MCHB/EMSC Webcast

The Institute of Medicine Study on the Future of Emergency Care in the U.S Health System

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DAN KAVANAUGH: Good afternoon, everybody. I would like to welcome you all to this panel on the future of emergency care in the United States health systems from the Institute of Medicine. I would like to read a few instructions for those joining us remotely by the webcast. The slides will appear in the central window and should advance automatically. Changes are synchronized with the speaker's presentations. You need not do anything to advance the slides. You may need to adjust the timing to match the audio by using the slide delay control at the top of the messaging window. We encourage you to ask the speakers questions during the presentations. Type the questions on the right of the interface, select question from speaker, the drop down menu and hit send. Please include your state or organization in your message so we know where you are participating from, and the questions will be relayed on to the speakers at the end of the presentation.

We'll have about 15 minutes for questions and answers from those who are questioning remotely and those here with us live in Silver Spring. If we don't have the opportunity to respond to the question during the broadcast we will email you afterwards. We encourage you to submit questions any time during the broadcast, we will try and answer as many as we can during the last 15 minutes of the session. On the left of the interface is the video

window. You can adjust the volume of the audio using the volume control slider which you can access by clicking on the loud speaker icon. For those of you who selected accessibility features when you registered, you will see the text captioning underneath the video window. At the end of the broadcast, you will have the opportunity to fill out an online evaluation. Take a couple minutes to do so. Your responses will help us plan future webcasts in the future and provide technical support. I would like to introduce Robert Giffin, who will be the moderator and introduce the panel members.

ROBERT GIFFIN: Thank you, Dan. It is really a great pleasure to be here today to introduce this study, and bring the distinguished panel to address your questions. I know that this has been long-awaited and we are all very excited about finally having it, having it ready for primetime. Let me briefly touch on the sponsors of the study. We owe great gratitude to the Josiah Macy, Jr. foundation, agency for health care research and quality, CDC, HRSA, and the national highway traffic safety administration to see the need for the study and putting it together in the comprehensive manner that it was done. What did we try to do, the statement of task is shown here on the screen in very brief form. There were four main objectives, one was to examine the state of emergency care in the U.S. To explore the strengths and limitations and try and understand what the challenges are it faces in the future.

To describe a vision for the future, and then to recommend strategies for achieving that vision over time. Also the study had special attention, obviously for the emergency care for children, and the emergency medical services. And so in order to undertake this study we

developed this structure that looks fairly simple but was actually quite complicated and had a lot of interconnected parts. A main committee with 25 members, and then we have three subcommittees dealing with three key issue areas, pediatrics, EMS, pre-hospital EMS, and the hospital-based emergency care. And although it looks fairly like these are fairly discreet components, there was a lot of cross fertilization. Each subcommittee had members from the main committee, as well as some additional members, just members of the subcommittee. There was also a lot of cross fertilization in terms of expertise across these groups. So we had pediatricians or pediatric people involved in the EMS subcommittee, for example, and vice versa. This really reflects the goal of the committee, which was to try to look at emergency care in a very broad and integrated fashion. A comprehensive study of emergency care had not been done in quite a long time. We looked at various aspects of it.

The I.O.M. looked at the pediatric issues and other issues of emergency care over the years as had different agencies of the government. But this is the first time that a truly comprehensive study had been done in quite a long time. During the course of the study, which lasted about two and a half years, the committee met 19 times. Received expert presentations from almost 60 people. Conducted multiple site visits. The committee selection process underwent the I.O.M.'s extremely rigorous bias and conflict process, and the reports underwent a very rigorous internal and external review process. And so we feel this is quite an achievement. These are difficult steps that the reports go through at the I.O.M. but we think it ensures their independence and credibility.

Okay. Now I would like to turn the podium over to our panelists, and first I would like to introduce them. This is a very distinguished group and it's an honor to introduce them. I've gotten to know them very well over the last two and a half years, and they are indeed a wonderful group of people. Gail Warden was the committee chair, and I will just give a very brief partial list of his credentials. President Emeritus, and then before that president and CEO of the Group Health cooperative in Puget Sound in Seattle. He's been on many boards, institute for health care improvement, RAND health care board of advisors, and others, the national quality forum, national committee on quality assurance and the American hospital association, and elected member of the national CAD miss and served on many committees in capacities over the years, and an incredible supporter and great supporter to the academies. John Prescott is Dean of West Virginia School of Medicine. The director of the Center for Rural Emergency Medicine. He was the first chair of the Department of Emergency Medicine at West Virginia. Before that he had a career in the army and served at brook army medical center in San Antonio and Fort Bragg in North Carolina, and board certified in emergency medicine.

Shirley Gamble was the chair of the EMS sub committee, and currently chief operating officer for the United Way Capital area in Texas. And a number of executive positions, including Incarnate Word, and Tampa General Hospital. Last but not least, David Sundwall was chair of the pediatric subcommittee, currently executive director of the Utah state Department of Health. Before that he was president and also senior medical and scientific officer of the American clinical laboratory association. Administrator of HRSA Public Health Service, assistant general in the U.S. Public Health Service, distinguished

career in government, and also the director of the health and human resources staff for the human resources committee in the early 1980s. Board certified in internal medicine and family practice. You can see we have a very distinguished group. I would like to now introduce, or ask Gail Warden to make a few remarks and we will -- each presenter will talk about the report that they were involved in, primarily, and we'll hold questions I think until the very end.

GAIL WARDEN: Thank you, Bob. Good afternoon. What Bob obviously couldn't say is that despite what a wonderful committee we had, we wouldn't have delivered the report we did if we did not have Bob's leadership and Megan and Ben,, the three people who staffed the committee over the period of time. My assignment this afternoon, different than last week, talk about what motivated the study and talk about what division was and what we needed to be done to achieve division. If we look at the slide saying motivation, I'm just going to briefly talk about each one of these bullets. Obviously it's no secret to anybody that emergency rooms are crowded pretty much everywhere in the country. There's been a 26% growth in emergency visits over the last ten years. And in that same period of time, we have also seen over 400 emergency departments close in hospitals and we have also seen about 200,000 beds taken off line. The crowding is for many people particularly after hours on weekends, emergency room is the primary care physician and consequently, there is a lot of business going there, 40% of the people that come to emergency rooms get admitted, one way or another, there is still a lot of primary care being delivered and it's particularly being delivered to people who are uninsured because that's their only source

of primary care. And the uncompensated care issue is a huge one in most communities, the hospital, health system I was CEO of, $150 million every year of uncompensated care.

