Legislating Stroke Healthcare Policy in Oregon

Fifth Annual Conference of the Oregon Stroke Network

September 9, 2011

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Hospital-Based Emergency Care: At the Breaking Point

Released On: June 14, 2006

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PRINT EMAIL

Despite the lifesaving feats performed every day by emergency departments and ambulance services, the nation's emergency medical system as a whole is overburdened, underfunded, and highly fragmented, says this series of three reports from the Institute of Medicine.

As a result, ambulances are turned away from emergency departments once every minute on average and patients in many areas may wait hours or even days for a hospital bed. Moreover, the system is ill-prepared to handle surges from disasters such as hurricanes, terrorist attacks, or disease outbreaks.

The Institute of Medicine's Committee on the Future of Emergency Care in the United States Health System was convened in 2003 to examine the state of emergency care in the U.S., to create a vision for the future of emergency care, including trauma care, and to make recommendations to help the nation achieve that vision. Their findings and recommendations are presented in three reports:

1. ***Hospital-Based Emergency Care: At the Breaking Point*** explores the changing role of the hospital emergency department and describes the national epidemic of overcrowded emergency departments and trauma centers.
2. ***Emergency Medical Services At the Crossroads*** describes the development of EMS systems over the last forty years and the fragmented system that exists today.
3. ***Emergency Care for Children: Growing Pains*** describes the unique challenges of emergency care for children.

The wide range of issues covered in this report, *Hospital-Based Emergency Care: At the Breaking Point,* includes:

- The role and impact of the emergency department within the larger hospital and health care system.
- Patient flow and information technology

Emergency Medical Services At the Crossroads

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1. ***Hospital-Based Emergency Care: At the Breaking Point*** explores the changing role of the hospital emergency department and describes the national epidemic of overcrowded emergency departments and trauma centers.
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By addressing the strengths, limitations, and future challenges of EMS, this report, *Emergency Medical Services At the Crossroads,* draws upon a range of concerns:

- The evolving role of EMS as an integral component of the overall health care system.

The National Report Card on the State of Emergency Medicine

Evaluating the Emergency Care Environment State by State 2009

Oregon

OR

D

	RANK	GRADE
ACCESS TO EMERGENCY CARE	41	F
QUALITY & PATIENT SAFETY ENVIRONMENT	36	D+
MEDICAL LIABILITY ENVIRONMENT	37	D-
PUBLIC HEALTH & INJURY PREVENTION	9	B
DISASTER PREPAREDNESS	42	D
OVERALL	47	D

hough Oregon ranked among the 10 states in *Public Health and Injury* vention, that was more than offset by ur grades in the remaining catego-s, including a failing grade for *Access to* ergency Care and a ranking among the m 10 in *Disaster Preparedness*.

ngths. Oregon's performance is stron-in *Public Health and Injury Prevention*. e state ranks first for the percentage of ults aged 65 and older who have ever ed a pneumococcal vaccine (74.7 per-t), and the rate of annual influenza vac-e among that population is only slightly her (71.3 percent). The state also has low average rates of smokers and binge inkers (18.5 and 14.1 percent of adults, spectively). Seat belt use is third highest the nation, with 95.3 percent of front ssengers using seat belts. Oregon also s shown considerable commitment to proving the health and safety of the pulation through relatively high levels of nding for intentional injury prevention ograms ($221.48 per 1,000 people).

spite Oregon's poor grade with regard *Disaster Preparedness*, the state has made me strides in this area. The state has nu-rous communications systems in place, cluding statewide "just-in-time" training ograms, a statewide medical communica-ns system with one layer of redundancy, d a real-time notifi-tion system to notify ntified health care oviders of an event.

allenges. Access to pes of medical care Oregon poses seri-s concerns. For instance, the state has gher-than-average rates of uninsured ults and children. More than 13 percent children and 19 percent of adults in Or-n are uninsured, compared to national es of 11.7 and 17.2 percent, respectively. e state also has the third lowest rate of fied inpatient beds (210.8 per 100,000 ople).

The *Medical Liability Environment* in Oregon is in need of reform. The state lacks many reforms aimed at retaining physicians and lowering medical liability premiums that other states have implemented. Oregon lacks expert witness rules such as requiring case certification by an expert witness and requiring witnesses to be of the same specialty as the defendant. The state also lacks a medical liability cap on non-economic damages and liability protections for EMTALA-mandated emergency care.

Oregon's poor grade for the *Quality and Patient Safety Environment* is partially due to the lack of funding for an EMS quality improvement program, as well as a lack of formal stroke and PCI/STEMI systems of care. Additionally, the state does not have a hospital-based infections reporting requirement and has a relatively low rate of emergency medicine residents (7.2 per 1 million people), a result of having only one residency program in the state.

Recommendations. Along with many problems identified in the *Access to Emergency Care* category, Oregon's emergency physicians also report significant problems with boarding of patients in the emergency department. Efforts should be made to address this problem, such as improving the excessively low rates of staffed inpatient and ICU beds. Further, despite the moderate number of psychiatric care beds compared with other states (28.8 per 100,000 people), emergency physicians report significant problems with patients being unable to access mental health care services; this problem must also be addressed. A first step in improving access to care for all residents would be to address the state's relatively high rates of uninsured adults and children.

Access to specialists and mental health care has posed problems for Oregon.

