

2010 Emergency Healthcare Task Force Report

Oregon
Health
Authority

PUBLIC HEALTH DIVISION
EMS and Trauma Systems Program/OCHHP





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Emergency Healthcare Task Force Report

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Foreword by Bruce Goldberg

“ One of the most sublime experiences we can ever have is to wake up feeling healthy after we have been sick. ”

- Harold Kushner

Meeting the “Triple Aim” of better health, better quality, and lower costs through regional accountability, better coordination of care and standards for safe and effective care are just some of the strategies that the Oregon Health Policy Board has identified for further developing our health care system. It is interesting and exciting that a separate process, focused solely on emergency healthcare would propose solutions that utilize similar strategies. The proposals in the attached report appear to be congruent with the goals of the Oregon Health Policy Board.

In December of 2008, the American College of Emergency Physicians released a nationwide report card on the status of Emergency Medicine in the country. Oregon received a D and was ranked 47th. This was not meant as an indictment of the quality of care provided by individuals, but represented criticism of the structures that were or were not in place with regards to emergency healthcare in the State of Oregon. It was also a call for action. Based on this report, I asked Dr. John Moorhead to Chair a multidisciplinary task force to review the problems identified in the report, look at best practices from both within and outside the State, and propose solutions.

Health care costs continue to rise and sound principles of prevention will serve to keep some of those in check. Time-dependent emergencies, however, will continue to happen and it is important that emergency care be provided in a thoughtful, patient-centered, evidence-based manner. In addition, regional resources and values should play a role in determining the most appropriate response to these emergencies. The recommendations of the Task Force appear to recognize the need for and provide the framework for a regional, accountable system of emergency healthcare.

I commend and thank the dedicated members of the Task Force for devoting the time, energy and expertise to develop these proposals to improve the health of Oregonians during their most trying times.

Bruce Goldberg, MD

*Director, Oregon Department of Human Services and
Director-designee, Oregon Health Authority*

Executive Summary — December, 2010

Introduction

In 2009, the American College of Emergency Physicians (ACEP) released its most recent edition of the National Report Card on the State of Emergency Medicine (www.emreportcard.org). Its intent was not to rank individual healthcare institutions, but more the statewide systems that support emergency care. Oregon received the grade of D. In fact, only one state received an overall worse grade. With this in mind, the Oregon Department of Human Services, under the direction of Dr. Bruce Goldberg, convened an Emergency Healthcare Task Force in the summer of 2009. Its mission was to seriously assess and make recommendations for improvements to the Oregon emergency health care system. The objectives of this group were to identify ways to improve the delivery system for emergency care. Deliberations of the group have suggested a series of six themes:

1. As recommended by the Institute of Medicine, **regionalization** of emergency healthcare; utilizing a state-wide definition of patients with the potential for the most serious and time-dependant need for acute care and a process to identify the most appropriate facility to which these patients should be directed with the goal of improving outcomes. Utilize regional, accountable 'Emergency Healthcare Regions' for planning, deployment of resources, coordinating acute care, monitoring system performance and quality improvement.
2. An emergency regional and state patient clinical **data registry** upon which resources needed can be predicted and outcomes measured using consistent metrics against state-wide benchmarks to continually improve system performance.
3. A comprehensive coordinated **communications** network to assist with activation of appropriate resources, direction of high risk patients to an appropriate facility, including transfer of the sickest patients to facilities with a higher level of resources; providing timely state-wide consultation for on-line providers, including telemedicine; that can serve as a network for disaster management.

4. Legislative and/or regulatory **authority** for regional and state-wide 'Emergency Healthcare Regions' to plan, and develop standards and monitor regional and state-wide performance; coordinate the delivery of emergency care, and perform clinical quality improvement in a manner that protects individual patient and provider information.
5. Recognize and coordinate with other state efforts to determine the **workforce** needs of a state-wide system that provides a well-trained cohort of providers that effectively and efficiently utilizes emergency care workers to provide acute care when needed; and to base the ongoing educational needs for future workforce planning and development.
6. Development of additional **funding** mechanisms to stabilize and ensure system function and availability throughout the state on an ongoing basis. Examples of programs successfully implemented in other states provide some models.

Task Force Recommendations

The State of Oregon should create a regionalized, accountable system of emergency healthcare. The Oregon Legislature should authorize the Oregon Health Authority, coordinating with the Oregon Health Policy Board, to use existing systems and structures as well create new authority and/or structure to develop such a system. In addition, the Legislature should identify a dedicated source of funding for the system. The strategy for accomplishing this would be to expand the current regional trauma model to become the regional emergency healthcare system.

Specific steps would include:

1. Creation of Emergency Healthcare Regions (EHR) which would be charged to create local plans/standards for the care of many time-dependent, emergency conditions. The current Area Trauma Advisory Board regions are an example of an existing structure that may become the Emergency Healthcare Regions. These regions should be compatible with any regionalization model that the Oregon Health Policy Board implements. Eventually, the EHRs may become Accountable Care Organizations for the delivery of emergency care.

