health subcommittee held a hearing last year on the IOM reports, then chaired by Republican Rep. Nancy Johnson—is examining the issue of on-call specialists, who often aren’t available to hospitals; when they are, they can cost a fortune.

There is also a lot that hospital administrators themselves can do. Consider the issue of overcrowding. Eugene Litvak at the Boston University Health Policy Institute has studied the flow of patients in and out of hospitals—not just those in the ER but throughout the facility. His conclusion: if elective surgeries like angioplasty or hip replacement could be scheduled in a more organized way, the ER might not get so backed up. Christy Dempsey, vice president for surgical and emergency services at St. John’s Hospital in Springfield, Mo., put Litvak’s plan to work in 2002. Surgeons began “smoothing” their elective surgeries throughout the week, rather than bunching them together on Mondays, Tuesdays and Wednesdays. They also carved out blocks of time to ensure that ER patients requiring surgery would have the beds and operating rooms they needed. The reforms created 59

percent more available space for inpatients—without actually adding any beds, says Dempsey. And they helped unclog the ER, resulting in better patient and staff satisfaction and less overtime. “It was a win-win for everybody,” she says.

Some hospitals have introduced innovations to deal with the boarding problem. Dr. Peter Viccellio, vice chair of the Department of Emergency Medicine at Stony Brook School of Medicine in Stony Brook, N.Y., came up with a simple fix: move patients waiting to be admitted from hallways in the ER to hallways in specialized units elsewhere in the hospital. They’re still not in rooms, but they receive better care and rest more comfortably outside of the ER. At Stony Brook, the program has reduced the average length of stay in the hospital from 6.2 days to 5.4 days—a dramatic savings in resources and money. The move has also reduced the strain on ER nurses, because patients awaiting admission usually require more attention. Since Viccellio’s innovation was implemented, Stony Brook has never had to divert a patient (it receives about 75,000 ER visits per year, compared to around 170,000 at a large urban hospital like Grady Memorial in Atlanta).

In the absence of grand solutions from government, hospitals will have to focus on internal steps like these. “You just keep chipping away at the stone and hope that at some point, someone will say, ‘We’ve got to fix this,’” says Dr. Frederick Blum, past president of the American College of Emergency Physicians. “We’re not there yet, but we’ll keep chipping away.” Hopefully it won’t take a catastrophic failure for others to realize the state of emergency the emergency health-care system is in.

With Claudia Kalb

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