

EMTALA TAG Releases Fourth Meeting Report

The fourth meeting of the EMTALA Technical Advisory Group (TAG) occurred on May 1 and 2, 2006. The primary purpose of the meeting was to enable the TAG to consider the work that its subcommittees had completed on specific issues tackled by the main group at previous meetings, as well as discuss the written responses received from various health care organizations regarding the same issues. Some topics that the TAG addressed and actions taken at this meeting included the following:

- ▶ Clarification that the Centers for Medicare and Medicaid Services (CMS) does not require physicians to take emergency calls as a Condition of Participation in Medicare.
- ▶ Affirmation of the TAG recommendation that hospitals with specialized capabilities not be required to maintain EDs, but that these same hospitals still be bound by the same responsibilities under EMTALA as hospitals with specialized capabilities that do have a dedicated emergency department.
- ▶ Review of the proposed revisions to the EMTALA regulations and corresponding Interpretive Guidelines submitted by the Action Subcommittee on

- (1) Emergency physician communication with other clinicians to seek advice regarding a patient's medical history and needs that may be relevant to the medical treatment and screening of the patient.
- (2) Definitions for "stabilization" and "emergency medical condition" as applied to psychiatric emergency patients and on transfer issues related to such patients.
- (3) When a hospital can discourage a non-hospital-owned ambulance from coming to the ED.
- (4) EMTALA compliance when an emergency is declared by a government authority at any level and the exceptions to compliance (e.g., massive equipment failure, bomb threat, snowstorm).

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IOM Report to be Released June 14, 2006

IOM's long-awaited report – *The Future of Emergency Care in the United States Health System* – will be released at a June 14 press conference at the Keck Center of the National Academies in Washington, D.C. The press briefing will begin at 11 a.m. (EDST), and will be followed by afternoon question and answer sessions dedicated to each report.

The briefing can also be viewed online real-time. If you wish to participate online, go to www.nationalacademies.org at 11 a.m. (EDST) on June 14th. Only starting at 11 a.m. will a live link appear on the site for you to join the web cast.

New Data on Drug-Related ED Visits Released

According to data obtained in the latest Drug Abuse Warning Network (DAWN) survey, out of the almost two million drug-related ED visits recorded in 2004, 1.3 million were associated with drug misuse or abuse. Of these 1.3 million visits, 30% involved illicit drugs only; 25%, prescription or over-the-counter medications only; 8%, alcohol only in patients under age 21; 15% involved illicit drugs and alcohol; 8%, illicit drugs and pharmaceuticals; and 14%, illicit drugs, pharmaceuticals, and alcohol. The findings are contained in a new report from the Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA) entitled, Drug Abuse Warning Network, 2004: National Estimates of Drug-Related Emergency Department Visits.

Due to changes from previous DAWN surveys – including an expanded definition of ED visits related to recent drug use, and a new sample of hospitals covering the entire United States – this latest survey is considered a new baseline for future years. As a consequence, the new data cannot be compared to data from prior years.

Based on data submitted by the 417 hospitals in its national sample, DAWN developed the following additional information:

- ▶ Cocaine was involved in 383,350 ED visits; marijuana in 215,665; heroin in 162,137; stimulants, including amphetamines and methamphetamine, in 102,843 visits. Other illicit drugs such as PCP, Ecstasy, and GHB were involved with much less frequency.
- ▶ Non-medical use of prescription and over-the-counter pharmaceuticals were involved in 495,732 ED visits. Over half (57%) of these non-medical use visits involved more than one drug, and nearly a third (32%) involved opiates and opioid analgesics.
- ▶ The most frequently used prescription medications were benzodiazepines (144,385 visits), hydrocodone products (42,491 visits), oxycodone products (35,559 visits), and methadone (31,874 visits).
- ▶ Alcohol in combination with an illicit drug was involved in 363,641 ED visits by persons of all ages. In patients under the age of 21, alcohol alone was involved in 96,809 visits.

In commenting on the report, SAMSHA administrator Charles Curie said, “Most of the 1.3 million visits to emergency rooms involving drugs or alcohol misuse or abuse are an opportunity for the health care system to intervene and direct patients to appropriate follow-up care.” The full report is available at <http://dawninfo.samhsa.gov>.

Chronic Illness Accounts for Large Percentage of Hospital Admissions Through ED

According to a new statistical brief from the Agency for Healthcare Research and Quality (AHRQ), a large percentage of patients admitted to the hospital via the ED have chronic conditions that should be controlled on an outpatient basis and through good primary care. The brief, *Reasons for Being Admitted to the Hospital through the Emergency Department, 2003*, is based on data culled from an AHRQ database of hospital inpatient stays.