2. Creation of the State Emergency Healthcare Board (SEHB), which would coordinate the EHRs as well serve in an advisory role to the State Emergency Healthcare Office (renamed EMS and Trauma Office) within the Oregon Health Authority.
3. Subcommittees of SEHB would include:
 - a. Currently existing committees:
 - i. Trauma (Currently the State Trauma Advisory Board)
 - ii. Emergency Medical Services (State EMS Committee)
 - iii. Pediatric Emergency Healthcare (EMS for Children)
 - b. Other subcommittees as created by the Oregon Health Authority.
Examples may include:
 - i. Acute cardiac disease (heart attack and cardiac arrest)
 - ii. Acute stroke care.
4. Creation of a data collection system that encompasses all of emergency healthcare which includes patient outcome tracking. This would include QA/QI protections and provisions for research purposes. These data collection and reporting efforts should integrate well with existing data collection efforts, whether they are federal, state or private. There should be regular data and outcome reporting to the SEHB, subcommittees and the public.
5. Utilizing the above noted data collection system, the SEHB and its subcommittees will also play a role in setting and reviewing statewide QA/QI indicators for the various components of the State Emergency Healthcare System.
6. Over the first two years, the SEHB will collect cost, utilization, outcomes and funding source data on the entire Emergency Healthcare System including emergency preparedness expenditures. This data effort will be coordinated with the all-payers database, but will also look at other data sources. This will be reported statewide and by Emergency Healthcare Region.
7. Over the next two years, the SEHB will utilize the above data to create a plan for ensuring an efficient, accountable, and sustainable emergency healthcare system.

8. Promote 24/7 coordination of emergency healthcare within existing statewide emergency communication efforts. This would provide a foundation from which to build systems for real-time coordination of patients' destinations and outcomes that could facilitate data collection and monitor the status of specialty care receiving centers. Eventually, it would lead to better patient-tracking/distribution during mass casualty or other disaster incidents. Ultimately, such activities would enhance every day emergency care and preparedness, and guarantee statewide availability of on-line medical control.
9. The SEHB and EHRs will coordinate efforts with the Oregon Health Policy Board's Workforce Committee to identify critical needs relating to the initial training, recruitment and retention of emergency healthcare workers, including both field and hospital based personnel. A key component of retention includes funding and making available training opportunities, such as the EMS Mobile Training Unit (MTU) and local/ regional educational conferences.
10. The need for developing specific designated funding for a regionalized emergency system was recognized but specific proposals require further study. Although we face difficult economic times, the Task Force would like to present some principles for policy makers to consider when making decisions about the emergency health care services system at this time.
 - a. Don't tear down programs or services that will be important to addressing Task Force recommendations. Since both the data system and systems development activities will build upon the work done over the past 20 years in Oregon by the Trauma System and Trauma Registry, it would be ill-advised to decrease resources for this program at the current time.
 - b. Include the provision of emergency health care services as part of the funded health care reform activities in the state. Utilization of electronic health records, integration with the all-payers data base, and participation in accountable health districts are all important for emergency health care.

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- c. The burden of funding should be diversified to a large extent in recognition that emergency health care services are available to anyone in the state. Virtually all Oregon residents rely on this system at some point(s) in their lives and all should be willing to support the availability of these services.
 - d. If new tax revenues are proposed to support emergency health care services, the tax should be related to the need for these services.

Report — October, 2010

Introduction

In 2009, the American College of Emergency Physicians (ACEP) released its most recent edition of the National Report Card on the State of Emergency Medicine (www.emreportcard.org). In it, 116 objective metrics were used to provide scores in Access to Emergency Care, Quality and Patient Safety Environment, Medical Liability Environment, Public Health and Injury Prevention, and Disaster Preparedness. Its intent was not to rank individual healthcare institutions, but more the statewide systems that support emergency care. Overall, the United States received the grade of a C-, which was unchanged from the 2006 report.

Oregon received the grade of D. In fact, only one state received an overall worse grade. The state fared well in Public Health/Injury Prevention (B), but lacked in Quality/Patient Safety (D+), Medical Liability (D-), and Disaster Preparedness (D). In particular, Access (F) to emergency care was among the worst in the country with a low rate of staffed inpatient beds and poor access to mental health services. The state report concluding remark was that “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.”

With this in mind, the Oregon Department of Human Services, under the direction of Dr. Bruce Goldberg, convened an Emergency Healthcare Task Force in the summer of 2009. Its mission was to seriously assess and make recommendations for improvements to the Oregon emergency health care system. Stakeholders from across the state involved in all aspects of emergency care were invited to participate. The objectives of this group were to identify ways to improve the delivery system for emergency care, including regionalization and integration of services, and in the process, create a system that promotes the interoperability and coordination of medical records, including Health Information Technology and Electronic Health Records. Lastly, as a significant deficiency in the report card, the task force was charged with promoting a statewide database for emergency care quality measures and continuous quality improvement initiatives to advance emergency care across the state.

In light of recent federal healthcare reform, it is predicted that such changes will lead to an increase in Emergency Department utilization. Therefore, it is incumbent upon the state, now more than ever, to address the emergency healthcare needs of its constituents. In doing so, the following recommendations are being made to the Oregon Department of Human Services and the new Oregon Health Authority. The recommendations will include legislative proposals.