There are some institutions that have twice that much. Another concern that we had as we looked at emergency medicine across the country was fragmentation. We found that the system was highly fragmented. Very much uncoordinated and inconsistent, and quite often patients didn't get to the right place at the right time because of a lack of coordination. We also were very concerned, particularly and this was kind of reinforced during the middle of our study because of Katrina, that there was inadequate search capacity to handle major disasters or major serious disease problems, and that there wasn't adequate training for people, wasn't adequate planning, and consequently, that was a big issue that needed to be addressed. We also found reinforced regularly the personnel shortages. The one that got the most attention, the lack of on call specialists available to emergency rooms around the country, largely because of the, some cases shortage of specialists, but more importantly, because it disrupted their lives. They were concern about medical liability and therefore it was very difficult to get on call specialists to come to emergency rooms in off hours particularly to see patients. There was limit data on quality, we have not had many performance standards for emergency rooms, per se, compared to what we are used to for inpatient care or other areas, and also found the research, there was very little research, if you look at the amount of research funding made available for emergency care, it's really at the bottom of the list. And NIH I think there was one project funded last year, so it's a serious issue. And you're going to hear from David about the limited preparedness for pediatric patient, which is something that

got reinforced constantly as we went through the study as we did site visits, as we had outside speakers come and talk to the committee.

When we developed the work plan for the study, we talked about the fact that one of the things we really were obligated to do as a committee is develop a vision for the future of emergency care, and when you have an opportunity to see the three reports, in the third chapter of every report there's a discussion of the vision and what needs to be achieved. Needs to be done to achieve that vision. The vision is that we would have a coordinated regionalized and accountable emergency care system. When we talk about coordination, what we are talking about is we'll coordinate all aspects of the system, EMS, the hospital emergency department, trauma centers, and local dispatches will work together to provide a seamless delivery of services to individual patients and to the community. When we talk about regionalization, we talked about the fact patients in a particular region would be taken to facilities that are best able to meet their needs, and particularly disease or injury, that there will be a plan and ground rule sorted out about what patients go where, and for what services, and certainly one of the issues related to that is this whole question of is on call coverage of specialists.

One of the problems we have now, every emergency room tries and finds a way to get on call specialists for their particular emergency room. The fact is, in many communities you don't need on call specialists and if you have a plan and know where people are going to go if they have a particular condition or trauma or whatever it might be. This is not a new issue. In the 1966 report which was called, which focused on mostly on trauma, but the

condition of the emergency system, it called for this kind of effort, and it did happen in trauma in most communities I'm sure you know about the different level of trauma centers with very specific characteristics that are expected.

The third issue, accountability, basically what we're talking about there, the categorization of facilities, so we know what they are and what the capacity and capabilities are, what technology they have, standardized protocols, we are talking about ways that the system can ensure that there's accountability and also ways that we can measure system performance against certain goals that are set and ground rules that are set in every community. The committee made these recommendations for achieving the vision, and as we did that, we basically had three very important considerations which were in chapter three of every one of the reports. Number one, that the Congress should establish a demonstration program to promote regionalized and coordinated emergency care services. It's not prescriptive. What it's basically saying is that with the government, ought to put $88 million over five years into two phases of really finding what best practices are, and also what different methodologies might be employed in order to achieve the vision.

The second recommendation was that there be an elite agency for emergency and trauma care. That's with the recognition there are a number of agencies that have done an excellent job and tried to work together very closely, HHS, HRSA, and others. The same time, the feeling of the committee, there needed to be an elite agency, it shouldn't be described and prescribed in a report, but instead we should establish a working group that can be brought together representing those agencies and representing the other

stakeholders to try to determine just exactly what needed to be done to consolidate functions and develop funding in order for us to achieve the visions. And finally, in order to achieve accountability, we felt the federal agencies needed to work together to establish evidence-based categorization system, pre-hospital protocol, and indicators of system performance. And this is a very important part of the report, in fact I think the most important part of the report in terms of the overall implications is the vision of coordination, regionalization, accountability, and the steps that we need to have taken by elite agency to make this happen. Now it's my pleasure to introduce John Prescott who will talk about the hospital ED report. John.

JOHN PRESCOTT: Thank you very much. I think each of us will be bringing our own perspective to this report, and probably be bringing a perspective as far as my background is emergency physician, I work in a rural environment, and I'm in academics now. I'm going to be doing -- I have that kind of perspective when I think about emergency care. Now I think when each one of you thinks about emergency care and you think about the emergency department there will be a, if I say to you think of an emergency department right now, you'll think of one thing. Or maybe think of a couple things. One of the things that will probably strike you, think of someplace very busy. Might think about an overflow, about a lot of patients. And that used to be how it was on Saturday night at 11:00. Emergency department used to be just like that. I'll tell you that now on Tuesday morning about 9:30, it's like that, too. I see a lot of heads nodding right now, that can be a pediatric, adult, rural or urban setting, that's the way it is. In 2003 there were over 114 million visits

to emergency departments. Over one quarter for folks suffering injuries, usually unintentional injuries, although a large number of folks have intentional injuries.