The data show that more than half (55%) of the 29.3 million hospital admissions in 2003 for conditions other than pregnancy, childbirth, or neonatal care first entered the hospital through the ED. Of the hospital admission cases with congestive heart failure, chronic obstructive lung disease, and asthma, 72% were admitted through the hospitals' EDs. In addition, almost half of the hospital admissions related to mood disorders, including depression and bipolar affective disorders, were admitted through EDs. (Cont'd page 3)

Chronic Illness Accounts for Large Percentage of Admissions (Cont'd from page 2)

Some of the specific conditions cited in the brief as accounting for hospital admissions through the ED included the following:

- Pneumonia – the most common condition admitted to the hospital through the ED – accounted for nearly one million hospital admissions, or 5.7% of all admissions through the ED.
- Four heart-related conditions – congestive heart failure, chest pain, hardening of the arteries, and heart attack – together accounted for more than 15% of all admissions through the ED.
- Chronic obstructive lung disease accounted for 445,200 hospital admissions via the ED. Stroke and irregular heartbeat followed closely, each with more than 400,000 admissions through the ED.
- Other top conditions for which patients were admitted to the hospital via the ED were: complications of procedures, devices, implants, and grafts; mood disorders; asthma; diabetes; urinary, skin, and blood

infections; gastrointestinal disorders; hip fracture; and fluid and electrolyte disorders.

The study also found that people in the Northeast were the most likely to enter hospitals through EDs relative to the population in their region, and those in the West were the least likely. As for cost, the average hospital stay for a patient admitted through the ED was \$7,400. Medicare and Medicaid bore the greatest burden of hospital admissions through the ED, covering 66% of all such admissions.

In pointing out the importance of its data, AHRQ noted that policymakers and health care professionals have raised concern about “potential overuse and inappropriate use of emergency rooms.” AHRQ added, “There is also concern that emergency departments care for patients with chronic conditions who may not be receiving adequate outpatient follow-up to control their conditions.”

The complete AHRQ statistical brief is available at www.hcup-us.ahrq.gov/reports/statbriefs.jsp.

2007 Medicare Reimbursements to Be Cut 4.6%

In a letter to the Medicare Payment Advisory Commission (MedPAC), CMS said that, as a result of growth in Medicare spending, physicians will receive an estimated average 4.6% reduction in Medicare reimbursements in 2007. Herb B. Kuhn, Director of CMS’s Center for Medicare Management, wrote that the major contributors to the increase in spending “appear to continue to be certain diagnostic and therapeutic services, including services particularly important in the treatment of the growing number of Medicare beneficiaries with chronic illnesses.” As examples of such services, he mentioned follow-up office visits, imaging, and physical therapy. Kuhn added, “Understanding the relatively rapid growth in these services, and determining whether there are ways to promote better health while slowing the rapid increase in use of these services, is an increasingly important issue.”

The estimated reimbursement cut is based on 2005 data showing that spending for physician services had increased by 8.5%. CMS broke down the 8.5% increase in spending for physician services as follows: evaluation and management services accounted for 2.6% of the total growth; procedures – 2.5%, with physical therapy, podiatry, and dermatology cited as the fastest-growing elements; imaging services – 2.3%; and laboratory and other tests – 1.3%. In light of the spending increases, CMS said that it supports the development of measures related to the quality and efficiency of care that could potentially avoid some tests, procedures, and visits, while reducing complications and improving outcomes. CMS also said that it is working with physician groups “who share our goal of improving quality and avoiding unnecessary health care.”

In 2005, the statutory formula would have given physicians a 4.4% cut in Medicare reimbursements for 2006. But Congress averted that cut by passing legislation to ensure that physicians received the same rates in 2006 as they did in 2005. That same scenario may be the best that the medical community can hope for in FY 2007.

IOM Advises Against Reuse of Disposable Masks and Respirators

Despite limited scientific evidence about the effectiveness of inexpensive, disposable medical masks and respirators against influenza, the use of protective face coverings will be one of many strategies employed to slow or prevent transmission of the flu virus in the event of a pandemic. Given predictions that these devices will be in short supply if a pandemic strikes in the near future, the Department of Health and Human Services asked the Institute of Medicine (IOM) to investigate the potential for reuse of disposable respirators or masks. According to IOM's report, no simple, reliable way to decontaminate these devices currently exists that would enable people to safely use them more than once.

The kinds of masks and respirators being considered for widespread use in an influenza pandemic are inexpensive, disposable medical masks and N95 filtering face piece respirators. While the committee that wrote the report added that it is possible an individual could reuse an N95 respirator by following a series of steps to protect it from contamination, committee members emphasized that, because the effectiveness of any face covering against flu is unclear, wearers should not risk unnecessary exposure.

