IOM Asks Congress to Rescue Emergency Care

BY JOEL B. FINKELSTEIN
Contributing Writer

WASHINGTON — Strained by rising demand and insufficient resources, the nation's emergency care is in a precarious state, an Institute of Medicine expert panel has concluded, and Congress must act to shore up the system.

Emergency departments are closing, the pool of available on-call specialists is drying up, and access to timely care in an appropriate setting is on the decline, warned Dr. A. Brent Eastman, chief medical officer of Scripps Health in San Diego, at the public release of the report compiled by the IOM's Committee on the Future of Emergency Care in the U.S. Health System.

The emergency care system's troubles are an especially frightening reality considering that it has traditionally provided the care of last resort, catching those unfortunate patients who have slipped through the gaps of the health care safety net, Dr. Eastman added. There is no longer any guarantee that it will be there when those patients need it, he cautioned at the meeting on emergency care sponsored by the Institute of Medicine.

The IOM panel recommended that Congress establish a single lead agency to oversee and manage emergency care, pulling together resources that are now currently overseen by an array of departments within various agencies, including the Department of Health and Human Services, the Department of Homeland Security, and the Department of Transportation.

As the committee envisioned it, that new lead agency would have planning and budgetary authority over the majority of emergency care activities at the federal level. Such an agency could raise the visibility of emergency medicine and emphasize the need to fund it.

Among other recommendations, the panel urged Congress to fund a demonstration program, to the tune of $88 million a year for 5 years, to assess strategies to coordinate and streamline the emergency care system. Federal agencies also need to support the development of national standards for measuring performance, the IOM said.

The report documents a host of issues besetting the emergency care system, including crowding, boarding, and diversions.

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Emergency departments can no longer guarantee to provide the care of last resort, said Dr. A. Brent Eastman (left).

"The signs of distress are unmistakable," said Dr. Arthur Kellermann, an IOM committee member and professor of emergency medicine at Emory University in Atlanta.

Over the past decade, visits to the emergency department—now up to about 114 million a year—have risen twice as fast as population growth. During the same period, the number of EDs shrank by 425, and the number of inpatient hospital beds fell by nearly 200,000.

"Do the math—with more people needing care and few resources available to provide that care, crowding in the ED was inevitable," Dr. Kellermann said.

And with fewer hospital beds available, more severely ill and injured patients are boarded in the emergency department's exam rooms or even hallways until an inpatient bed can be made available.

Often, EDs have no alternative but to divert inbound ambulances to other facilities. "When I started in my career, this was considered a rare and disturbing event," Dr. Kellermann said. "It now happens more than half a million times a year in the United States."

Demand Outpaces Resources

Emergency department responsibilities have grown over the years, with many now being expected to provide primary care to the uninsured, diagnostic services at night or on the weekend, and behavioral health care to the community.

Meanwhile, revenue has not kept pace. Medicare and Medicaid pay below cost for many emergency services, and uncompensated care has risen.

The emergency department is considered such an important public good that it is the only medical service that all Americans have a legal right to access. But hospitals are expected to finance that care through the free market system, Carmela Coyle, senior vice president for policy at the American Hospital Association, said during a briefing the day before release of the IOM report.

And because of low, and sometimes no, reimbursement, hospitals are finding it increasingly difficult to convince specialists to agree to be on call to the emergency department. Liability, especially in a setting where many uninsured patients are in poor health, is also a major concern for specialists, according to an AHA survey.

Some hospitals have begun to pay specialists a retainer to be on-call, but that is just another financial burden making emergency departments a money-losing proposition, she said.

Stress on the System

Such financial difficulties have led to the closing of scores of emergency departments, which places more pressure on the remaining facilities. Hospitals aren't inclined to give up inpatient beds to admit patients from the emergency department, who may pay at Medicaid rates or not at all, Dr. Kellermann said.

"Right now, all the incentives are to leave the patient in the ED so that they can keep admitting electives," he said.