The emergency departments are crowded. We have a lot of people in there. And that's probably a central theme. That was the central theme looking at the emergency departments as a whole. And over the last 25 years, I have been involved in emergency medicine, I have seen emergency medicine and the practice evolve. We are still in charge of and take care of primary responsibility for urgent matters and for lifesaving procedures, but we also have additional responsibilities. This is what the report found, that emergency departments have support to the communities, providers and patients. The role for the emergency department, providing and being the safety net of the safety net, we are caring for the uninsured. When there's a disease outbreak, where will it be seen first? Usually, not usually but lots of times in the emergency department, so they have a public health surveillance mode. People expect the emergency department is a place where there is a lot of preparation for any type of a disaster. Man-made disaster, natural disaster, the emergency department will have a central role, a focal role in the response. It certainly serves as a role, an adjunct to community physicians. It's a place they go and they recommend their patients go. We cannot see you now, go to the emergency department. We need you to go to the emergency department. That is something we can't handle in the office. They play the role certainly in an academic institution and certainly in communities.

From a rural perspective, emergency departments are often the only place the patient can get care. There may not be another provider around for many, many miles. What we have seen, though, with the increased demands, there is an expectation of the kind of care that people will get and the kind of care they actually receive. And thaft -- that was part of what we focused on as a committee. What were the key problems? Between 1993 and 2003, population grew by 12%, admission by 13%, and the overall emergency department visits, 26%. Our patients are also sicker and older. The same time, we have seen the net loss of hospitals, 700 hospitals less, 450 emergency departments less, over 200,000 less beds. What we have now, more and more folks coming in to a smaller, smaller entryway. The energy departments also do take care of a large number of uninsured. We have -- there are some problems, the patients come in and all patients get seen and evaluated and stabilized in the emergency department. Again, it adds stress to the system. We have seen people who are Medicaid beneficiaries use the emergency department more so than other patient, but seen also a lot of insured patients now turning to the energy departments because they can get quick, accurate care in the emergency departments. What's that done, it's caused us to have overcrowding. And overcrowding is not simply a problem in Boston, Chicago, or Texas, it occurs throughout the nation. Every emergency department is feeling it. We have seen issues with boarding. Something we never thought we would see. Actually patients are not waiting an hour or two hours, but sometimes they are waiting days to get admitted to hospitals. Waiting until a bed opens up. That's not good for the patient, we all know that. It's certainly not good for the staff either. It was a rare time in the past where I would go home at 7:00 and come back at 7:00 and see a patient still there, that's not that rare anymore. That continues to occur. And I think -- there

we go, there is the sound back again, great. And diversion, this used to be something very rare. But now it occurs in this nation once every minute of every day of the year. Patients are not only going, they get diverted from the appropriate facility or the closest facility to someplace else and that can compromise care.

So many other problems we noted -- we have had -- there is a, you know, used to be a thought that when the emergency department was crowded it was just the emergency department's fault. Well it isn't just the folks are not working hard enough, we have set up systems which have allowed emergency departments to get more and more crowded. We found this is actually a multi-focal problem. Something the committee had looked at and examined in great detail. We have adapted methods we found being successful in other industries out there. Gail mentioned before, on call specialists. Certainly we have had increasing patients are faced with a lack of available on call specialists. Sometimes they just are not in the community, a lot of times they don't want to or can't accept new patients because liability concerns or sometimes even lifestyle. But it's an issue that we are facing as the emergency care providers.

Regarding emergency preparedness, an old saying, as the emergency department goes, so goes disaster response. If the disaster response is well going, things in general will tend to work out well. If you have a system which is so close -- close to the tipping point on a daily basis, that's what we have found again and again and again, we can't and do not have the ability to handle the Surge when a disaster occurs. And finally, we have fragmentation. We have a system that is set up that works, where things are not real

coordinated. Who is responsible, how are we coordinated, make sure the people get, or patients get the right care at the right time, the right location? And certainly the lack of accountability that Gail mentioned before, a critical component we found again and again, not only in our subcommittee, but throughout all the committee discussions. And again, academic perspective, we don't have answers to many simple questions. We have not done the research. We think we know what is right but have not done the research to actually prove what is the things that make the most difference as far as our patient, and making sure they get the appropriate care. So as a committee, our subcommittee and others with recommendations that we have made, we thought it was very important that Congress provide this year, $50 million for uncompensated emergency and trauma care, and this is separate from the typical dish payments out there now. This is for to help for those who are taking care of those at greatest risk.

Regarding boarding and diversion, very simple message. This must stop now. We can't have this go on any more. We have to say, the committee has come back out, a strong recommendation saying it's time for this to stop. We have drawn a line in the sand and said this is it. This must be supported, we feel, by JCHO, and very presence of these rules by JCHO and their enforcement of them will help push the process along very much. Convene a working group with folks from emergency medical, critical care, nursing and others, to help develop standards as well as guidelines, measures so we can implement things that work, so we can address these issues of diversion and boarding. We had a wonderful discussion on the committee about management techniques that we need to implement throughout the entire hospital and throughout the systems. We have and

antiquated systems right now, and you know there are some hospitals that have very sophisticated systems. I'll make you a bet in most hospitals there is one individual who has the clipboard who knows how many beds there are in the hospital. And you have to contact that one individual and beg sometimes for that bed and you have to reserve it and we need to get out of that way of doing business. We should look at the hotel industry, look at the banking industry, how people manufacture things. We can certainly do a better job, the committee felt strongly about this, we can do a better job as an industry in addressing this need. Regarding the on-call specialty services, we do believe, and Gail mentioned before how important it is to regionalize this. We know not every community can do this. We serve as a primary back-up. This happens again and again to other institutions and it's much needed to really address and make sure the patients get the appropriate back-up care they need. We ask Congress to make sure they establish to take a look at the impact of medical liability on call medical services. We feel it's incredibly important. And we also, excuse me one second here. We need to, there was another recommendation here that we had, do we have enough personnel, I think we need to ask ourselves are they adequately trained, can they work better together? Obviously an important thing we need to do. We need there should be significant funding for hospital emergency preparedness. Clearly emergency departments and hospitals must receive more funding to be better prepared so we can lead a response and can provide the proper care for people when the response does occur. We have to build an infrastructure for day-to-day trauma systems. We found we work very closely with the colleagues from across the medical spectrum, particularly the trauma, looking at that as a system, as being a model that we could work towards and work with so that when we have that system in

place we will be better able to respond. We need to address the issues that have to do with surge capacity, absolutely positively. Even in a regular emergency department, it's the one car crash that tells you have to have the ability to open up, find beds, take care of others. In a disaster situation, it's magnified a lot more. Adequate preparation for the personnel. Research is key for our understanding so we can move ahead and do this in a coordinated fashion. Now the last thing on this, in regard to the research, we have numerous gaps in the knowledge. It's optimal we come up with a strategy for direction. Not only for patient care, that's critical. But also for systems research. So we know what system works best in a particular region of the country, particular hospitals, in different settings. We need to put the time and money and effort into doing this. We feel it must be dedicated research. I'm going to step down here and I will answer later on. Shirley Gamble will talk about the emergency medical services at the crossroads.