Disposable masks and respirators do not lend themselves to reuse because they work by trapping harmful particles inside the mesh of fibers of which they are made. The committee found that this hazardous buildup cannot be cleaned out or disinfected without damaging the fibers or other components of the device such as the straps or nose clip. Moreover, the committee could not identify any simple modifications to the manufacturing of the devices that would permit reuse, or any changes that would dispense with the need to test the fit of respirators to ensure a wearer is fully protected. In its conclusions, the report said that research should be done to determine more precisely how flu viruses spread from person to person, and to test how well masks, respirators, and other new filtering materials specifically protect against the spread of flu viruses.

Guidelines for Treating Severely Injured Patients Being Developed

With funding from NIH's National Institute of General Medical Sciences (NIGMS), an interdisciplinary team of scientists and physicians is developing a series of standard procedures for the care of severely injured patients. Based on the best available evidence, the guidelines will describe how to implement the most successful treatment protocols and will include summaries of each procedure ready to print on 3-by-5 index cards for quick bedside reference.

The team is part of a collaborative, NIGMS-supported initiative called the Inflammation and Host Response to Injury "Glue Grant" Program launched in 2001 with a 5-year award totaling \$37 million. Glue grants bring together scientists with diverse expertise to address major biomedical questions that are beyond the scope of any one research group. In this case, the question is why patients who experienced comparable traumatic injuries can have dramatically different outcomes.

The team's first article – on mechanical ventilation – appeared in the September 2005 issue of the *Journal of Trauma: Injury, Infection, and Critical Care*. In line with its decision to cover aspects of care for which practices vary the most and those that have the greatest potential to influence patient outcomes, the team has planned future topics on resuscitation, prevention and treatment of venous blood clots, diagnosis of ventilator-associated pneumonia, blood sugar control, nutritional support, transfusion thresholds, and sedation.

The inflammation glue grant focuses on the care of patients once at the hospital. Another, complementary NIH program, the Resuscitation Outcomes Consortium, aims to improve patient survival before an injured person reaches the ED.

Arizona Governor Vetoes ED Malpractice Bill

On May 2, **Arizona** Governor Janet Napolitano (D) vetoed a bill aimed at making it more difficult for patients to collect damages in lawsuits against ED personnel. Supporters of the measure said the threat of costly lawsuits has led to fewer doctors, especially specialists, working in EDs. Opponents said the bill would have left the public at risk of not being able to receive compensation for injuries caused by negligence.

The legislation would have raised the burden of proof necessary to win a lawsuit against ED personnel from a “preponderance of evidence” to “clear and convincing” evidence, the highest standard in civil cases. Supporters said the higher standard would encourage specialists to return to the ED by reducing their chances of losing a career-ending lawsuit, while opponents countered that raising the burden of proof would hurt those least able to defend themselves and do nothing to relieve the problems of overcrowded EDs.

Napolitano wrote in her veto letter that there is no proof the bill would have alleviated a shortage of ED doctors. In addition, she said that five former **Arizona** Supreme Court justices had written to her to express concern that the bill may have been unconstitutional. Napolitano also announced in her veto letter that she had signed an executive order to create a task force to study access to emergency care.

Georgia Addresses Need for Aid to Trauma Centers

Legislators in **Georgia** are considering several strategies to bring more attention and funding to the state’s financially struggling trauma centers that care for

about 10,000 seriously injured people a year. A number of trauma-related bills have passed their chambers, while both the House and Senate have proposed \$4 million in funding to begin partially reimbursing trauma centers for the uncompensated care they provide to the poor and uninsured.

Senator Cecil Stanton (R-Macon) has proposed creating a commission that would be responsible for establishing and maintaining a statewide trauma network to coordinate care and direct patients to the most appropriate trauma center. With the cost to create a statewide network as much as \$25 million to \$30 million, legislators are considering such funding options as additional fines on moving violations or DUI offenses.

In addition to Stanton’s proposal, another resolution to create a trust fund to help pay for trauma care passed the House with bipartisan support. Also, Senate President Eric Johnson (R-Savannah) has proposed creating a study committee on the issue with the intention of drafting legislation to address the problem in the 2007 session.

The flurry of activity comes at a time when **Georgia**’s hospitals are struggling to provide increasingly expensive care, while coping with a growing number of uninsured patients. The number of trauma centers has dropped from more than 20 to 14 – out of 185 hospitals. The state has only four level I trauma centers and could lose one of those. The Medical Center of Central Georgia – a level I trauma center – is considering dropping its trauma care entirely because it faces rising costs and the challenge of almost 20% of trauma cases going unpaid because patients lack insurance.

EMTALA TAG Releases Fourth Meeting Report (Cont’d from page 1)

- Assessment of the proposed revisions to the Interpretive Guidelines submitted by the On-Call Subcommittee on hospital policies for (1) physician response times and (2) availability of on-call physicians.

A copy of the full meeting report can be found under the “**Downloads**” section of the CMS website at www.cms.hhs.gov/FACA/07_emptalatag.asp.