Future on Emergency Care in the U.S. Health System
Federal Status Update

Hospital-Based Emergency Care: At the Breaking Point
May 2009

“Knowing is not enough; we must apply.
Willing is not enough; we must do.”

- Goethe

“How’my Doin’?”

- Ed Koch

Michael T. Handrigan, MD
Acting Director, ECCC
Emergency Care Coordination Center, OPEO, ASPR
2.1 Congress should establish dedicated funding, separate from DSH (Disproportionate Share) payments, to reimburse hospitals that provide significant amounts of uncompensated emergency and trauma care for the financial losses incurred by providing those services.

2.1a- Congress should initially appropriate $50 million for the purpose, to be administered by the Centers of Medicare and Medicaid Services.

2.1b- CMS should establish a working group to determine the allocation of these funds, which should be targeted to providers and localities at greatest risk; the working group should then determine funding needs for subsequent years.
110th Congress Bill
S. 2499: Medicare, Medicaid, and SCHIP Extension Act of 2007
Enacted 29-Dec-07
Section 204 - Amends SSA title XIX (Medicaid) to extend through June 30, 2008, the Medicaid disproportionate hospital share (DSH) allotments for the states of Tennessee and Hawaii, with specified adjustments.

H.R. 6331: Medicare Improvements for Patients and Providers Act of 2008
Enacted 15-Jul-08
Section 202 - Amends SSA title XVIII to extend the Medicaid disproportionate share hospital (DSH) allotment for Tennessee and Hawaii.

111th Congress Bill
H.R. 1502: Puerto Rico Hospitals Medicare DSH Equity Act of 2009
Introduced 12-Mar-09
H.R. 2: Children's Health Insurance Program Reauthorization Act of 2009
Enacted 4-Feb-09
Section 616 - Amends SSA title XIX, as amended by the Medicare Improvements for Patients and Providers Act of 2008, to extend the Medicaid disproportionate share hospital (DSH) allotments for Hawaii and Tennessee.

S. 275: Children's Health Insurance Program Reauthorization Act of 2009
Reported by Committee 16-Jan-09
Section 616 - Amends SSA title XIX (Medicaid), as amended by the Medicare Improvements for Patients and Providers Act of 2008, to extend the Medicaid disproportionate share hospital (DSH) allotments for Hawaii and Tennessee.

Reported by Committee 27-Jan-09
Extends from FY2008 through FY2013 the special rule for increase of Medicaid disproportionate share hospital (DSH) allotments for low DSH states.

S. 318: Medicare Rural Health Access Improvement Act of 2009
Introduced 26-Jan-09
(4) eliminate temporarily the disproportionate share hospital (DSH) adjustment cap

H.R. 688: Kids First Act
Introduced 26-Jan-09
Repeals: (1) the waiver of certain Medicaid provider tax provisions under the Balanced Budget Act of 1997; and (2) the requirement of special payments for certain public hospitals, without regard to the state DSH allotment limitations, under the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000.

S. 326: Kids First Act
Introduced
Repeals: (1) the waiver of certain Medicaid provider tax provisions under the Balanced Budget Act of 1997; and (2) the requirement of special payments for certain public hospitals, without regard to the state DSH allotment limitations, under the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000.

Introduced 13-May-09
(7) REDUCTION IN CONNECTION WITH AHBP-Notwithstanding the previous provisions in this paragraph, the Secretary shall provide for a phased-down reduction over a 5-fiscal-year-period beginning with fiscal year 2012 of the amount of the DSH allotment for each State so that, by the end of such period, such amount is equal to 10 percent of the amount of such allotment for such State for fiscal year 2011

H.R. 1776: Quality FIRST (From Incentives, Reporting, Standards, and Technology) Act of 2009
Introduced 30-Mar-09
S. 391: Healthy Americans Act
Introduced 5-Feb-09
H.R. 1321: Healthy Americans Act
Introduced 5-Mar-09
3.1 The Department of Health and Human Services and the National Highway Traffic Safety Administration, in partnership with professional organizations, should convene a panel of individuals with multidisciplinary expertise to develop an evidence-based categorization system for EMS, EDs, and trauma centers based on adults and pediatric services capabilities.
EBM Conference convened by Drew Dawson
Follow up opportunities with ECCC, CEMC and FICEMS
3.3 The Department of Health and Human Services should convene a panel of individuals with emergency and trauma care expertise to develop evidence-based indicators of emergency care system performance.
Council for Emergency Care (CEMC)