SHIRLEY GAMBLE: Good afternoon. Last week when I had the opportunity to be on the panel here in D.C. when we rolled out these reports it was odd to me but a statement that I made about we have all seen TV where EMS rolls up, saves your life, gets you to the hospital and it works every time. Seems strange to me many of the things we are talking about that got picked up. The others thing I talked about was the huge variation in the effectiveness of the EMS system, we really don't know what works. If you had sudden cardiac arrest or death, you have a 5% survival rate. Some communities, 45% survival rate. To me those were anecdotes, stories, part of the presentation.

On Saturday my best friend's daughter was in Austin, she had a C-section, wonderful, beautiful baby girl and my girlfriend was packing to come to Austin. She's 49 years old. She weighs 120 pounds, runs four days a week, no history of heart disease. Her husband ran to the grocery store to get something. While he was gone my best friend keeled over with sudden cardiac arrest. Now the good news is that very shortly after the incident her husband walked back in the door knew what to do, this was miracle number one. Miracle number two, they lived three minutes from the medical center. She got to care immediately. And miracle number three is that there was no divert in Houston that day. She is going to see her baby next weekend, her new grand baby. She survived. And Houston the survival rate for that event is 5%. If she would have been in Seattle, the survival rate is 45%. As I was coming here for this meeting it really took new meaning for me when I thought about what do we know about the EMS system, what do we need to do in this country to really make a difference in pre-hospital medical care. That's what we are talking about.

Let me talk about some of the problems that we have in EMS today. First is fragmentation. Fragmentation comes across in a variety of ways from community to community. Certainly there is fragmentation anchored -- and coordination between the local service providers. Fragmentation between dispatch and EMS. Fragmentation between EMS and the various hospitals. Understanding where to go, who is on divert, who can take patient, how long does it take to get dispatch through, do we truly know the condition of the patient, know what side of resources and services to send to that patient, we heard evidence from one community, in one county there are 18 different EMS systems. What happens to the

boundaries? How do we make sure patients are getting to the right place, getting to the place with the best pediatric care, best cardiac care, best stroke care? Who has the on care specialist available? Fragmentation makes it difficult to coordinate between the various components of the medical system, add on to that the public. The lack of coordination between police, fire and other public safety components. The second is the issue of uncertain quality. We really don't have or understand quality performance data. In most places it's very difficult to collect outcome data. It's difficult to get consent at the scenes of an event. It's -- then you hand off the patient from the EMS to the hospital, so there is a very lack of integration of the data between them. And we also don't have much information about what is the best training program for professionals at the scene.

What do they need to know in terms of what is the difference of how you attend different clinical events. It gets to that ten-fold difference in part for outcomes of sudden cardiac arrest. The next thing we learned in the EMS committee was that while in many communities EMS is a critical part of the first responder system. To date only 4% of the funding for first responders in the case of national disasters. In addition to that, generally in many communities, EMS has been left out of the table, and the discussion of the dialogue about how do we plan and prepare for these disasters? The last thing is an understanding of both clinical effectiveness and operational effectiveness. No data collected on what is the best way to organize an EMS system, does it make a difference if it's organized around a fire system, fire-based, difference if it's a hospital-based, if it's a third service, does it matter what set of personnel that you put on the EMS system when it first arrives in response. Do we know anything about how you make sure your

professionals have the best training for what they are doing? We don't have much data about that. And then certainly we have very little information about clinical services, what is the best set of protocols people should work with. So in many cases, we have very hard working professionals around EMS. It's a difficult and dangerous job. In many cases they are doing the best they can without much information about what is the best scope of practice.

So our recommendations start with the notion that we have to have a well educated, coordinated work force that really rises to the best of the knowledge that we have. We would like to focus the country on improving the quality, consistency of EMS, states adopt national standards for licensure certification and reciprocity. We would like to see them develop a common scope of practice for EMS personnel and make sure everybody needs a minimum standard of practice. The second -- alluded to it before, is ear medical services. In many communities operated by police, or fire, or the various hospitals in the community. Little coordination between those, and there's again not a common understanding of scope of practice. We are recommending states regulate air medical services. One of the things we dealt with in the community was the issue of the state of technology and EMS. There was initially funding for EMS back in the 1970s and early 1980s. Many systems put in place communication technology in the 1970s. It's 35 years old. As a result of that, fire, police, hospitals and EMS systems cannot talk to each other on a day-to-day basis about the patients, and it's a disaster. So we are recommending that we invest in state of the art communication systems and technology between all the

components that need to coordinate for care, not only in the case of mass casualties, but a day-to-day basis of individual events.

Thirdly, we are asking the EMS be brought to the table in that preparing for a disaster, both in terms of planning and dedicated funding for EMS preparedness. And then we think it's critical that we address those issues of gaps and knowledge about both the clinical issues and the systems organization issues. If you don't know, you don't know. If we don't have a clear understanding of what we don't know, and then do research in terms of best practices, we won't see any improvements. If you always do what you always did, you will always get what you always got. So to take the next step, we have to step back and make the investment in knowledge, and growing knowledge, so we know how to improve the system, so hopefully the next time a loved one has an event like my friend had this weekend, it's not just an accident or good Luck, or the grace of God she survived, but we can count on that every time it happens in a community. And just before here I was talking to one of the members of the panel about maybe the country will respond to this report, we hope so, we hope we don't have to wait for the next big disaster to get people's attention, and I was thinking about this weekend and think the disasters happen every day on a one on one basis. It's not the big disaster. It's happening every day people are not getting the possible care because we don't know what the best possible care is.

