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Robert A. Malson
President

Testimony Before the

Task Force on the Emergency Medical Services

on

Emergency Medical Services Reform

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Presented by

Robert A. Malson

President

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Children's National Medical Center • George Washington University Hospital • Georgetown University Hospital • Greater Southeast Community Hospital
Howard University Hospital • Malcolm Grow Medical Center, Andrews AFB, MD • National Naval Medical Center, Bethesda, MD
National Rehabilitation Hospital • Providence Hospital • Psychiatric Institute of Washington • Riverside Hospital
Saint Elizabeths Hospital, D.C. Department of Mental Health • Sibley Memorial Hospital • Specialty Hospital of Washington – Capitol Hill
Specialty Hospital of Washington – Hadley • Veterans Affairs Medical Center • Walter Reed Army Medical Center • Washington Hospital Center

Chief Rubin and members of the Task Force on Emergency Medical Services, I am Robert A. Malson, President of the District of Columbia Hospital Association (DCHA). I am joined today by Dr. Joseph Wright, Medical Director of Emergency Medical Services at the Children's National Medical Center and Dr. Carlos Silva, Medical Director at the George Washington University Hospital. DCHA members employ approximately 30,000 people who are on the front lines for delivering quality health care and for responding to any medical emergency in the District of Columbia. We provide over 1 million days of patient care annually with an annualized occupancy rate of approximately 75 percent. In our private hospitals, the emergency room visits exceed 389,000 and, collectively, we provide nearly \$200,000,000 in unsponsored care annually. Clearly, we play a critical role in the District's health care delivery system.

District hospitals are pleased that the Emergency Medical Services (EMS) system has been the focus of so many reform initiatives over the last few months. The EMS system has long been plagued by service delivery problems. It has struggled to overcome conflicts within its corporate culture created by an organizational structure that combines the Fire Department and EMS. EMS has also grappled with ways to strengthen a system bogged down by a requirement to transport all calls, including non-emergent cases which that comprised 60 percent of all transports in 2006. Finally, EMS has to improve the consistency of pre-hospital care. For these reasons, DCHA is pleased to see the focused effort by the District government and community stakeholders to address problems in EMS.

We believe that the delivery of emergency care to ambulance patients and the management of emergency department operations require clearly defined care coordination criteria. After experiencing a decline for several years, District hospitals saw emergency

department visits increase by 2.38 percent in 2006 in our acute care hospitals. As mentioned earlier, our data shows that acute care hospitals in the District saw 398,568 emergency patients in 2006.

District hospitals understand that there has been a lot of discussion around hospital drop times, and its impact of EMS operations. We believe the reported average drop time of almost 40 minutes should not be laid solely at the door of the hospital. The drop time is symptomatic of a broken system. As you know, in 2002 the Office of the Inspector General (IG) evaluated EMS operations. The IG found deficiencies in the processing of emergency calls, problems with paramedic certifications, lack of policies and procedures, staffing deficiencies and inadequate quality assurance programs. A 2006 evaluation conducted by the IG following the Rosenbaum incident found significant problems in the area of quality assurance, including faulty patient assessment, faulty transfer of patient from ambulance, incorrect assignment of patient priority, as well as flawed communications between first responders and transporters.

We acknowledge that our emergency departments are operating at maximum capacity, and are sometimes overwhelmed by the demand. Today, hospital emergency departments are overcrowded with patients who do not need emergency treatment. Hospital overcrowding impacts our ability to effectively manage patient flow and affects hospital drop times. Our hospitals believe that some of the pressure of overcrowding would be alleviated with a well defined patient triage system, as well as a stronger primary and urgent care delivery system.

District hospitals also believe hospital emergency departments and EMS would benefit from the development of a comprehensive ambulance patient triage system. An appropriate triage system would establish level of care designations for hospitals that are appropriate to meet the needs of patients and establish protocols that help emergency medical technicians assess the

severity of the individual's care needs. Based on the required level of care, EMS would triage the patient to a qualified hospital. This process could help to distribute patients more equally.

From an overall system of care, District hospitals are working with Department of Health officials to strengthen the availability of non-emergency care services. More specific to EMS service delivery, hospitals support legislation pending consideration in the District Council that would allow EMS to transport patients to designated urgent care centers. District hospitals believe a system of appropriately defined non-emergent care transports would go a long way toward reducing hospital overcrowding. We also believe that Fire and EMS would benefit from the development of a separate non-emergency transport system.

During peak demand times, it is standard practice for hospital emergency departments to receive multiple ambulance transports while also accepting walk-ins. We believe an important strategy toward improving emergency care coordination is effective communications. Some policymakers have suggested that establishing a mandatory drop time is the way to improve EMS service delivery. However, we believe hospital managers and EMS providers should engage in a collaborative process to develop an effective communications system. Such a system would insure that the patients who show up in hospital emergency departments, whether by ambulance or by walking-in, get necessary care.

The District Council is considering legislation that would allow the EMS Medical Director to decide when a hospital emergency department could close. DCHA recommends that the District continue the existing process of shared decision-making between EMS and emergency department managers on hospital emergency department closures. There are times when it is no longer safe for a hospital to receive ambulances. Only hospital personnel know the number and acuity of patients already in the emergency department. Only hospital personnel

know the hospitals' ability to care for additional patients. Since the EMS Medical Director is not in the hospital, we believe the Medical Director could not safely make a decision about closure without consulting emergency department managers. We believe a collaborative communication process advocates what is best for all patients in a hospital emergency room.

In addition to coordination of pre-hospital care and emergency department status, District hospitals believe it is critical to improve the training of both EMS and Fire personnel on providing pre-hospital care. All EMS and Fire personnel must be properly qualified and certified before being put into service. All Fire Department personnel must be cross-trained to provide pre-hospital care.

Finally, we cannot overlook the structural issues related to EMS. District hospitals believe that there is an inequitable distribution of resources for EMS services in relation to Fire services. We strongly believe the District should evaluate the option of separating EMS from the Fire Department even though we have some concern that the separation could create additional bureaucracy. In any organization where a majority of the service calls stem from one operational sector, that operation generally drives management and financial focus. It is our understanding that this is not true for EMS. It is our understanding that the distribution of resources leans more toward Fire operations. As a result, the hospitals believe the option of separating EMS and Fire should be given full consideration. We also believe that an investment of appropriate resources, coupled with the reforms mentioned earlier in our testimony, would help the District establish a world-class EMS system.

Again, we appreciate the opportunity to comment on EMS operations and necessary reforms. We are available to answer any questions.