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Testimony before the Senate Health Care Committee

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SB 817 Definition of Emergency

Chair Monnes Anderson and members of the committee, my name is Robert Barriatua, MD, and I'm here today representing OR-ACEP, the Oregon Chapter of the American College of Emergency Physicians. I also served as the chapter representative on the OHA's advisory committee to adopt rules pertaining to the use of the term "emergency care" in signage and advertising by urgent care facilities.

I am here today to oppose SB 817. Our opposition is based on three issues:
- Potential confusion for patients.
- Potential delays in treatment.
- And access to care regardless of a person's ability to pay.

In short, SB817 amends ORS 677, the medical practices act, and create two different types of emergency medical conditions: emergency and non-life threatening emergency. Emergencies must be treated in a hospital. And non-life-threatening emergencies could be treated anywhere.

That would be inherently confusing for patients.

We're also concerned that redefining the term "emergency" may be an attempt to circumvent the patient safety rules promulgated by the Oregon Health Authority last fall.

But let's get back to the issue of confusion for patients.

We believe the general public has a common sense understanding of the difference between urgent care and emergency care. "Urgent" and "Emergency" are different words. That makes it less likely that patients would be confused.

We are confident the the Urgent Care Association of America is not confused. Their website reads, and I quote, "Urgent care centers … treat minor or acutely rising medical conditions that patients feel require immediate medical attention but that are not medical emergencies…."

While Emergency Departments are not confused, and the Urgent Care Association of America isn't confused, the issue here is patients. And patients confused by inappropriate signage could end up being taken to the wrong facility. It's estimated that at least 40 percent of acute myocardial infarctions arrive at the hospital by private car.

When that happens, patients likely will need to be transferred to an Emergency Department. And therein lies our second concern: delays in treatment.

The Joint Commission on Accreditation of Healthcare Organizations, or JCAHO, has determined that even small delays in diagnosis and treatment can have catastrophic consequences, and has established a series of core measures to which hospitals are held accountable.

For example, the American College of Cardiology and the American Heart Association helped set JCAHO guidelines for 30 minute door-to-drug and 90 minute door-to-balloon time, for patients with acute myocardial infarction requiring thrombolytic drugs or angioplasty.

Similarly, the American Stroke Association has set a door-to-needle time for thrombolytics of 60 minutes from arrival to an ED for patients having an acute thrombotic stroke.

In the case of trauma, we refer to the "golden hour," during which prompt interventions can be life-saving, particularly in the case of chest or abdominal injuries which may not appear imminently critical.

This is especially important for children and teens, for whom trauma remains the leading cause of death.

Urgent care facilities have the skills to diagnose emergency medical conditions. And they have the skills to properly triage emergency medical conditions. What they don't have is a mandate to actually treat the emergency medical condition. And that leads to my third issue: access to care regardless of a person's ability to pay.

In 1986, Congress enacted the Emergency Medical Treatment and Active Labor Act, or EMTALA, also known as the "patient anti-dumping act." The purpose of this law is to prevent hospitals from refusing to provide emergency medical treatment based on a patient's ability to pay. Urgent care facilities are immune to EMTALA, and patients arriving with no insurance, or even insurance that is viewed unfavorably by the facility, may be simply "dumped" back on the street, regardless of their presenting condition.

This law prevents hospitals from transferring patients before their conditions are stabilized. Urgent care facilities are not required to do so.

And beyond the medical need to treat patients within the JCAHO standards, there also is the issue of the additional costs generated at the destination hospital. Costs passed on to the patient or the insurance carrier. That includes the cost of ambulance transport. That includes minor delays in care, which may result in longer hospital stays.

A single extra day in an ICU can result in an increase in the thousands of dollars, and could wipe out the potential financial benefit of multiple urgent care visits.

Here's an example: One of our board members, an emergency physician, reports that he had a patient with a traumatic brain bleed. The patient arrived at a ZoomCare facility. Upon realizing the nature of the trauma, the patient was transferred to an emergency department. That was a delay. Then his CT scan had to be repeated, because the CT image disk they received from ZoomCare was not compatible with their ED imaging system. It would have been, had the patient come from any hospital in Oregon. But of course, ZoomCare technology isn't required to be compatible with hospital ED technology.

In this case, the technical problem required a new CT scan — another delay, and another increased expense for the patient.

A patient's safety should not be put at risk due to confusing signage nor should anyone lose access to emergency services based on their ability to pay. After all, the primary concern of ORACEP with respect to this issue is public safety.

Thank you for the opportunity to testify. I'd be pleased to answer any questions.