DAVID SUNDWALL: Well, good afternoon. I'm delighted to be here and report on the pediatric subcommittee report, we call our thing emergency care for children growing pains. I was delighted to be asked to chair this committee because I'm really not one of

the front line providers. I'm not a pediatrician and not an emergency room person, but I'm a family physician, primary care doctor and have had a bit of experience in federal health policy as you have heard, but it was really an honor to work with the experts, Dr. George Fulton is here from New York City, and others, truly national leaders in their field. And I played orchestra leader and we had fine-tuned instruments. And as Gail said, thank you the staff, they were great to work with. And task masters.

The pediatric report is a bit different, not just because kids are different as we are frequently told and because a lot of reasons, we were not starting from scratch. There was an institute of medicine report done, if you go back to 1966, but nonetheless, we focused on pediatric emergency services for children in 1993, and then there was a ten-year kind of follow-up where do we stand in meeting the recommendations of the report in 2003, so there was a body of research on this, and we weren't starting from the beginning. So what's different now? I'm sure my fellow panel members and I could tell you about the reporters who have been nagging us this last week and wanting quotes from one thing or another. And one asked me kind of probably a predictable question. So what's new, what's new with kids? In fact, kids are not new, and the difference is identified in 1993, but what's different is the context. I think you have heard about from my previous speakers here.

The system, the context you all work in is very different indeed. It is fragmented, poorly coordinated, the burdens on ERs are clearly apparent, shortages of trained personnel or providing for children, they are not adequately prepared. You have heard about the -- the

context we are working in makes the recommendations for previous reports all the more important. Okay. This has a different title than mine, but that's all right. I think the bullets are the same. One thing I want you to know in case you don't, did you realize 27% of all ED visits are children, extraordinary disproportionate number, and probably for a lot of wrong reasons. Only 6% of those ERs that we survey from the essential supplies and equipment needed to manage pediatric emergencies. Many emergency providers receive little training in pediatric care, and this is not to put the providers down in any way. Many of them are family physician, ER doctors or pediatricians, but they probably have not had adequate training to address the very special needs of children. As you know, the medications are different, in fact when medications are used, that have been approved by the FDA, they are being used off label because they are not approved for the use of children in the ages they are being used for. And you have also heard that we are calling for a lead agency to have oversight of pediatric emergency care. Actually, I would amend that bullet, we would call for a lead agency that must have oversight in coordinating responsibilities for pediatric emergency care. I can just tell you that within the committee in our deliberations, this was not an easily arrived at recommendation, this idea of having some big centralized entity in HHS to coordinate. This was a back and forth, up and down discussion and my pediatric colleagues told me they have misgiving, if we have such an entity, kids might get lost in the shuffle.

Pediatric issues have to be an important responsibility of that. When we talk about including children here, we want to make sure that the regionalization applies for them as well. That we have categorization of pediatric capacity on a regionalized basis. We have

done it for newborn ICUs, for burn care, trauma, we need to do it for pediatric too. Protocols are important for guidance, but understand they are guidance not rules. I had an interesting experience, a little anecdote for you, my fourth grandchildren was born here in Silver Spring just the other side of the beltway. I was chagrined this youngster, born at term, C-section, good Apgars, had a little meconium aspiration. A week in the hospital on I.V.s, breathing normally, nursing doing fine, anyway, I think it had a little more to do with reimbursement than it did the baby. The good news is he survived the hospital, which you know can be a risk. But anyway, we all need guidance, and protocols are okay as long as they are guidance and not rules. You have heard my predecessors talk about performance measures and they are hard to come by, but it's a challenge. You can't improve what you can't measure. We have heard many recommendations on quality improvement and it applies here for emergency care and for children.

So, let's talk just a bit about public health. As you know, I'm now a public health state officer, commissioner of health and the executive director of our state. And there is nothing more front and center on our minds in emergency preparedness and disaster preparedness. That along with the obesity epidemic has put public health back in the limelight. Not things you want to deal with, but people are appreciating the importance of public health in ways they may not have before. Katrina was a terrific example what we need to deal with. We have talked about the importance of minimizing child separation, obviously a very bad problem in the Katrina thing, disaster. We need to make sure that as we have our state plan, that we have pediatric expertise present. I'm a little embarrassed to say as we have developed the Utah plan, it's in refinement and improving, we have not

had pediatric improvement sufficient, and I need to address that in my own state. We have not got the plans for surge capacity for Children's Hospital or general hospitals that need to be attend to. And develop specific mental health therapies for children and Social Services. Utah took 600 plus evacuees from Katrina. What a terrific exercise that was for us. Not only the humane thing for the governor to reach out and we are able to take a small percentage, but it came off very, very well. We had six plane loads of such evacuees come in. Because of the exercises done for hosting the Olympics in 2002, we had our ducks in a row. I was just amazed when the planes came, I would do triage with a nurse and EMT, there were the doctors, gurneys, the medications, fluids lined up in the hangar at the national guard airport, transportation provided down to Camp Williams.

It was a wonderful event for us that it went quite well but we certainly identified gap, that's why I think the calls for drills in pediatric mass casualty are very important. We learned on the ground some things we didn't do as well, not so much with medical care as it was Social Services and mental health. We also, as I said, need to may more attention to provider training and resources. Talk about the pediatric competencies caring for children in an in an urgent setting. There was a movement to change a large amount of geriatric doctors for the elderly, and the consensus was we ought not to consider everyone treating older people -- it's the competency you need if you are an internist or family physician, and they have a certification in competency in geriatrics. There ought to be the same sort for people regardless of their discipline or what kind of health professional if they are going to care for children, and it shouldn't be just to have the certificate or document they're competent, it should be ongoing training and CME. We also called for the appointment of

pediatric cord may coordinators to be in emergency rooms, Ombudsman for coordinator, backed away from saying it had to be a doctor or nurse, but it has to be someone who has the coordinating responsibility, deal with other agencies and the hospital. And you have heard quite a bit about research. It came up repeatedly over the two and a half years we were talking about. But really what astounded me, as we proceeded to discuss the importance of improving the emergency care for children, how little there is in the literature about this. We kept looking for documentation or evidence of the problems that we were concerned about, and we had plenty of anecdotes and lots of people experienced on the ground, but there's a remarkable amount of peer reviewed literature on this.