Proceedings

The Task Force met monthly from December 2009 until July 2010. The meetings were open and attendee participation was encouraged. Minutes were kept and posted on the Oregon EMS/Trauma Program website. The meetings began with an overview of ACEP report card findings and the 2006 Institute of Medicine report on emergency medical care in the United States. Subsequent Task Force meetings included presentations that either described model emergency health care systems in other States or gave an overview of the status of a facet of emergency healthcare in the State of Oregon. Finally, the group met in September of 2010 to review and approve the final recommendations. What follows is an overview of the meetings:

December, 2009

Introductory Meeting

The initial meeting of the Oregon Emergency Healthcare Task Force was an introduction to the issues and the specific charge of the Task Force. Individual members discussed their views of the Task Force goals and what they believe are important attributes of a high-performing Emergency Healthcare System.

January, 2010

Regionalization of Emergency Care: The Maryland Experience

Data Systems and Performance Improvement

Dr. Robert Bass, Executive Director of the Maryland Institute for Emergency Medical Services Systems, presented an overview of the Maryland model of regionalized emergency healthcare. Key philosophies include: getting the right patient to the right facility, in the right time, with the right care. He emphasized that regionalization does not mean centralization. The key components of the system include the creation of distinct Emergency Regions, Statewide protocols, and a statewide QA/QI programs. In addition, there is designation of trauma and other specialty centers (stroke, cardiac, etc),

a statewide voice/data communication system that includes a 24 hour coordination center, and a state-funded air medical transportations system. Funding for the system comes from a dedicated \$11/year surcharge on vehicle registrations.

Dr. Craig Newgard of the OHSU Center for Policy and Research in Emergency Medicine (CPR-EM) presented a model for the creation of an electronic data system that could be used for system monitoring and performance improvement. He outlined the May 2008 EMS pilot project, in which statewide EMS data was collected and individual patient encounters were linked to other existing databases, such as the hospital discharge database and the state trauma database. In addition, he described a vision for the future in which a number of these databases are linked so that system and outcome data could be generated that could improve the quality of both pre-hospital and in-hospital emergency healthcare, aid in policy recommendations, and aid in disaster/preparedness planning. In addition, this comprehensive data system could be utilized for research to improve emergency care.

February 2010

The Oregon Trauma System

Stroke Care in Oregon and the Benefits of a State System

Dr. Nicole Vanderheyden, Chair of the Oregon State Trauma Advisory Board and Trauma Surgeon at Salem Hospital, provided an overview of the history and benefits of the Oregon Trauma System. Oregon was one of the first states to create a statewide, integrated trauma system, which has been demonstrated to save lives and reduce overall cost. The trauma system is a coordinated system of care that works to get the “right patient to the right place at the right time.” The hallmarks of the system include: voluntary hospital designation, regionalized bodies (area trauma advisory boards) in which both hospital and prehospital providers participate, a State Trauma Advisory Board, and a state trauma database. It is proposed that the success of the Oregon Trauma System should provide the “framework” for development of a comprehensive emergency healthcare system.

Dr. Lisa Yanase discussed the delivery of care to patients suffering symptoms of acute stroke care in general, and specifically in Oregon. Highlights of this talk included recognition that Oregon ranks between 3rd and 5th highest in stroke

mortality in the country. She emphasized that stroke is a treatable disease and that a coordinated system can improve outcomes for stroke patients. Dr. Yanase discussed the general system elements needed to achieve stroke care/outcome improvement. These include: early public identification and 911 activation, EMS protocols to identify and triage stroke to stroke-ready hospitals (designation/categorization), responsive, interdisciplinary stroke care teams and a regional/statewide team to develop and oversee the entire system. Dr. Yanase then outlined some preliminary success from her experience with implementation of these proposals in St. Louis and Salt Lake City.

Further discussion focused on the challenges of funding the current trauma system as well as the reiteration that the current trauma system should be the foundation for further regionalization of care.

March 2010

Pediatrics

Emergency Medical Services (Pre-hospital care)

Dr. Robert Cloutier, pediatric emergency physician at OHSU, presented an overview of emergency pediatric care in Oregon as well as some proposals about regionalization of acute pediatric care. There are only two hospitals in the State that have dedicated Pediatric Intensive Care Units. These units receive transfers from the entire State. Regions have varying expertise and resources to deal with pediatric emergencies, with significant challenges in providing pediatric emergency care in rural areas.

Evelyn Lyons from the State of Illinois EMS for Children Program, presented an overview of Illinois' pediatric facility designation program. This multi-year process started with a needs assessment of Illinois pediatric capabilities and resulted in a 3 level voluntary pediatric hospital designation system. A key aspect of this system is public accountability. Participating hospitals meet regularly to review quality indicators and set quality goals. Much like Oregon's trauma system, they have demonstrated an improvement in patient mortality and outcomes.

