

EMERGENCY MEDICAL SERVICES

American College of Surgeons/Acute Care Surgeon. Just like the carnival game “whack-a-mole” the acute care surgeon issue continues to pop-up. Alex Valadka continues to be privy to various manuscripts on the topic that have been submitted for publication to a variety of journals. Most recently, the Advisory Council for General Surgery once again put forward a position statement that they want the ACS Board of Regents to approve. The statement, which is far more problematic than last summer’s proposal, was slightly amended and adopted by the ACS Board of Regents in February. The statement reads as follows:

American College of Surgeons Statement on Emergency Surgical Care

The American College of Surgeons believes that it is the responsibility of all surgeons, regardless of their practice, to participate in their local system of emergency surgical care in order to provide for the health of the public. Emergency surgical care should be provided by surgeons who have completed an accredited residency, are board certified or are in the certification process, and possess the appropriate knowledge, experience, and skills for the delivery of emergency surgical care. This care should be patient-centered, humane, responsive, and readily accessible to all.

We recognize that general surgeons with the proper training, knowledge, experience, and skills can provide optimal treatment for many surgical emergencies. Other available medical and surgical specialists should be consulted to enhance care when appropriate. Credentialing criteria for emergency surgical practice should be developed at the local level based on the surgeon’s qualifications, experience, and the community need. The treating surgeons should be responsible for providing coordination and continuity of surgical care.

We believe that this level of coordinated, skilled, optimal care can be delivered only if healthcare organizations commit the necessary resources and support, and appropriate reimbursement is provided by insurers and other responsible agencies.

Martin Camins, MD, the neurosurgery representative on the ACS Board of Regents (BOR) vigorously opposed the adoption of this policy, as did the orthopaedic surgeon on the BOR, Bruce Browner, MD.

ACTION TAKEN: The AANS and CNS a letter to the American College of Surgeons outlining our serious concerns about this statement and requesting that the College rescind the recently approved “Statement on Emergency Surgical Care”. In addition, we will Send a copy of the AANS/CNS letter along with the ACS statement to other surgical specialty societies encouraging them to express their concerns, if any, to the College as well.

Institute of Medicine. Following the release of the Institute of Medicine Report, *The Future of Emergency Care*,¹ last June, the IOM held a series of workshops throughout the fall. Representatives from neurosurgery attended each meeting as follows: Salt Lake City – Rich Ellenbogen, MD; Chicago, IL – Gail Rosseau, MD, Hunt Batjer, MD and Shelly Timmons, MD; New Orleans – Dom Esposito, MD and David Kline, MD; and Washington, DC – Alex Valadka, MD.

Various efforts are now afoot to implement key recommendations from the IOM report.

¹ The Future of Emergency Care - Hospital Based Emergency Care at the Breaking Point; Emergency Medical Services - At the Crossroads; and Emergency Care for Children - Growing Pains.
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- **ACEP Summit.** On March 7, 2007, the American College of Emergency Physicians convened a summit of organizations² involved in emergency care. Alex Valadka, MD, Shelly Timmons, MD and Katie Orrico attended the meeting on behalf of the AANS and CNS. The objective of the meeting in Washington, D.C., was to develop a group consensus about the priorities of the IOM recommendations. More specifically, the 15 organizations met to identify at least one priority recommendation in each of five key areas that would serve as the basis of a joint federal legislative/regulatory agenda:

- emergency care research,
- hospital-based care,
- pediatric emergency medicine,
- trauma, and
- emergency medical services.

After a day-long debate, this group, with very diverse priorities and interests, coalesced around the following 6 priorities (pared down from over 60 recommendations contained in the IOM report.

1. Emergency Medicine Research -- Hospital-Based Report Recommendation 8.2. The Secretary of the Department of Health and Human Services should conduct a study to examine the gaps and opportunities in emergency and trauma care research, and recommend a strategy for the optimal organization and funding of the research effort. This study should include consideration of: training of new investigators; development of multi-center research networks; funding of General Clinical Research Centers (GCRC's) that specifically include an emergency and trauma care component; involvement of emergency and trauma care researchers in the grant review and research advisory processes; and improved research coordination through a dedicated center or institute. Congress and federal agencies involved in emergency care research (including DOT, DHHS, DHS, and DoD) should implement the study's recommendations.

2. Hospital-Based Care -- Hospital-Based Report Recommendation 2.1. Congress should establish dedicated funding, separate from DSH payments, to reimburse hospitals that provide significant amounts of uncompensated emergency and trauma care for financial losses incurred by providing those services.

- Congress should initially appropriate \$50 million for the purpose, to be administered by the Centers for Medicare and Medicaid Services.
- CMS should establish a working group to determine the allocation of those funds, which should be targeted to providers and localities at greatest risk; the working group should then determine funding needs for subsequent years.

NOTE: Summit participants support additional funding for care provided by hospitals and physicians that provide significant uncompensated emergency and trauma care. The IOM's specific funding level should only be regarded as a floor for additional support.

3. Pediatric Emergency Medicine -- Pediatrics Report Recommendation 3.7. Congress should appropriate \$37.5 million each year for the next five years to the EMS-C Program.