- New Federal Interagency group
- Broad-based expertise, knowledge, and information on Federal efforts in and around daily hospital-based emergency care efforts
- Representation from agencies including HHS, DoD, DHS, DoT, VA, others
- CEMC to be chaired by ECCC director
- CEMC representatives to serve as liaisons to their respective organizations, conveying information on CEMC meeting activities, priorities, and policy discussions
3.4 The Department of Health and Human Services should adopt regulatory changes to the Emergency Medical Treatment and Active Labor Act (EMTALA) and the Health Insurance Portability and Accountability Act (HIPAA) so that the original goals of the laws are preserved but integrated systems may further develop.
Emergency Medical Treatment and Labor Act Technical Advisory Group (EMTALA TAG) chartered in May 2006

CMS Adopts Changes to EMTALA Regulations in Final 2009 Inpatient IPPS Rule

- CMS Withdraws Proposed Rule Applying EMTALA Requirements to Hospital Inpatients
- CMS Deletes Language Requiring that an On-Call List Must Be Maintained “in a Manner that Best Meets the Needs of Hospital Patients”
- CMS Approves Community Call Arrangements

H.R. 1998: To improve access to emergency medical services, and for other purposes

- SEC. 4. PROTECTION FOR EMERGENCY AND RELATED SERVICES FURNISHED PURSUANT TO EMTALA.
- In committee
3.5 Congress should establish a demonstration program, administered by the Health Resources and Services Administration, to promote regionalized, coordinated, and accountable emergency care systems throughout the country, and appropriate $88 million over 5 years to this program.
S. 733: National Trauma Center Stabilization Act of 2009
  - In committee

ECCC/SAEM Regionalization Town Hall Meeting
  - May 16th 2009

IOM Regionalization forum
  - September 10 and 11

ECCC FY2010 Regionalization Demonstration Program
3.6 Congress should establish a lead agency for emergency and trauma care within 2 years of the publication of this report. The lead agency should be housed in the Department of Health and Human Services, and should have primary programmatic responsibility for the full continuum of EMS, emergency and trauma care for adults and children, including medical 9-1-1 and emergency medical dispatch, prehospital EMS (both ground and air), hospital based emergency and trauma care, and medical-related disaster preparedness. Congress should establish a working group to make recommendations regarding the structure, funding and responsibilities of the new agency, and should develop and monitor the transition. The working group should have representation from federal and state agencies and professional disciplines involved in emergency and trauma care.
Emergency Care Coordination Center
Chartered January 2009

The Emergency Care Coordination Center
The Emergency Care Enterprise

In partnership with:
Department of Health and Human Services
Department of Homeland Security
Department of Veterans Affairs

Emergency Care Coordination Center
Chartered January 2009

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4.1 Hospital chief executive officers should adopt enterprise-wide operations management and related strategies to improve the quality and efficiency of emergency care.
4.2 The Centers for Medicare and Medicaid Services should remove the current restrictions on the medical conditions that are eligible for separate clinical decision unit (CDU) payment.
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4.3 Training in operations management and related approaches should be promoted by professional associations; accrediting organizations, such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the National Committee for Quality Assurance (NCQA); and educational institutions that provide training in clinical, health care management, and public health disciplines.
4.4 The Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) should reinstate strong standards that sharply reduce and ultimately eliminate ED crowding, boarding, and diversion.
4.5 Hospitals should end the practices of boarding patients in the ED and ambulance diversion, except in the most extreme cases, such as a community mass casualty event. The Centers for Medicare and Medicaid Services should convene a working group that includes experts in emergency care, inpatient critical care, hospital operations management, nursing and other relevant disciplines to develop boarding and diversion standards, as well as guidelines, measures and incentives for implementation, monitoring, and enforcement of these standards.
S. 468: Access to Emergency Medical Services Act of 2009

TITLE III--CENTERS FOR MEDICARE & MEDICAID SERVICES
WORKING GROUP TO IMPROVE EMERGENCY CARE EFFICIENCY

Establishes a bipartisan commission to examine factors that affect the effective delivery of such services, by providing for additional payments for certain physician services furnished in such emergency departments, and by establishing a Centers for Medicare & Medicaid Services Working Group, and for other purposes.