Will Bauscher and Shawn Baird presented an overview of prehospital care in Oregon. Mr. Bauscher is EMS Officer for a Fire Department based EMS service (Corvallis Fire Department) and Mr. Baird is owner/operator of Woodburn ambulance. They provided an overview of the components of EMS and then

discussed the structure of EMS in Oregon. The Oregon EMS and Trauma program, which is in the Public Health Division of the Oregon Health Authority, certifies EMS personnel and regulates transport ambulance providers. EMS agencies and associations that do not transport are not regulated. County government creates and awards franchises for Ambulance Service Areas (ASAs). Medical Direction occurs at the local level. Although areas have created informal networks, protocols are ultimately at the local Medical Director's discretion. The Scope of Practice for individual EMS Providers is regulated by the Oregon Medical Board. Discussion ensued about the relatively poor funding of EMS in general and the fragmented nature of EMS. Rural challenges as described in the pediatric discussion also apply to prehospital care. Issues revolving around helicopter-EMS (HEMS) were discussed and it was noted that there relatively little regulation and integration of HEMS into the rest of the system.

General discussion emphasized the advantages of a regional approach to Emergency Health Care. There was also discussion about the benefits of telemedicine and how it could be integrated into a regional approach to pediatrics as well as other critical areas.

April 2010

ST Elevation Myocardial Infarction care in Southern Oregon

Political/economic challenges

Dr. Moorhead provided some overview comments about previous deliberations and proposed that a regionalized approach to care similar to our trauma system appears to be the vision that is evolving within the task force.

Dr. Brian Gross, an interventional cardiologist from Medford, presented an overview of the ST elevation myocardial infarction (STEMI) program in Southern Oregon (otherwise known as the State of Jefferson). STEMI, often called a "heart attack" occurs when an artery that feeds the heart becomes acutely blocked resulting in chest pain, shortness of breath, etc. If the blockage is not relieved in a timely manner, then the portion of the heart fed by that blood vessel can die. This may ultimately lead to severe disability or the patient death. Treatment for STEMI focuses on opening the occluded vessel(s) as quickly as possible. The most effective process utilizes percutaneous coronary intervention (PCI). This is a procedure in which a catheter is utilized to enter the coronary artery, and a

balloon is inflated in the blockage. Often a stent is placed to keep the artery open over time. The faster this procedure is performed, the better the patient outcome. The second method of treatment is to give “clot-busting” medication to the patient in an IV. This is less effective than PCI and has more risk to the patient, but should be done if PCI is not available in a timely manner. Dr. Gross noted that there were a number of processes that were necessary to get a patient from initial symptoms to the procedure room to get the PCI. Improved coordination among prehospital providers and hospitals could provide efficiencies that lead to shortening the time until the patient’s artery is open, thereby decreasing the number of people who die or have significant disability. Dr. Gross and Dr. Paul Rostykus, local EMS Medical Director, worked together to create a STEMI system in their area that allowed the paramedics in the field to identify the STEMI patient, notify the appropriate personnel and then transport the patient directly to a hospital that would be ready to provide the care as soon as the patient arrived. This includes bypassing hospitals that did not provide the PCI therapy. The results were dramatic and they now report that overall mortality from STEMI has dropped considerably. In addition, mortality from STEMI if the patient has come directly by EMS is significantly better than mortality for patients who were “walk-ins” to the hospital. The project demonstrates the clear benefits of a regional system that includes coordination, feedback and accountability.

Katy King, Government Affairs Liaison for the Division of Public Health in the Oregon Health Authority led a discussion that outlined the legislative process and challenges that impact any large policy bill. The main challenge in developing a coordinated system of acute care is a large projected deficit in the state budget during the next fiscal biennium.

May, 2010

The committee reviewed the examples presented at previous meeting and determined that there are six concepts that appear to be consistent throughout the presentations:

1. Regionalization of care.
2. Emergency regional and state patient clinical data registry.
3. A comprehensive, coordinated communications network.

4. Legislative and/or regulatory authority for regional and state-wide Emergency Healthcare regions.
5. Recognize and coordinate with other to determine workforce needs.
6. Development of funding mechanisms to stabilize and ensure system funding.

June 2010

Mental Health Care

Hospital Capacity Website

Availability of “On-Call” Subspecialists

Dr. David Pollack, from the OHSU department of psychiatry, presented an overview of the mental health system in Oregon and discussed its challenges. Mental health does have some current regionalization but is primarily funded and managed through county government. In addition, a significant portion of designated State funding for mental health goes toward operating the State Hospital. There has been some evidence that greater regionalization of care may lead to more efficient utilization of the system.

Rhonda Warnack presented an overview of the Oregon Hospital Capacity website (HOSCAP). HOSCAP is a tool in which hospitals track both their real-time diversion status as well their ability to accept patients in surge/disaster situation. HOSCAP is managed by the Public Health Emergency Preparedness program. It appears that HOSCAP could be a tool that could assist in real-time coordination of a regional, emergency healthcare system.

Dr. Nicole Vanderheyden briefly outlined the challenges that trauma hospitals face when providing subspecialty care. The availability of on-call subspecialists, such as neurosurgeons or hand surgeons, continues to diminish and, as a result, trauma centers find that they must compensate physicians to provide “availability” of these services and face increasing funding challenges.