The call for research I think is important. Furthermore, it's clear we need to have more research on new medical devices, technologies, medications, equipment, anything that's being used in the care of children. I have already talked about research. Going to the next one here. And I'm going to just mention a word about the reports' call for the continuation and funding for emergency medical services for children program. This is something I'm very, very pleased is in the report because I have a vested interest. I won't go into details but just tell you that I got, I had the privilege when I worked in the co-authoring with staff. I'm sure the senators that put their name on the bill would be a little offended but it really wasn't the Hatch/Inouye bill, it was the Sundwall and other bill. Good members help staff do good policy and good legislation, but both Pat and I had experiences with children of our own who needed emergency care. In my case it was a near tragedy in that I ran over our two and a half-year-old daughter in our driveway. It was a terrible, terrible experience for me, fortunately she got good medical care and survived, and I did to a degree. I will

make a point here when we called for mental and social support services for kids, that's as important for parents as for kids. If you've taken care of kids critically ill, you've got to understand how hard that is on the parents. But anyway, I had a good outcome with remarkable coming together of the team that was needed to care for her in a very critical situation.

Pat, the staffer for senator Inouye, he had a daughter with meningitis or something, I don't think things came together. But regardless we worked together well and helped with legislation authorized in the EMC program, meant to be a demonstration to see how it worked, and here we are years later and look how well it's worked. You are to be commended for your involvement in this. Some have criticized this in the report, and say why do you single out that for the funding? And we did kind of come full circle. We were advised up front. Bob, if I recall, saying we shouldn't do this, shouldn't single out a program or recommending it. But as we progressed and deliberated on the program, I think it was a clear consensus. Not only was it worthwhile and worth sustaining, but worth recommending increased funding for. So I'm pleased to see that not only included, but kind of lauded and recommended for strengthening. And whatever comes of this report, I hope that this is an important part of all of our response to emergency preparedness. And the last thing I'll say, this, if I'm, I don't know how familiar you are with I.O.M. reports, I think Bob did a good idea of explaining how rigorous they are, and making sure it's fair and balanced and edited carefully, to maintain the credibility of the Institute Of Medicine they do a terrific job. I have not seen any study funded this handsomely and with such an investment of resources and talent, and to show you how unusual it is, not only do we now

have the three fine reports and all the recommendations that you've heard presented, they're going to take it the next step to help the public become more aware of this. And by the public, they make policy makers and citizens throughout the country. We want to make sure we do regional workshops to explore their recommendations, identify the research better, consider how to implement it. And proud to tell you we are discussing having the very first one in Salt Lake City this summer, hopefully in July, and I'm doing what I can to get Secretary Levit to come. I think it would be terrific if the secretary of HHS would come to his home state and acknowledge the importance of this report. In the meantime, we'll make sure we commit him to get some things done to have it become a reality.

So I think the last slide is the regional workshops you see there, July, September, October, Capstone workshop later this year, and the final report le lease in -- release in March of 2007. It has been a pleasure to work on this report, and especially for the benefit of children everywhere in our country. To the extent we can include them in improving the emergency health care system we'll all benefit. Thank you. [APPLAUSE]

DAN KAVANAUGH: I would like to thank our panel and now what I would like to do is actually we have a couple of microphones in the room, if people want to ask questions and I'll let Bob facilitate this, and he can figure out who might be the appropriate panel member to answer the question or they can figure out themselves. Microphones are live in front of you, if you have any questions, feel free to start the discussion.

ROBERT GIFFIN: Okay. Here in the blue shirt.

UNIDENTIFIED SPEAKER: I'm a council member of the American college of emergency physicians for the past five years, and the question I had was regarding boarding in the ED and also diversion. Situation has actually gotten worse. What can be done to try to rectify these problems short of making it a COBRA and TALLA issue with administration?

JOHN PRESCOTT: Sure. We certainly appreciate the council's resolutions, been there myself at times. The idea would be that we have called for -- first of all, we are bringing it back to everybody's attention and have called for it and asked for institutions that do review the hospitals to push forward with this. And also pushed forward to the concept to the folks who run hospitals so others are aware the recommendations are out there. We understand the problem is multi-focal. Not just what you do in the emergency department. It's what happens inside the entire hospital and in the region. Again, the recommendation is we have a regionalized accountable system. We would like people to know that systems are not working right, Art used the analogy last week, across the screen you can see thunderstorm approaching take cover. Imagine if it came off the screen once, emergency department closed down the street due to overcrowding. Things would start to change pretty quickly. I think we need to continue to bring it to the public's attention. Shirley made the comment before about the individual -- we are seeing things happen on an individual basis. What people have to understand, it's not just individuals but the entire system we have problems with.

GAIL WARDEN: I think the other consideration, too many people think of emergency room -- it's about in the hospital, and how efficient beds can be turned over, what kind of policies they have about when patients are supposed to be discharged and what kind of information systems are available. All those kinds of things. All those are talked about in the report. And I hope that my colleagues who are health care executive managers will pick up on that and recognize that they are part of the problem as well as the emergency room.

ROBERT GIFFIN: Okay. Anyone else? I would like to ask people asking a question to state their name and let us know where you are from. Is there anyone else with a question in the audience here? Okay. Right here.

UNIDENTIFIED SPEAKER: Good afternoon, I'm from Arizona. Has Congress received a copy of the reports and will a copy be made to the state Department of Health directors?

ROBERT GIFFIN: Gail.

GAIL WARDEN: We, on the day before we made the release we had congressional briefings on the hill and there was another one actually on Friday. And we gave them summaries of the report. There is just a limited number of the prepublication, the books. But there will be more. But we will see that that information is in the hands of state health directors as well as every member of Congress and the staff. It's just a matter of getting it

to them because we had certain limitations on what we could distribute and what time frame. But that will be done.