Oregon has the opportunity to substantially improve the *Medical Liability Environment* in the state. Policymakers should vigorously support a constitutional amendment permitting medical liability caps on non-economic damages. In addition, Oregon could benefit from stronger expert witness rules and implementation of pretrial screening panels. With emergency physicians in the state reporting problems in accessing specialists willing to provide on-call emergency services, particularly in rural areas, the state should consider enacting special liability protections for EMTALA-mandated care.

Finally, funding for an EMS quality improvement program and investing in the development of formal stroke and PCI/STEMI systems of care would substantially improve Oregon's *Quality and Patient Safety Environment*.

Emergency Healthcare Task Force Principles

- Regionalized Approach to emergency healthcare
- Clinical Data collection
- Improved communication
- Regional and statewide authority
- Well trained and effective emergency healthcare workforce
- Sustainable funding

Specific Recommendations

- Healthcare Regions
- State Emergency Healthcare Board
- Trauma, Stroke, Cardiac, Pediatric, Mental Health subcommittees
- Emergency healthcare data collection system
- Coordinate with State Workforce Committee
- Designated funding

DHS: PUBLIC HEALTH DIVISION

Oregon EMS & Trauma Systems Section

EMERGENCY HEALTH CARE SYSTEM

OREGON 2008 EMS FACT SHEETS

EMS & Trauma System statistics by state and county

DHS | Independent. Healthy. Safe.

Academic Emergency Medicine

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Proceedings of the 2010 *AEM* Consenus Conference: Beyond Regionalization: Integrated Networks of Emergency Care

Guest Editors:
Robert T. Gerhardt, MD, MPH
Steven L. Bernstein, MD

Commentaries

Consensus Breakout Sessions

Contents continued inside

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DRAFT

SUMMARY

Modifies provisions relating to emergency medical services.

Changes name of Emergency Medical Services and Trauma Systems Program to Emergency Health Care System Program.

Changes name of Oregon Trauma Registry to Oregon Emergency Health Care and Trauma Registries.

Creates Emergency Health Care System Advisory Board, State Trauma Advisory Board and State Pediatric Emergency Health Care Advisory Committee.

Declares emergency, effective on passage.

A BILL FOR AN ACT

Relating to emergency medical services; creating new provisions; amending ORS 127.675, 181.637, 353.450, 431.607, 431.611, 431.613, 431.617, 431.623, 431.627, 431.633, 431.635, 431.671, 442.625, 445.030 and 682.039; repealing ORS 431.609; and declaring an emergency.

Whereas the American College of Emergency Physicians National Report Card on the State of Emergency Medicine, issued in 2009, gave Oregon a grade of "D" for the problems in this state with emergency medical services and the trauma system; and

Whereas Oregon's poor grade is partially due to the lack of funding for an emergency medical services quality improvement program and the lack of formal stroke and PCI/STEMI systems of care; and

Whereas Oregon's emergency physicians also report significant problems with boarding of patients in the emergency department; and

Whereas in 2009 the Department of Human Services formed an Oregon Emergency Health Care Task Force to assess and make recommendations for improvements to the emergency health care system; and

NOTE: Matter in **boldfaced** type in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted. New sections are in **boldfaced** type.

Senate Bill 234

Printed pursuant to Senate Interim Rule 213.28 by order of the President of the Senate in conformance with presession filing rules, indicating neither advocacy nor opposition on the part of the President (at the request of Senate Interim Committee on Health Care)

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure **as introduced.**

Modifies provisions relating to emergency medical services.

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Whereas Oregon's poor grade is partially due to the lack of funding for an emergency medical services quality improvement program and the lack of formal stroke and PCI/STEMI systems of care; and

Whereas, despite significant advances in diagnosis, treatment and prevention, stroke is the third leading cause of death and the leading cause of disability; an estimated 795,000 new and recurrent strokes occur each year in this country; and with the aging of the population, the number of persons who have strokes is projected to increase;

Whereas Oregon's emergency physicians also report significant problems with boarding of patients in the emergency department; and

NATIONAL QUALITY FORUM

TO: NQF Members and the Public

FR: NQF Staff

RE: Pre-voting review for *Establishing a Measurement Framework for Regionalized Emergency Care Systems Using an Episodes of Care Approach*

DA: July 25, 2011

This framework report is intended to broaden the knowledge base for the measurement of regionalized emergency care systems. It is structured with domains, subdomains, and guiding principles to highlight past measure development, and offer both opportunities and obstacles for future measure development.

This report supplements and expands upon the National Quality Forum (NQF)-endorsed® guidance on emergency care provided in *National Voluntary Consensus Standards for Emergency Care: Phase I and Phase II* reports. It lays the groundwork for a more efficient, higher standard of care across our emergency healthcare system.

NQF was contracted by the Department of Health and Human Services to build upon this previous work in emergency care. This project is comprised of two parts: an environmental scan of measures (at all stages of development) for emergency care at the system level, and a framework for measurement of regionalized emergency care systems at the national, state, and regional levels. The measurement framework is also intended to serve as the basis for future efforts in this area, including any potential NQF measure endorsement projects. During this process, NQF contracted with the University of North Carolina-Chapel Hill to aid in the development of the environmental scan and the measurement framework report.

Within your review of this report, please specifically consider the following questions:

1) Does the framework adequately provide for measurement of both individual patient care and the measurement of "regionalized emergency care systems"?