



Regionalizing Emergency Care Systems

Lessons from Other Systems

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REGIONALIZATION OF HEALTH CARE – NOT A NEW IDEA

- Selected milestones in regionalization of health care in the USA
 - Blind rehabilitation in the VA (1948)
 - Trauma care
 - Trauma care centers, Chicago and San Francisco (1966)
 - Trauma care system, Maryland (1969)
 - EMS systems (1970s)
 - Cardiac surgery volume-outcome relationship (1979)
- Informal regionalization has been the norm in USA since formal regionalization requires a *system* of care and there is no overall health care system



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REGIONALIZATION OF EMERGENCY CARE – EMS SYSTEMS

- EMS-targeted conditions in California (1984)*
 - Acute cardiopulmonary conditions
 - Trauma
 - Burns
 - Spinal cord injuries
 - Poisonings
 - Neonatal and pediatric emergencies
 - Behavioral emergencies
 - Domestic violence
 - Environmental emergencies
 - Transplantations and replantations

* Kizer KW, Moorhead GV, McNeil M. *Emergency Medical Services Systems Standards and Guidelines*. Sacramento, CA. Emergency Medical Services Authority, State of California. 1984. pp 73-88.



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REGIONALIZATION OF EMERGENCY CARE – EMS SYSTEMS

- EMS-targeted condition system requirements in California (1984)
 - Training in
 - condition recognition
 - condition-specific management
 - Coordinated emergency medical plan, including *referral and transport to appropriate emergency care and special care facilities*



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REGIONALIZATION OF CARE IN THE VETERANS HEALTH CARE SYSTEM

- By clinical condition
 - Visual impairment/blind rehabilitation
 - Spinal cord injury
 - Transplants
 - Multiple sclerosis and Parkinson's Disease
 - Cardiac care
 - Traumatic brain injury
 - Polytrauma (TBI, vision impairment, hearing loss, burns, amputations/orthopedic impairment, PTSD/psychiatric)
 - Stroke (?pending)



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REGIONALIZATION OF CARE IN THE VETERANS HEALTH CARE SYSTEM

- **By clinical service**

- Pharmacy
- Radiology services and teleradiology support
- Emergency management



REASONS FOR REGIONALIZING SERVICES

- Complex, high risk conditions requiring a high intensity of care (e.g., highly technical, multidisciplinary)
- Limited availability of key resources (personnel, technology, etc.)
- Demonstrated quality of care benefit (e.g., volume-outcome relationship, multidisciplinary approach)
- Continuum of care needed
- Control of care beneficial from cost and/or quality perspectives
- Demonstrated economies of scale



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ISSUES FOR AND CHALLENGES TO REGIONALIZATION

- Information flow
- Patient/family satisfaction
- Social support
- Reduced availability of services in some care settings
- Quality management of a system vs. a facility
- Continuity of care in the community
- Impact on training programs
- Financial consequences
- Status and image issues
- Political and community impact considerations



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REGIONALIZING CARE: SELECTED LESSONS LEARNED

- More difficult and complicated than often expected
- Medical leadership crucial
- Financial impacts often misunderstood
- Quality of care benefits often overshadowed by loss of service concerns
- Importance of cultural issues generally underestimated