Emergency Medicine Still In Crisis, Despite Warning

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WASHINGTON — Almost nothing has been done in the year since the Institute of Medicine called on Congress to help enact a comprehensive overhaul of the nation's emergency medicine system, two emergency physicians and a trauma surgeon told a U.S. House committee.

"I'm absolutely shocked that more hasn't been done to fix this in the last year," Dr. William Schwab, chief of the division of trauma and surgical critical care at the University of Pennsylvania Medical Center in Philadelphia, testified at a House Committee on Oversight and Government Reform hearing.

Dr. Schwab was a member of the IOM's Committee on the Future of Emergency Care in the U.S. Health System, which issued its report in June 2006.

So far, the only congressional action has been the introduction of the Access to Emergency Medical Services Act (H.R. 882), which would increase payments to physicians through an emergency medicine–specific trust fund and create a commission to study potential solutions. A companion bill has been introduced in the Senate (S. 1003).

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DR. O'CONNOR

Dr. Schwab and his colleagues told House committee members that if anything, emergency departments have become more crowded and overburdened, and that it is becoming increasingly difficult to find specialists such as orthopedic surgeons or neurosurgeons who will accept on-call assignments.

Leaving his written testimony behind, Dr. Schwab told the committee members that a recent experience at his hospital more fully revealed the crisis. On one of his days off, a partner in his practice called and said he was needed to help attend to a department bursting at the seams from a multivehicle accident. Upon arrival, Dr. Schwab instead was diverted to a gunshot victim. He performed an emergency thoracotomy, and when he was done, he looked up and realized that the accident patients had been watching from just 40 feet away because the trauma bay was so crowded.

The burden is not limited to big-city facilities, said Dr. Schwab, noting that his brother-in-law, a transplant patient on dialysis who had become very ill, recently had been refused initial admittance through the ED at Rodney Strong Hospital in Rochester because of overcrowding. Eventually, he was seen.

Dr. Ramon Johnson, director of emergency medicine at Mission Hospital Regional Medical Center in Mission Viejo, Calif., agreed that the crisis did not respect demographic boundaries. "Even in my sleepy suburban community," the emergency department is "understaffed, underfunded, overworked, and overcrowded," said Dr. Johnson, who also related anecdotes in place of his written testimony. He spoke of having to scramble to find an open bed for a child who was brought in—blue and choking—by his mother. Staff removed a less-ill patient from a bed, which was quickly occupied by the choking child. Dr. Johnson then reached into the child's trachea to fish out the offending apricot pit. But he had a moment where he thought he'd have to tend to the child on the floor.

"We have state-of-the-art technology, and yet we're practicing in a non–state-of-the-art environment," echoed Dr. Robert E. O'Connor, incoming chair of emergency medicine at the University of Virginia, Charlottesville.

At the hearing, the physicians were well received by Democrats and Republicans.

"The fact of the matter is that we have a crisis in emergency care, and it is nationwide," said acting panel chairman Elijah Cummings (D-Md.). "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?"

Rep. Tom Davis (R-Va.) also questioned whether many of the nation's emergency departments are ready to handle a surge from a multiple-casualty highway crash, much less a terrorist event. The crisis has many roots, said Rep. Davis. "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," he said.

Several committee members asked whether the 2006 Pandemic and All Hazards Preparedness Act had benefited emergency care. The answer: a resounding no.

"I don't think we could track a dime to actual practice at the bedside," said Dr. Schwab.

But he and the other physicians emphasized that just throwing more money at emergency medicine would not be a panacea. "There's no way a simple solution can fix this," said Dr. Schwab.

Rep. Cummings and other committee members took the Department of Health and Human Services to task for not ensuring that more of the Pandemic law's money made it directly to hospitals.