July 2010

Health Care Reform and Oregon

Dr. Jeanene Smith of the Oregon Office of Health Policy and Research (OHPR) presented an overview of health care reform efforts in Oregon, the function of the Oregon Health Policy Board and how state proposals interact with Federal health care reform efforts.

Discussion

Emergency medical care is an essential community service that should be available to all in a timely manner. Public expectations as well as federal law require the ready availability of emergency care. Resources, including funding, should be made available to meet this well-intended goal. Over the past forty years emergency medicine has become an established discipline. It is a recognized specialty with a unique body of knowledge

Regionalization of emergency care, as recommended in the Institute of Medicine report, may help to more efficiently utilize the supply of appropriately trained board certified emergency physicians. Regionalization refers to an organized system for the delivery of emergency care within a region. The goal is to assure access while avoiding duplication of services. In Oregon, a successful model for regionalization has been the trauma system. Early attempts at regionalization of cardiac and stroke care have had some local success. However, these efforts fall short of a state-wide system, due to a lack of categorization of acute health care facilities. Facilities achieve greater reimbursement for providing interventional cardiac care and interventional stroke care than for caring for injured patients. This offers greater incentives for hospitals to keep lucrative patients at their own facilities and not rely on a regional system. Today, there is no other regionalization of emergency care.

The Emergency Care Coordination Center of the US Department of Health and Human Services has been charged by the federal government with examining regional models of emergency care. One obstacle in the development of a functional categorization or regionalization plan is the lack of comprehensive data regarding the delivery of emergency care in the United States. There is consensus that additional research is needed to improve the quality and efficiency of emergency care.

Even basic system elements such as the number of emergency departments, the number of emergency physicians, and the resources available at each facility are unavailable or unreliable. Simple contact information for each emergency department is often unavailable or erroneous. The task force believes that an Emergency data registry medical should be developed. This registry would be similar to the current trauma database and would supply crucial information needed to develop categorization criteria, perform comparative effectiveness research, establish value-based best practices, reduce costs, and improve quality.

The discussions and deliberations of the Oregon Emergency Care Task Force have coalesced around defining a future system of emergency care for Oregon that is focuses on providing care on a regionalized basis. State-wide coordination and definition of minimum standards are essential. However, the system should be built on regions' demonstrated capability to define local systems that improve care for the most potential at-risk emergency situations.

Suggestions from the group have suggested a series of six themes:

1. As recommended by the Institute of Medicine, regionalization of emergency healthcare; utilizing a state-wide definition of patients with the potential for the most serious and time-dependant need for acute care and a process to identify the most appropriate facility to which these patients should be directed with the goal of improving outcomes. Utilize regional accountable 'Emergency Healthcare Regions' for planning, deployment of resources, coordinating acute care, monitoring system performance and quality improvement.
2. An emergency regional and state patient clinical data registry upon which resources needed can be predicted and outcomes measured using consistent metrics against state-wide benchmarks to continually improve system performance.
3. A comprehensive coordinated communications network to assist with activation of appropriate resources, direction of high risk patients to an appropriate facility, including transfer of the sickest patients to facilities with a higher level of resources; providing timely state-wide consultation for on-line providers, including telemedicine; that can serve as a network for disaster management.
4. Legislative and/or regulatory authority for regional and state-wide 'Emergency Healthcare Regions' to plan, and develop standards and monitor regional and state-wide performance; coordinate the delivery of emergency care, and perform clinical quality improvement in a manner that protects individual patient and provider information.

5. Recognize and coordinate with other state efforts to determine the workforce needs of a state-wide system that provides a well-trained cohort of providers that effectively and efficiently utilizes emergency care workers to provide acute care when needed; and to base the ongoing educational needs for future workforce planning and development.
6. Development of additional funding mechanisms to stabilize and ensure system function and availability throughout the state on an ongoing basis. Examples of programs successfully implemented in other states provide some models.

Task Force Recommendations

The State of Oregon should create a regionalized, accountable system of emergency healthcare. The Oregon Legislature should authorize the Oregon Health Authority, coordinating with the Oregon Health Policy Board, to use existing systems and structures as well create new authority and/or structure to develop such a system. In addition, the Legislature should identify a dedicated source of funding for the system. The strategy for accomplishing this would be to expand the current regional trauma model to become the regional emergency healthcare system. Specific steps would include:

1. Creation of Emergency Healthcare Regions (EHR) which would be charged to create local plans/standards for the care of many time-dependent, emergency conditions. The current Area Trauma Advisory Board regions are an example of an existing structure that may become the Emergency Healthcare Regions. These regions should be compatible with any regionalization model that the Oregon Health Policy Board implements. Eventually, the EHRs may become Accountable Care Organizations for the delivery of emergency care.
2. Creation of the State Emergency Healthcare Board (SEHB), which would coordinate the EHRs as well serve in an advisory role to the State Emergency Healthcare Office (renamed EMS and Trauma Office) within the Oregon Health Authority.