In committee
5.1 Hospitals should adopt robust information and communications systems to improve the safety and quality of emergency care and enhance hospital efficiency.

Directs the Secretary of Health and Human Services to invest in the infrastructure necessary to allow for and promote the electronic exchange and use of health information for each individual in the United States, consistent with the goals outlined in the Strategic Plan developed by the Office of the National Coordinator for Health Information Technology.

Health IT Strategic Plan Synopsis

http://healthit.hhs.gov/portal/server.pt/gateway/PTARGS_0_10731_848084_0_0_18/HITStrategicPlanSummary508.pdf

National Health Information resources

6.1 Hospitals, physician organizations, and public health agencies should collaborate to regionalize critical specialty care on-call services.
EMTALA Community Call Plans and On-Call List Rules Finalized

permits hospitals to meet the EMTALA requirement for maintaining an on-call physician list by participating in a formalized community call plan among hospitals
6.2 Congress should appoint a commission to examine the factors responsible for the declining availability of providers in high risk emergency and trauma care specialties, including the role played by medical malpractice liability in specific, and to recommend targeted state and federal actions to mitigate the adverse impact of the responsible factors and ensure quality of care.
S. 468: Access to Emergency Medical Services Act of 2009

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In committee
6.3 The American Board of Medical Specialties and its constituent Boards should extend eligibility for certification in critical care medicine to all acute care and primary care physicians who complete an accredited critical care fellowship program.
6.4 The Department of Health and Human Services, the Department of Transportation, and the Department of Homeland Security should jointly undertake a detailed assessment of emergency and trauma workforce capacity, trends, and future, needs, and develop strategies to meet these needs in the future.
ECCC in Collaboration with FICEMS is well positioned to accomplish this
6.5 The Department of Health and Human Services, in partnership with professional organizations, should develop national standards for core competencies applicable to physicians, nurses, and other key emergency and trauma professionals, using a national, evidence based, multidisciplinary process.
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ECCC - CMS - NQF - AHRQ
6.6 States should link rural hospitals with academic health centers to enhance opportunities for professional consultation, telemedicine, patient referral and transport, and continuing professional education.
7.1 The Department of Homeland Security, the Department of Health and Human Services, the Department of Transportation, and the states should collaborate with the Veterans Health Administration to integrate the VHA into civilian disaster planning and management.
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- HSPD #21
- National Health Security Strategy
7.2 All institutions responsible for training, continuing education, and credentialing and certification of professionals involved in emergency care (including medicine, nursing, EMS, allied health, public health, and hospital administration) incorporate disaster preparedness training into their curricula and competency criteria.
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National Center for Disaster Medicine and Public Health at USUHS
7.3 Congress should significantly increase total disaster preparedness funding in FY 2007 for hospital emergency preparedness in the following areas:

- strengthening and sustaining trauma care systems;
- enhancing ED, trauma center, and inpatient surge capacity;
- improving EMS response to explosives;
- designing evidence-based training programs;
- enhancing the availability of decontamination showers, standby ICU capacity; negative pressure rooms, and appropriate personal protective equipment;
- conducting international collaborative research on the civilian consequences of conventional weapons (CW) terrorism.
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March 2009
Total Revenues and Outlays in CBO's Baseline and Under the President's Budget (Percentage of GDP)
8.1 Academic medical centers should support emergency and trauma care research by providing research time and adequate facilities for promising emergency care and trauma investigators, and by strongly considering the establishment of autonomous departments of emergency medicine.
8.2 The Secretary of the Department of Health and Human Services should conduct a study to examine the gaps and opportunities in emergency and trauma care research, and recommend a strategy for the optimal organization and funding of the research effort. This study should include consideration of: training of new investigators; development of multi-center research networks; funding of General Clinical Research (GCRCs) that specifically include an emergency and trauma care component; involvement of emergency and trauma care researchers in the grant review and research advisory processes; and improved research coordination through a dedicated center or institute. Congress and federal agencies involved in emergency care research (including DOT, DHHS, DHS, and DoD) should implement the study's recommendations.
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NIH Roundtable on Emergency Care:
- Neurological and Psychiatric Emergencies
- Surgical-Medical Emergency Care Research
- Trauma Topics
8.3 Congress should modify Federalwide Assurance Program (FWA) regulations to allow the acquisition of limited, linked, patient outcome data without the existence of an FWA.
Questions?