Regionalizing Emergency Care Systems

Lessons from Other Systems

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• Selected milestones in regionalization of health care in the USA
  – Blind rehabilitation in the VA (1948)
  – Trauma care
    • Trauma care centers, Chicago and San Francisco (1966)
    • Trauma care system, Maryland (1969)
  – EMS systems (1970s)
  – Cardiac surgery volume-outcome relationship (1979)
• Informal regionalization has been the norm in USA since formal regionalization requires a system of care and there is no overall health care system
• EMS-targeted conditions in California (1984)*
  - Acute cardiopulmonary conditions
  - Trauma
  - Burns
  - Spinal cord injuries
  - Poisonings
  - Neonatal and pediatric emergencies
  - Behavioral emergencies
  - Domestic violence
  - Environmental emergencies
  - Transplantations and replantations

• EMS-targeted condition system requirements in California (1984)
  – Training in
    • condition recognition
    • condition-specific management
  – Coordinated emergency medical plan, including referral and transport to appropriate emergency care and special care facilities
• By clinical condition
  – Visual impairment/blind rehabilitation
  – Spinal cord injury
  – Transplants
  – Multiple sclerosis and Parkinson’s Disease
  – Cardiac care
  – Traumatic brain injury
  – Polytrauma (TBI, vision impairment, hearing loss, burns, amputations/orthopedic impairment, PTSD/psychiatric)
  – Stroke (?pending)
• By clinical service
  – Pharmacy
  – Radiology services and teleradiology support
  – Emergency management
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REASONS FOR REGIONALIZING SERVICES

• Complex, high risk conditions requiring a high intensity of care (e.g., highly technical, multidisciplinary)
• Limited availability of key resources (personnel, technology, etc.)
• Demonstrated quality of care benefit (e.g., volume-outcome relationship, multidisciplinary approach)
• Continuum of care needed
• Control of care beneficial from cost and/or quality perspectives
• Demonstrated economies of scale
ISSUES FOR AND CHALLENGES TO REGIONALIZATION

- Information flow
- Patient/family satisfaction
- Social support
- Reduced availability of services in some care settings
- Quality management of a system vs. a facility
- Continuity of care in the community
- Impact on training programs
- Financial consequences
- Status and image issues
- Political and community impact considerations
More difficult and complicated than often expected
Medical leadership crucial
Financial impacts often misunderstood
Quality of care benefits often overshadowed by loss of service concerns
Importance of cultural issues generally underestimated