3. Subcommittees of SEHB would include:
 - a. Currently existing committees:
 - i. Trauma (Currently the State Trauma Advisory Board)
 - ii. Emergency Medical Services (State EMS Committee)
 - iii. Pediatric Emergency Healthcare (EMS for Children)
 - b. Other subcommittees as created by the Oregon Health Authority.
Examples may include:
 - i. Acute cardiac disease (heart attack and cardiac arrest)
 - ii. Acute stroke care.
4. Creation of a data collection system that encompasses all of emergency healthcare which includes patient outcome tracking. This would include QA/QI protections and provisions for research purposes. These data collection and reporting efforts should integrate well with existing data collection efforts, whether they be federal, state or private. There should be regular data and outcome reporting to the SEHB, subcommittees and the public.
5. Utilizing the above noted data collection system, the SEHB and its subcommittees will also play a role in setting and reviewing statewide QA/QI indicators for the various components of the State Emergency Healthcare System.
6. Over the first two years, the SEHB will collect cost, utilization, outcomes and funding source data on the entire Emergency Healthcare System including emergency preparedness expenditures. This data effort will be coordinated with the all-payers database, but will also look at other data sources. This will be reported statewide and by Emergency Healthcare Region.
7. Over the next two years, the SEHB will utilize the above data to create a plan for ensuring an efficient, accountable, and sustainable emergency healthcare system.

8. Promote 24/7 coordination of emergency healthcare within existing statewide emergency communication efforts. This would provide a foundation from which to build systems for real-time coordination of patients' destinations and outcomes that could facilitate data collection and monitor the status of specialty care receiving centers. Eventually, it would lead to better patient-tracking/distribution during mass casualty or other disaster incidents. Ultimately, such activities would enhance every day emergency care and preparedness, and guarantee statewide availability of on-line medical control.
9. The SEHB and EHRs will coordinate efforts with the Oregon Health Policy Board's Workforce Committee to identify critical needs relating to the initial training, recruitment and retention of emergency healthcare workers, including both field and hospital based personnel. A key component of retention includes funding and making available training opportunities, such as the EMS Mobile Training Unit (MTU) and local/regional educational conferences.
10. The need for developing specific designated funding for a regionalized emergency system was recognized but specific proposals require further study. Although we face difficult economic times, the Task Force would like to present some principles for policy makers to consider when making decisions about the emergency health care services system at this time.
 - a. Don't tear down programs or services that will be important to addressing Task Force recommendations. Since both the data system and systems development activities will build upon the work done over the past 20 years in Oregon by the Trauma System and Trauma Registry, it would be ill-advised to decrease resources for this program at the current time.
 - b. Include the provision of emergency health care services as part of the funded health care reform activities in the state. Utilization of electronic health records, integration with the all-payers data base, and participation in accountable health districts are all important for emergency health care.

- c. The burden of funding should be diversified to a large extent in recognition that emergency health care services are available to anyone in the state. Virtually all Oregon residents rely on this system at some point(s) in their lives and all should be willing to support the availability of these services.
- d. If new tax revenues are proposed to support emergency health care services, the tax should be related to the need for these services.

Appendices

Appendix I: Emergency Healthcare Task Force Roster 2009-2010

Name	Role
John Moorhead, MD, Chair	Emergency Physician
Dan Handel, MD, Vice Chair	Emergency Physician
Shawn Baird, EMT-P	Private Ambulance
Mary Barnum, NP	Trauma / Cardiac Coordinator
Senator Alan Bates, DO	Legislator
Will Bauscher, EMT-P	Public Ambulance
Kent Brown	Hospital Administration
Representative Jean Cowan	Legislator
Gina Craven, RN	Pediatric Nurse
John Donovan	Public
Bob Duehmig	Rural Health
Mark Enger	Hospital System Administration
Matt Eschelbach, DO	Oregon Medical Board
Brian Gross, MD	Cardiology
Bob Joondeph	Disability Rights
Jim Lace, MD	Pediatrics
Cathy Murphey, RN	Trauma Coordinator
Barbara Prowe	Healthcare Purchasers
Ritu Sahni, MD	EMS Medical Director
Nicole Vanderheyden, MD	Trauma Surgeon
Lisa Yanase, MD	Stroke Neurologist
Gary Young, MD	Emergency Physician

Appendix II: ACEP Report Card

The National Report Card on the State of Emergency Medicine

OR
D

Oregon

Although Oregon ranked among the top 10 states in *Public Health and Injury Prevention*, that was more than offset by subpar grades in the remaining categories, including a failing grade for *Access to Emergency Care* and a ranking among the bottom 10 in *Disaster Preparedness*.

Strengths. Oregon's performance is strongest in *Public Health and Injury Prevention*. The state ranks first for the percentage of adults aged 65 and older who have ever had a pneumococcal vaccine (74.7 percent), and the rate of annual influenza vaccine among that population is only slightly lower (71.3 percent). The state also has below-average rates of smokers and binge drinkers (18.5 and 14.1 percent of adults, respectively). Seat belt use is third highest in the nation, with 95.3 percent of front occupants using seat belts. Oregon also has shown considerable commitment to improving the health and safety of the population through relatively high levels of funding for intentional injury prevention programs (\$221.48 per 1,000 people).

