

**Emergency Medicine &**  
American College of Emergency  
Physicians (ACEP)  
Perspective

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*Disclosure: I am not an elected ACEP  
official nor an official spokesman*

# D2B Teamwork

- Is it “**my**” Emergency Department Door ...and “**your**” Cath lab Balloon?
- Or Vice Versa?

It's **OUR** Door-to-Balloon Time

ACEP is a co-sponsor of this  
Emergency Cardiovascular Care  
2009 Course

Dr. Robert Solomon is an  
ACEP Board member and formal  
representative to Mission: Lifeline  
ECC Committee

## "Access to Emergency Medical Services Act of 2009"

In June 2006, the Institute of Medicine (IOM) released three landmark reports on the "Future of Emergency Care in the United States Health System" detailing the challenges and concerns this nation faces in maintaining access to emergency medical services. As articulated in the IOM reports, the nation's emergency medical system as a whole is overburdened, underfunded and highly fragmented. 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 hospital beds. Moreover, the system is ill-prepared to handle surges from disasters, such as hurricanes, bombings or disease outbreaks.

Demand Increasing/Capacity Decreasing: According to the Centers for Disease Control and Prevention (CDC), from 1996 through 2006 the number of emergency department visits increased from 90.3 million to 119.2 million visits annually (32% increase). As the number of visits to the emergency department has increased over this 10-year period, the country experienced a net loss of 186 emergency departments (5% decrease), thus increasing the annual number of visits per emergency department. Furthermore, only 12 percent of these patients were classified as non-urgent.

Emergency Department Crowding/Boarding: The aggregate result of the imbalance between public demand and hospital capacity is an epidemic of overcrowded emergency departments with frequent "boarding," or leaving, of admitted patients for extended stays in the emergency department until a hospital inpatient bed becomes available. Emergency department boarding is further worsened by competition between emergency department admissions and scheduled admissions, such as elective-surgery patients. When acutely ill patients are boarded in an emergency department because no inpatient beds are available elsewhere in the hospital, it leads to ambulance diversion and severely limits a hospital's ability to meet periodic surges in demand, such as those from natural or man-made disasters.

Unfunded Mandate/Uncompensated Care: Emergency care obligated by the Emergency Medical Treatment and Labor Act (EMTALA), which requires hospitals to treat everyone who comes through their doors regardless of their ability to pay, is an unfunded mandate because the law does not require health insurance companies, governments or individuals to pay for the services. Emergency and on-call physicians bear the brunt of this policy, often receiving little or no payment for the treatments they provide. Emergency physicians also increasingly treat older Americans, with more chronic conditions, who require more time to diagnose and treat, yet Medicare payments remain capped at below-market levels.

## Regional STEMI Networks address many of ACEP Issues

- **A = Access:** 9-1-1 provides entire communities with timely Access to Quality care
- **B = Boarding:** There is No boarding of STEMI patients. They are immediately dispositioned to the Cath Lab (<30 minutes)
- **C = Crowding:** STEMI patients enter a virtual express-lane to the Cath Lab. No “wall-time” for paramedics bringing a STEMI patient

# Regional STEMI Networks address many of ACEP Issues

- **D = Diversions**: STEMI Receiving Centers stay open to STEMI patients, regardless of ED diversion status for routine ambulances.
- **E = EMTALA**: Despite unfunded mandate for uncompensated medical care, Cath Lab staff routinely perform primary PCI for ALL patients
- **F = Fear**: Clinicians fear medical liability. However regional STEMI networks optimize patient care and thus minimize liability exposure

# American College of Emergency Physicians (ACEP)

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## The National Report Card on the State of Emergency Medicine: Evaluating the Emergency Care Environment State by State 2009 Edition


Stephen K. Epstein, MD, MPP, FACEP (Chair), Jonathan L. Burstein, MD, FACEP, Randall B. Case, MD, MBA, FACEP, Angela F. Gardner, MD, FACEP (ACEP Vice-President and Board Liaison to the Task Force), Sanford H. Herman, MD, FACEP, Jon Mark Hirshon, MD, MPH, FACEP, FACPM, John W. Jermyn, DO, FACEP\*, Mary Pat McKay, MD, MPH, FACEP, James C. Mitchiner, MD, MPH, FACEP, William P. Sullivan, DO, JD, FACEP, Mary Jo Wagner, MD, FACEP, Susan Beer (Executive Director, Massachusetts College of Emergency Physicians), Laura Tiberi, CAE (Executive Director, Ohio Chapter ACEP), Craig Price (Staff Liaison to the Task Force), Ron Cunningham, Dean Wilkerson, JD, MBA, CAE (ACEP Executive Director), Marilyn Bromley, RN, Marjorie Geist, PhD, RN, Laura Gore, Cynthia A. Singh, MS, Gordon Wheeler, Stacy F. Gleason, MPH, Jennifer Decker, BA, Valerie M. Gwinner, MPP, MA, Renee H. Schwalberg, MPH

Annals of Emergency Medicine or website [emreportcard.org](http://emreportcard.org)

# ACEP EM Report Card 2009

<b>NATIONAL GRADE BY CATEGORY</b>	
<b>ACCESS TO EMERGENCY CARE</b>	<b>D-</b>
<b>QUALITY &amp; PATIENT SAFETY ENVIRONMENT</b>	<b>C+</b>
<b>MEDICAL LIABILITY ENVIRONMENT</b>	<b>C-</b>
<b>PUBLIC HEALTH &amp; INJURY PREVENTION</b>	<b>C</b>
<b>DISASTER PREPAREDNESS</b>	<b>C+</b>
<b>OVERALL</b>	<b>C-</b>

# California

QUALITY & PATIENT SAFETY ENVIRONMENT	D-
Funding for quality improvement within the EMS system	NR
Funded state EMS medical director	NR
Emergency medicine residents per 1M pop.	 11.6
Adverse event reporting required	Yes
Hospital-based infections reporting required	Yes
Mandatory quality reporting requirement	Yes
% of counties with E-911 capability	100.0
Uniform system for providing pre-arrival instructions	NR
State has or is working on a stroke system of care	NR
State has or is working on a PCI network or a STEMI system of care	NR
Statewide trauma registry	NR
% of hospitals with computerized practitioner order entry	15.8
% of hospitals with electronic medical records	37.3
% of patients with acute myocardial infarction given PCI within 90 minutes of arrival	55
Number of Joint Commission reviewed sentinel events per 1M pop. (1995-2006)	10

**NR** = Not Reported, based upon ACEP survey of State Health Officials, 2008

State **has** or **is working on** a PCI network or STEMI system of care

**55%** of acute MI patients in CA given PCI **≤ 90 minutes** of arrival (2006 TJC Hospital Compare data)

# AHA-ML: A call to arms for EM

ACEP News, January 2009

by Drs O'Connor and Solomon

- EM is at a **“vital intersection”** which connects pre-hospital care with hospital specialists
- “At times, the specialty of EM has been noted to particularly sensitive to other specialties or authorities...dictating our practice.”
- Mission: Lifeline is a “call to arms” for EM  
**...GET INVOLVED**