Dr. Kevin Yeskey, director of the Office of Preparedness and Emergency Operations at HHS, defended the agency, saying that federal money had been distributed to states, not directly to hospitals. But, he agreed that there should be more accountability for how the almost $3 billion in funds has been and will be distributed. ■

POLICY & PRACTICE

AMA: Investigate Store Clinics

The American Medical Association has called for investigations into potential conflicts of interest posed by joint ventures between store-based health clinics and pharmacy chains. Physicians at the AMA's House of Delegates in Chicago voted to ask state and federal agencies to determine whether these joint ventures pose a threat to patients' welfare. "There are clear incentives for retailers to participate in the implementation and operation of store-based health clinics," said AMA board member Dr. Peter Carmel in a statement. "The nation's physicians want the AMA to ensure these incentives do not compromise the basic obligation of store-based clinics to provide patients with quality care." The AMA also noted that some insurers are allowing store-based clinics to waive or lower patient copayments, while still requiring physicians to collect such payments. The House of Delegates, noting concerns that these lower copayments for in-store clinics could inappropriately steer patients to the clinics on the basis of cost, rather than quality of care, voted to seek equal treatment for physicians regarding health insurers' copayment policies.

CDC: 43 Million Lack Coverage

Nearly 15% of Americans—43.6 million—lacked health insurance in 2006, according to the Centers for Disease Control and Prevention. Among Americans ages 18 through 64, nearly 20% lacked health insurance in 2006, a slight increase from about 19% in 2005, the CDC said. About 9% of children did not have health coverage in 2006, a marked drop from 14% in 1997, the year the State Children's Health Insurance Program (SCHIP) was enacted. The CDC noted that the percentage of uninsured Americans in the 20 largest states varied from less than 8% in Michigan to nearly 24% in Texas. The CDC study was based on data collected from interviews in more than 100,000 households nationwide.

CMS Launches Health Record Pilot

The Centers for Medicare and Medicaid Services has launched a pilot program to enable certain beneficiaries to access and use a personal health record provided through participating health plans and accessible through www.mymedicare.gov. The tools, provided by Medicare Advantage and Part D drug plans that already offer such tools to their commercially insured members, will allow beneficiaries to look up information about their own medications and medical conditions in order to better manage their own health care, according to the CMS. Beneficiaries also will be in charge of their own personal health record and will control who is able to see its contents, including the beneficiaries' physicians and other health care providers, according to the agency. The program, which includes four health plans, is expected to run for 18 months.

Hawaii to Offer Kids Free Flu Shots

This fall, Hawaii will become the first state to offer free influenza vaccinations to school children aged 5-13 years. The shots will be available October 2007-January 2008 at school during the school day. Funding for the estimated $2.5-million program is being provided primarily by the Centers for Disease Control and Prevention and the State of Hawaii, with additional support from the state's largest insurer, the Hawaii Medical Service Association. Nationally, school children have very high rates of influenza illness, exceeding 10% in most years, according to the Hawaii State Department of Health.

Services Behind Medicare Growth

The growth in Medicare's per-beneficiary spending can be explained by growth in the volume and intensity of physicians' services, rather than by changes in Medicare's payment rates, according to a Congressional Budget Office study. Between 1997 and 2005, Medicare's inflation-adjusted payment rates for services actually declined slightly, but per-beneficiary spending jumped by more than 34%, the CBO study found, with volume and intensity of services growing by about 4% per year. The CBO said that physicians tended to increase volume and intensity of services provided when payment rates were cut, but added that this behavioral response accounted for just a small fraction of the change in per-beneficiary spending. Still, projected cuts in Medicare payments to physicians may result in a different behavioral response from doctors, the CBO noted.

CMS Enhances Hospital Web Site

The CMS said that it has improved the hospital comparison tool available on its Hospital Compare consumer Web site (www.hospitalcompare.hhs.gov). A total of 21 measures of hospital care quality are available on the Web site for consumers to view, according to the CMS. The agency also unveiled the first annual update of pricing and volume information on certain elective hospital procedures, and noted that the information available also includes details on mortality outcome measures that reflect care of patients with acute myocardial infarction and heart failure at more than 4,500 hospitals across the country. These mortality outcome measures are risk-adjusted and take into account previous health problems to "level the playing field" among hospitals. In 2008, the CMS will add patient satisfaction information. Through the Hospital Compare consumer Web site, the CMS is working to implement the principles of a value-based system in the Medicare program, the federal agency said. Next year, hospitals will be required to report on 27 quality measures in order to receive full payment from Medicare, the CMS said.

—Jane Anderson