DAVID SUNDWALL: Follow-up on that. I have a meeting tomorrow morning with the new president of the association of state and territorial health officers, all of us belong to that, and I'll be giving him the copy of the reports that Bob is bringing with him to our meeting prior to that, and I'll hand deliver that to Dr. Jaris and ask him if he will make all of that available. It can be done online to all of my colleagues in state health departments.

ROBERT GIFFIN: Any other questions in the audience? Okay. Over here.

NATE KUPPERMAN: My name is Nate Kupperman:, pediatric emergency physician but the chair of the department of emergency medicine at University of California-Davis. I addressed The CEO, Dean, and the department about the ED gridlock. I appreciate all your work you have done over the last couple of years. And basically a lot of the things that have been stated here, it's not an emergency department problem, the ED overcrowding, sort of the Sentinel chicken for a problem that is hospital-wide. All of these are somewhat band aid solutions. One solution that has worked in Stoney Brook is the model, we take a patient hospitalized, we might have 20 hospitalized patients boarded and cared for in the ED in the hallways, and what they do, they take them two at a time to hallways in the hospital, two here, two there, two over there with the notion your hallway is better than our hallway. Because we have 20 hospitalized patients with no nurses really dedicated to that area, whereas in the inpatient setting, adds two to 30 patients on a

particular ward so the ratio goes up a trickle. They have had good success with that. We are considering that ourselves. A long winded question, but did your panel talk about the Stoney Brook model as one possible band aid to the issue of ED crowding? And one last thing, part of the problem as you all know, people on the ward, and I'm a pediatrician as well, been on both ends. They look at the ED like with blinders, that there is patients down there, but they are dealing down there, as opposed to once they are on the ward, they are right there in front of them and amazingly beds become available. And that is the premise behind the Stoney Brook model.

JOHN PRESCOTT: We did talk about different models out there. I cannot say we actually, put a name to this concept. However, I will tell you that was certainly advocated. If we can move patients from the emergency department to other places in the department, it becomes a hospital problem versus the emergency. I think it’s key, it's making people away it's an entire hospital problem versus just the hospital problem. We did spend time on that particular model.

SHIRLEY GAMBLE: I'm -- I think the work that they have done at Stoney Brook in terms of getting a commitment from the entire hospital to deal with the instances they cannot get patients placed is a breakthrough in a number of hospitals. I think it's important to think about how can you avoid having to put patients in the hallway anywhere in the hospital, whether ts in the ED or medical or surgical unit. And one of the things the committee recommends and I think we have a lot of evidence now is that if you start with a rigorous top down evaluation and commitment to improving patient flow throughout the hospital,

through a variety of methods, that includes looking at how you schedule your OR, discharge times, put through the various ancillary services, you don't have to board anybody anywhere. Certainly you are going to have surge times you can't get everybody through the hospital. What we found at urgent matters, we can increase capacity in the hospital between 17 and 30%. By just doing a rigorous committed effort to managing every patient every day all the way through the hospital. It's not ideal for any patient to ever be managed in a hallway, when it's a med-surg unit or anywhere. A focus on making sure we manage the patient sufficiently throughout the system.

ROBERT GIFFIN: We have a question from the webcast audience. Carrie Chisholm asks does the panel believe emergency medical training is sufficient to take care of pediatric patients or is pediatric-specific specialization required to adequately take care of children in emergencies.

DAVID SUNDWALL: Let me try and clarify that. George, you can compliment my answer because you are on the front lines. But I think, I may not have made it as clear as I should. We do not believe everybody in an emergency setting needs to be a pediatric emergency specialist to care for children. But there is a corset of competency that all set of things they should be trained in and further medical education to bolster this. What did the committee recommend, George?

GEORGE FULTON: George Fulton, New York City. We very clearly noted that the vast majority of emergency care takes place at general hospitals and access to pediatric

emergency specialist's not something the majority of this country's children have in emergency settings. It is clear from a physician point of view the answer to solving the problem, having board certified resident in the emergency departments, and they were at less than 50%, and the residents are trained by us and others in the care of children. So we see them as the answer. Certainly not as the problem. We need core competency for everybody, which includes the nurses, paramedics, the P.A.s, appear the allied health professionals. I don't want to insult anyone if I failed to mention them but we need to have the core competency to be accountable and continually train.

ROBERT GIFFIN: Any other questions from the audience? Okay, who was next? Okay.

UNIDENTIFIED SPEAKER: Good afternoon. Particularly interested in your recommendation that the lead EMS agency should be housed in DHHS. Other advisory groups have recommended it be housed under homeland security or maybe with hospital systems. EMS stands at the crossroads of health care delivery and public safety and public health. How did you come to the recommendation it should be in the health and human services?

ROBERT GIFFIN: Anybody.

GAIL WARDEN: We spent, as you might expect, we spent a tremendous amount of time discussing this. And I think when all was said and done, it came down to the fact that we felt that number one, we had to build upon what already existed in terms of the work that

was being done by the different agencies, but at the same time we needed the lead agency that had the reach that could reach into pretty much everything. And that it wasn't to be a prescriptive kind of approach where we just anointed DHHS. We were very careful, and if you read the report, pointing out the forums needed to be, and I think I mentioned that in my presentation, forums needed to be created to bring the right stakeholders together both on the provider side as well as government agency side to work through that. But we felt that DHHS in the long time ought to have probably more access to resources, that's the reason we selected. But it wasn't an easy choice.

ROBERT GIFFIN: Okay. Next. How about up front here.

RON MAYO: Ron Mayo from the University of Michigan, emergency physician. I had a question about the elite agency issue. Seems to me some of the things are elite agency for operational issues, and some are for research. Are these, is this lead agency, are these lead agencies going to be covering both things, or do you see separate lead agencies, and if you had a lead agency in emergency medicine would you have underneath that lead agency also there are concerns about pediatric care and prehospital care as well? I'm just a little confused and I was wondering if you could clarify that.

ROBERT GIFFIN: Somebody on the panel want to take a stab?