² American College of Emergency Physicians, American College of Surgeons, Society of Academic Emergency Medicine, American Association of Neurological Surgeons/Congress of Neurosurgeons, American Academy of Orthopaedic Surgeons, American Academy of Family Physicians, American Academy of Emergency Medicine, American Trauma Society, American Public Health Association, American Academy of Pediatrics, Emergency Medicine Residents' Association, Emergency Nurses Association, National Association of EMS Physicians, National Association of EMTs, National Association of State EMS Officials.

4. **Trauma -- Hospital-Based Report Recommendation 3.5/EMS Report 3.4.** Congress should establish a demonstration program, administered by the Health Resources and Services Administration, to promote regionalized, coordinated, and accountable emergency care systems throughout the country, and appropriate \$88 million over 5 years to this program.
5. **EMS -- EMS Report Recommendation 3.7.** CMS should convene an ad hoc work group with expertise in emergency care, trauma, and EMS systems to evaluate the reimbursement of EMS and make recommendations regarding inclusion of readiness costs and permitting payment without transport.
6. **Boarding -- Hospital-Based Report Recommendation 4.5.** Hospitals should end the practices of boarding patients in the ED and ambulance diversion, except in the most extreme cases, such as a community mass casualty event. The Centers for Medicare and Medicaid Services should convene a working group that includes experts in emergency care, inpatient critical care, hospital operations management, nursing and other relevant disciplines to develop boarding and diversion standards, as well as guidelines, measures, and incentives for implementation, monitoring, and enforcement of these standards.

NOTE: Summit participants recognize the severity of the crowding and boarding problem and agree that this recommendation can serve as the basis for a strategy to address boarding and its causes.

ACTION TAKEN: The AANS and CNS will review the final ACEP document, and determine whether or not we will endorse the above consensus recommendations.

Legislation

- **Trauma System Legislation.** Representatives Gene Green (D-TX) and Michael Burgess, MD (R-TX) in the House and Senators Jack Reed (D-RI) and Pat Roberts (R-KS) have introduced the “Trauma Care Systems Planning and Development Act” (H.R. 727 and S. 657, respectively). This program was not funded last year. The purpose of the legislation is to provide matching grants to states and localities for the purposes of developing and implementing trauma systems. The AANS and CNS continue to work with the American College of Surgeons and the Coalition for American Trauma Care (Alex Valadka was recently appointed to their Board of Directors) to seek passage of this legislation. As of the writing of this report, the House was poised to pass the bill in late March and the Senate is scheduled to do likewise after the Easter recess. Since both versions of the bill are identical, once passed by both chambers, the bill will go to the President for his signature.
- **Surgery Proposals.** The AANS and CNS are working with the American College of Surgeons and the American Association of Orthopaedic Surgeons to develop comprehensive legislation to address many of the key issues that we identified as important to us from the IOM report. To that end, the ACS convened a working session in January, and Alex Valadka and Katie Orrico participated in this effort. More work needs to be done to refine and flesh-out the details of the legislation, which will aim to address the topics of regionalization, compensation, liability reform and increased manpower.
- **Emergency Physicians Bill.** The American College of Emergency Physicians (ACEP) has gotten legislation (HR 882, the Access to Emergency Medical Services Act of 2007) introduced in the House of Representatives and a companion bill is scheduled to be introduced in the Senate shortly. ACEP has asked the AANS and CNS to formally endorse this legislation, which:
 1. Creates a commission that will examine factors, such as emergency department crowding, the availability of on-call specialists and medical liability issues, which affect the delivery of emergency medical services;

2. Authorizes an additional payment through Medicare to all physicians who provide EMTALA-related care, including on-call specialists whose services are needed to stabilize the patients; and
3. Requires hospitals to report to the Secretary of the Department of Health and Human Services (HHS) the amount of time admitted patients are being held or "boarded" in the emergency department while they wait for inpatient beds to become available. If the data collected justifies the development of a quality measure to ensure improved patient care, HHS would work with all affected parties to develop a hospital boarding measure.

ACTION TAKEN: The AANS and CNS are considering endorsing ACEP's emergency care legislation, but will hold-off on making any official decision pending the development of a surgery specific bill so as to ensure that the two bills are complementary and not contradictory to one another.

- **Uncompensated ER Care.** Rep. Mary Bono (R-CA) recently introduced H.R. 1233, the Mitigating the Impact of Uncompensated Service and Time Act of 2007. Introduced to help alleviate the financial burden placed on doctors who are federally mandated to provide emergency medical care, this legislation would amend the Internal Revenue Code of 1986 to allow physicians to partially offset the cost of providing uncompensated care that is required under the Emergency Medical Treatment and Labor Act (EMTALA) by providing board certified physicians a deduction equal to the amount of the Medicare fee schedule payment.

EMTALA. John Kusske continues to serve on the EMTALA Technical Advisory Group (TAG), which is making some progress in further clarifying the rules required for on-call physicians. Dr. Kusske, the chairman of the TAG's On-call Subcommittee, has done an excellent job in preventing the hospitals from implementing more onerous EMTALA burdens (e.g., the hospitals attempted to make on-call coverage mandatory as a condition of Medicare participation for physicians). The first set of TAG recommendations, relating to specialty hospitals, were included in the FY 2007 Hospital Inpatient Prospective Payment regulations. The TAG is scheduled to sunset 30 months from its first meeting, which was in March 2005, and therefore we anticipate that (absent Congressional action extending its charter) that the TAG will conclude its business and make any final recommendations at the end of June.