Despite Oregon's poor grade with regard to *Disaster Preparedness*, the state has made some strides in this area. The state has numerous communications systems in place, including statewide "just-in-time" training systems, a statewide medical communication system with one layer of redundancy, and a real-time notification system to notify identified health care providers of an event.

Challenges. Access to all types of medical care in Oregon poses serious concerns. For instance, the state has higher-than-average rates of uninsured adults and children. More than 13 percent of children and 19 percent of adults in Oregon are uninsured, compared to national rates of 11.7 and 17.2 percent, respectively. The state also has the third lowest rate of staffed inpatient beds (210.8 per 100,000 people).

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

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.

	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

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*.

For additional information, visit www.acep.org.

ACCESS TO EMERGENCY CARE **F**

Board-certified emergency physicians per 100,000 pop.	13.4
Emergency physicians per 100,000 pop.	15.6
Neurosurgeons per 100,000 pop.	2.5
Orthopedists and hand surgeon specialists per 100,000 pop.	9.4
Plastic surgeons per 100,000 pop.	1.8
ENT specialists per 100,000 pop.	3.9
Registered nurses per 100,000 pop.	804.6
Additional primary care FTEs needed	37.0
Additional mental health FTEs needed	9.0
Level I or II trauma centers per 1M pop.	1.3
% of population within 60 minutes of Level I or II trauma center	76.4
Accredited chest pain centers per 1M pop.	0.3
% of population with an unmet need for substance abuse treatment	8.5
Pediatric specialty centers per 1M pop.	2.7
Physicians accepting Medicare per 100 beneficiaries	2.9
Medicaid fee levels for office visits as a % of the national average	96.3
% change in Medicaid fees for office visits (2004-05 to 2007)	0.4
% of adults with no health insurance	19.3
% of children with no health insurance	13.1
% of adults with Medicaid	7.1
Emergency departments per 1M pop.	15.7
Hospital closures in 2006	0
Staffed inpatient beds per 100,000 pop.	210.8
Hospital occupancy rate per 100 staffed beds	65.9
Psychiatric care beds per 100,000 pop.	28.8
State collects data on diversion	NR

MEDICAL LIABILITY ENVIRONMENT **D-**

Lawyers per 10,000 pop.	13.4
Lawyers per physician	0.5
Lawyers per emergency physician	8.4
ATRA judicial hellholes (range 0 to -7)	0
Malpractice award payments/100,000 pop.	1.5
Average malpractice award payments	\$251,695
Databank reports per 1,000 physicians	16.3
Patient compensation fund	● No
Health court pilot project grant	No
Number of insurers writing medical liability policies per 1,000 physicians	6.3
Average medical liability insurance premium for primary care physicians	\$9,685
Average medical liability insurance premiums for specialists	\$48,510
Pretrial screening panels	● No
Are pretrial screening panels' findings admissible as evidence?	N/A
Periodic payments	No
Medical liability cap on non-economic damages	● No
Additional liability protection for EMTALA-mandated emergency care	● No
Joint and several liability abolished	● Yes
State provides for case certification	No
Expert witness required to be of the same specialty as the defendant	No
Expert witness must be licensed to practice medicine in the state	No

QUALITY & PATIENT SAFETY ENVIRONMENT **D+**

Funding for quality improvement within the EMS system	No
Funded state EMS medical director	Yes
Emergency medicine residents per 1M pop.	● 7.2
Adverse event reporting required	No
Hospital-based infections reporting required	No
Mandatory quality reporting requirement	Yes
% of counties with E-911 capability	100.0
Uniform system for providing pre-arrival instructions	No
State has or is working on a stroke system of care	No
State has or is working on a PCI network or a STEMI system of care	No
Statewide trauma registry	Yes
% of hospitals with computerized practitioner order entry	24.1
% of hospitals with electronic medical records	56.9
% of patients with acute myocardial infarction given PCI within 90 minutes of arrival	59
Number of Joint Commission reviewed sentinel events per 1M pop. (1995-2006)	10

PUBLIC HEALTH & INJURY PREVENTION **B**

Traffic fatalities per 100,000 pop.	12.9
% of traffic fatalities alcohol related	41.0
Front occupant restraint use (%)	95.3
Helmet use required for all motorcycle riders	● Yes
Child safety seat/seat belt legislation (10 points possible)	7
% of children immunized, aged 19-35 months	78.8
% of adults aged 65+ who received flu vaccine in the last 12 months	71.3
% of adults aged 65+ who ever received pneumococcal vaccine	74.7
Fatal occupational injuries per 1M workers	39.5
Homicides and suicides (non-motor vehicle) per 100,000 pop.	18.2
Unintentional fall-related fatal injuries per 100,000 pop.	10.4
Unintentional fire/burn-related fatal injuries per 100,000 pop.	0.9
Unintentional firearm-related fatal injuries per 100,000 pop.	0.3
Gun-purchasing legislation (8 points possible)	1
% of tobacco settlement funds spent on health-related services and programs	28.8
Total injury prevention funds per 1,000 pop.	\$182.79
Unintentional injury prevention funds per 1,000 pop.	\$41.36
Intentional injury prevention funds per 1,000 pop.	\$221.48
Fall injury prevention funds per 1,000 pop.	\$2.67
Infant mortality rate per 1,000 live births	5.9
% of adults with BMI > 30	24.8
Current smokers, % of adults	18.5
Binge alcohol drinkers, % of adults	14.1