GAIL WARDEN: I think maybe we were a little confused, too. But I think what we hope would happen by creating these forums or discussion is that we would be able to sort

some of those things out. And we had a limited amount of time that we could spent focusing on that issue, even though as I said we felt it was perhaps, that set of recommendations might be the most important part of the whole effort. And I think we have to sort out, you know, what's the best way, what, who should be taking a lead on research. We have to sort out who should be taking the lead on disaster preparedness. And surge. And who should be taking a lead in trying to put some teeth into changing the operation of hospitals, such as the discussion about joint commission and others. And we tried not to be totally prescriptive, we tried to instead get the issues on the table, and, and to create some forums for where those kinds of things could be worked through. With the understanding that again, as I said, building upon what already existed, not starting all over. I don't know if that answers your question.

ROBERT GIFFIN: Over here.

UNIDENTIFIED SPEAKER: Perhaps the, Carl from South Dakota. Perhaps the issue might be helped if you dropped the term EMS. If we're talking pre-hospital care, then it may fall more closely along with the emergency room, we use EMS to mean just pre-hospital care, we mean it to mean all care. And separating that term out would make life a lot easier for all of us. It's -- strikes me that your comments are focused on two areas, one is the overall problem of overfilling, overutilization, part of that is our problem, part is the public's problem. But we also have the issue of a major surges, whether disaster-related or whatever. And I hope you help address in the written work how critical it is for all of our states to have trauma systems which they don't have, real disaster plans that involve all

levels of care, which many of them don't yet have, although they may be present on paper. And one last -- my ER colleagues in one of the hospitals I work in have just been replaced by ER residency-trained colleagues, a far better and far more consistent job. So we have seen that change dramatically over the course of a year just with people of different training. The general ER physician -- ER-trained physician needs to be supported, however, by a pediatric specialist. If we had PDD or PEM physicians for everything that would be fabulous. But when we don't, those of us who are ped. subspecialties, I'm a pediatric surgeon, need to be more attentive and more available. Thank you.

DAVID JAFFE: Good afternoon. I'm Davie Jaffe from St. Louis. I want to thank you for your presentation, and I will ask about the research recommendations. I recognize you have identified significant gaps in research, research funding, and also in training for future researchers, I'm wondering if you would elaborate for a moment on what changes you think would be most important in funding agencies, for example, NIH and other funding agencies that might address some of the gaps that you have identified.

ROBERT GIFFIN: John?

JOHN PRESCOTT: One of the inherent problems with emergency medicine is that a time-based specialty, in the sense there are different areas of research that tend to focus on systems or organs or disease states. With us it's usually something that happens that wasn't happening a few minutes ago. We do believe that there is -- that we should

emphasize and work towards getting others to appreciate that fact that this is a distinct body of knowledge, that there is a distinct body of knowledge that needs to be explored and dealt with. Up until now it's the classic example of yes, we are going to do research on an infarction, we are looking at research that has to do with chest pain. We don't know when they are coming through. The same thing with all the pediatric issues coming out there. I think it's working towards a better understanding of what we are and what we represent, and the people we represent. All the individuals in this room, all the work that you do, and those issues and questions that come up. It's going to be a long haul, we understand that. We spent a considerable amount of time looking at all the different aspects of research. Looking at the clinical aspects and the operational aspects, understanding we have to do work in both these areas.

ROBERT GIFFIN: Anybody on this side? No, okay

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UNIDENTIFIED SPEAKER: Michigan State University. We have a large number of rural emergency departments that have low volume, often separated by long distances to tertiary care centers. We have trouble recruiting residency trained to fill these.

JOHN PRESCOTT: We looked at -- yes, look at the rural aspects, we spent a considerable amount of time discussing the issues out there. Not only is it the distance, it's the geography, the training, education, transport, it's all the issues that come up. We did not -- we explored, we talked about the idea of how to get additional personnel out there. We really emphasized more than that, the concept of functional regional systems.

Pediatric surgeon, the gentleman in the back mentioned about the trauma systems. Where they are in place and working they are a great model for us to use, idea of the inclusive trauma system. It's a model that seems to work very well. We want to try and do this again in many, many rural areas. So you are not going to be able to have all the time the same quality or quantity of individuals out there, taking care of individuals. But make sure they have the back-up to the system there in place, and that's where we are talking about. That's why the main vision statement Gail talked about before, about a regionalized accountable system is so important. One thing to leave the session from is that main vision. Certainly works in the rural area.

ROBERT GIFFIN: We have time for one more questions, I believe.

JIM WILEY: Jim Wiley, pediatric emergency room physician. I want to thank you, I felt some of the things in pediatric emergency care I value the most have been under siege. How did you arrive at some of the funding levels you recommended for disproportionate care, as well as for the regionalization, and secondly, how I, and those in the room feel strong about this, how can we advocate with the health care funding recommended at the federal level?

ROBERT GIFFIN: Gail, you want to talk about that?

GAIL WARDEN: First of all, the dollars that we ask for, we are very conscious of the fact if we ask for huge amounts of money it might cause the whole report or reports to be

ignored. And for instance, $50 million for uncompensated care is like a drop in the bucket. That keeps Henry Ford going for three months or something. But we wanted to get their attention, we wanted to get it on the record. Some of the other numbers are more realistic. $88 million for the demonstrations I think is fairly realistic. The expansion of EMSC, although this audience probably thinks a drop in the bucket. It is probably realistic. And we try to treat it that way because we want to get into the dialogue so we can look at this thing over the next few years, not just what gets decided the year the report comes out. And so that's basically how we arrived at those. As far as letting us know what your feelings are, you can email us, I would urge you to go to one of the workshops and participate and let your thoughts be known. And, and I also know that the staff and any member of the committee, if you want to contact us will try to get you to the right person on any issue that you want to talk about.

ROBERT GIFFIN: Well, thank you very much. We enjoyed having this opportunity to present our findings to you and I would echo what Gail just said. We welcome your comments and questions and inquiries by email or other means. And please consider coming to the workshops. Thank you.