The IOM committee also concluded that the emergency care system is not equipped to cope with a large-scale emergency.

"You've got to ask yourself, 'If our emergency departments are struggling to handle their daily and nightly load of 911 calls, how in the world are they going to handle a mass casualty event following a terrorist strike, an outbreak of infectious disease, or a natural disaster?" Dr. Kellermann said.

Federal funding for emergency preparedness has been and remains inadequate, the committee found. In 2002 and 2003, emergency care providers received 4% of $3.38 billion in first-responder funding distributed by the Department of Homeland Security—although emergency medical services personnel make up one-third of first responders.

Time to Act

The committee's findings show that emergency departments cannot continue to operate without more financial support, said Dr. Rick Blum, president of the American College of Emergency Physicians.

"Hospitals must be reimbursed for the significant amounts of uncompensated emergency and trauma care they provide," he said in a statement.

Dr. Blum called for Congress to hold hearings on the state of emergency medicine and to pass the Access to Emergency Medical Services Act, introduced in the House last September and in the Senate in May 2006. The legislation targets several problems addressed in the report, including boarding, the lack of on-call specialists, and poor reimbursement for emergency care services.

While emergency care on the whole is deeply troubled, the IOM committee found that there are islands of excellence—a select few facilities that have developed innovative approaches to dealing with the problems that all emergency departments face.

"Our goal should be for these islands to coalesce and eventually blanket the United States with an emergency care system that has no holes," Dr. Eastman said.

The panel envisioned a new regionalized system to coordinate care, so that patients are only taken to facilities that are appropriate and prepared to care for them, he said.

"Where there is no vision, the people perish," Dr. Kellermann said. "Our committee has described a vision for a coordinated, regionalized, and accountable emergency care system. It's time to act." ■

Opioid Prescribing Increasing Nationally, Varies Widely by State

BY TIMOTHY F. KIRN
Sacramento Bureau

SEATTLE — The rate of opioid use varies considerably from state to state, with some of the highest rates found in Indiana and Maine, and the lowest in California and Minnesota, federal prescription claims data show.

That variation is inexplicable medically, and suggests that either opioids are being used too liberally in some states, not enough in others, or both, Dr. Judy T. Zerzan said in a poster presentation at the annual research meeting of Academy Health.

Medicare and Medicaid prescribing figures from the start of 1996 to the end of 2002 show that nationwide, the increase in prescribing of opioids since the middle of the 1990s was great. Furthermore, that increase coincides with efforts aimed at improving the treatment of pain, noted Dr. Zerzan of the division of general internal medicine at the University of Washington, Seattle.

Over the 7 years of the study, opioid prescribing nationally increased a mean of 24% per year. That figure compares with a mean annual increase of just 12% for an index known as the "market basket" that is used to measure general prescribing, according to the figures.

But the increase in opioid prescribing has not been exactly uniform. For example, only two-thirds of the states had an increase in the prescribing of opioids. And some had a greater relative increase than others, Dr. Zerzan said.

Moreover, her study found that 10 states had prescribing at the rate of 87-200 defined daily doses per 1,000 Medicaid beneficiaries per day in 2002, while 8 states had prescribing at a rate of 0-39 defined daily doses per 1,000 Medicaid beneficiaries per day. The rest had rates that fell in between the two.

"Defined daily dose" is a construct developed by the World Health Organization that states a standardized dose rate for different drugs.

The 10 states with the highest rate were Alaska, Indiana, Louisiana, Maine, Maryland, Missouri, Mississippi, Montana, North Carolina, and West Virginia. The eight states with the lowest rate were California, Minnesota, New Jersey, New Mexico, New York, Pennsylvania, Tennessee, and Vermont.

Among the possible explanations for the variation in use are differing state prescription benefit policies, marketing of the drugs has been different in different regions, and physician attitudes toward opioids vary by region, Dr. Zerzan said. ■