DISASTER PREPAREDNESS **D**

Per capita federal disaster preparedness funds	\$8.70
Disaster preparedness funds used specifically for health care-related preparedness are tracked	Yes
All-hazards medical response plan or ESF-8 plan?	Yes
Plan shared with all EMS and essential hospital personnel?	Yes
Public health and emergency physician input into the state planning process	Yes, Yes
Public health and emergency physician input into the daily operations of the SEOC	Yes, No
Written plan for the coordination of the SEOC or local EMAs to provide security to hospitals in case of emergency events	Yes
Number of drills and exercises conducted involving hospital personnel, equipment, or facilities	40
Accredited by the Emergency Management Accreditation Program	No
Written plan specifically for special needs patients	NR
Written plan to supply medications for chronic conditions	NR
Written plan to supply dialysis for patients	NR
Real-time notification system in place to notify identified health care providers of an event	Yes
"Just-in-time" training systems in place	Statewide
Statewide medical communication system with one layer of redundancy	Yes
Statewide patient tracking system	No
Statewide victim tracking system	No
Statewide real-time or near real-time syndromic surveillance system	Yes
Real-time surveillance system in place for common ED presentations	Yes
Bed surge capacity per 1M pop.	309.5
Burn unit beds per 1M pop.	4.3
ICU beds per 1M pop.	251.1
Verified burn centers per 1M pop.	0.3
State able to verify credentials and assign volunteer health professionals to four ESAR-VHP levels	No
Nurses registered in ESAR-VHP per 1M pop.	0.0
Physicians registered in ESAR-VHP per 1M pop.	0.0
Training required in disaster management and response to bio- and chem terrorism for essential hospital personnel, EMS personnel	No, No
State or regional strike teams or medical assistance teams	Yes
Additional liability protections for health care workers during a disaster	Yes, civil
% of RNs that received any emergency training	48.0
State requires EMS and essential ED personnel to be NIMS compliant	No

	Improved since 2006
	Worsened since 2006
●	No change since 2006
NR	Not reported
N/A	Not applicable
See Summary Statistics for State Comparisons	

Report Card: Oregon

Appendix III: Oregon Emergency Health Care System

Proposed Implementation Timeline

Fiscal Year 2012 (July 2011 – June 2012)

1. Appoint a State Emergency Health Care System Advisory Board
(to be completed by November with initial meeting in January 2012).
2. Begin drafting rules for establishing a statewide STEMI (cardiac) program.
3. Develop the RFP for upgrading or developing the data system
which would incorporate the trauma registry with cardiac, stroke
and pediatric patient data elements.
4. Select data system by the end of June 2012.

Fiscal Year 2013 (July 2012 – June 2013)

1. Begin to establish and staff regional Emergency Health Care
Advisory Committees.
2. Epidemiologist implements data collection process and work out data needs
of regional Emergency Health Care Advisory Committees.
3. State Emergency Health Care System Advisory Board reviews data system
and reporting requirement, regional Emergency Health Care Advisory
Committees and State Board data needs.
4. Begin to set up regional STEMI programs.
5. Begins work on Stroke rules and standards to implement statewide
stroke care system with State Emergency health Care Board.
6. Develop and publish scientific analysis of the emergency health care system
in Oregon document changes quality and outcomes of patient care.

Fiscal Year 2014 (July 2013 – June 2014)

1. Continue developing STEMI (cardiac) program in additional regions and maintains activities in the original regions.
2. Contracts are made with coordinating facilities/ institutions in three regions to coordinate work and staff regional Emergency Health Care Advisory Committees.
3. Complete stroke rules and begins work to implement Stroke procedures in two regions.

Fiscal Year 2015 (July 2014 – June 2015)

1. Complete STEMI (cardiac) program in all regions and maintains activities in the original regions. All regions would now be operational.
2. Epidemiologist continues implementation data collection process and establish data evaluation and quality analysis criteria and data points with State Emergency Health Care Board and regional Committees. Develop reports for Board, Committees, provider community and public.
3. State Emergency Health Care System Advisory Board reviews data system, quality assurance measures and data points, also reviewed by regional Emergency Health Care Advisory Committees.
4. Data analyst working with epidemiologist assists in data collection, developing and producing standardized reports and provided data to the regional committees and state board.
5. Set up stroke program in additional regions. All regions have functioning stroke programs by the end of the biennium.

Continue to develop and publish scientific analysis of the emergency health care system in Oregon document changes quality and outcomes of patient care.

2010 Emergency Healthcare Task Force Report

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