



Review of Healthy People 2020 Objectives

December 2009

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Topic Area: Access to Health Services

Time to see physician

AHS HP2020-8: Reduce the proportion of hospital emergency department visits in which the wait time to see an emergency department physician exceeds the recommended timeframe.

Data Source: National Hospital Ambulatory Medical Care Survey (NHAMCS), CDC, NCHS.

Action: Retained but modified Healthy People 2010 objective 1-10.

The American College of Emergency Physicians has serious concerns about this proposed objective. ACEP recommends modification of proposed objective AHS HP 2020-8 to clarify its reference to the NHAMCS definitions and to focus on improving access for the most acutely ill and injured.

ACEP Proposed AHS HP2020–8 (Modified): Improve access to emergency care by reducing the proportion of “Immediate”, “Emergent” and “Urgent” visits, as defined in NHAMCS, in which the wait time to see an emergency department physician exceeds the recommended timeframe.

We further propose the following target:

Target: Reduce the proportion of visits in these three categories that are not seen in the recommended time frame by 25%.

Access to emergency care remains an important national priority and lack of access to timely emergent medical care is a serious ongoing problem nationwide.(1) ACEP endorses efforts to highlight this problem, such as the proposed objective. Further, we recognize the limitations of using “self-reported difficulties” as a measure of access and applaud the decision to seek a more accurate method of monitoring the issue of access to emergency care. However, we believe that the objective in its current form will not achieve that purpose.

It is important to understand that the “wait time to see a physician” encompasses multiple administrative and clinical components that do not include the physician: wait time to triage, nurse assessment at triage, wait time to registration, collection of administrative data by clerical personnel during the registration process, wait time for a stretcher or treatment slot to become available in the emergency department (ED), nursing assessment within the ED; all of these steps typically must occur prior to a physician seeing the patient.

Hospitals nationwide have significant throughput issues which have led to an overcrowding crisis felt most acutely in EDs, where admitted patients are boarded for many hours and sometimes days prior to transfer to inpatient beds. As a result, fewer beds are available for new ED patients, and their care is delayed.(2-4) Encouraging hospitals to address overcrowding will greatly benefit patients and improve access to emergency care. However, we are concerned that the proposed rewording of AHS HP2020-8 does not target the core issues behind this dangerous situation and misinterpretation of the objective may cause adverse unintended consequences.

ED crowding causes delays in time-to-physician that are not a simple function of physician efficiency but rather are largely a reflection of hospital-wide flow. We are concerned that focusing on time-to-physician could be used to remove the emphasis from the hospital-wide nature of the problem. We would like the

objective to clarify that time-to-physician is not a quality indicator to be improved for its own sake, but a way of measuring a symptom of a greater problem.

The ED is a very fast-paced environment which is currently in crisis due to ED crowding, which is, in turn, largely due to the practice of boarding. Physicians in EDs must always prioritize emergent medical issues such as preventing death, loss of limbs or organ function, and treatment of pain. It is unrealistic to expect across-the-board improvements in the “time to see a physician” in all levels of visits without a large influx of new resources (nurses, ancillary staff, space, etc.). Assuring timely access to emergency care for the most seriously ill and injured often necessitates longer waits for those patients who are identified by the triage system as less urgent.

The “immediacy with which patient should be seen” is a variable collected as part of the NHAMC Survey Tool; it is not a resource-based triage categorization scheme.⁽⁵⁾ While it may be useful as an indicator of system performance as discussed above, it would be inappropriate for the NHAMCS definitions to be misused as performance benchmarks for physicians. We do not believe this was the intent of the objective but we believe it is imperative to explicitly state this.

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Topic Area: Access to Health Services

ACEP proposed new objective: Reduce Boarding to Alleviate ED Crowding

The American College of Emergency Physicians suggests the addition of this important objective in the Access to Care Chapter of HP 2020:

ACEP Proposed AHS HP2020 Protect the availability of emergency care by reducing the practice of boarding admitted patients in the emergency department.

Potential data source: National Hospital Ambulatory Medical Care Survey (NHAMCS)

Target: Reduce by half the number of hours admitted patients spend boarding in hospital Emergency Departments

The practice of holding admitted patients in the emergency department (ED) until an inpatient bed becomes available is commonly referred to as 'Boarding.' There is substantial literature that demonstrates long delays in transferring admitted patients to inpatient floors causes EDs to become overcrowded, compromising care for all ED patients and causing significant negative financial impact on both the institution and the patient.(1-5) The problem of boarding is a multi-factorial, hospital-wide issue. Addressing this problem to ensure timely access to emergency care will require active involvement of leadership at all levels including but not limited to, hospital administration, inpatient services, hospitalist service, nursing leadership, and ED providers.

The 2009 survey instrument for the NHAMCS (6) includes data elements that allow tracking of this critical phenomenon (ie: time a bed was requested and time the patient left the ED). Reducing the practice of boarding would improve access to emergency care.

The American College of Emergency Physicians supports the addition of this important objective to Access to Health Services.

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Topic Area: Access to Health Services

EMS objective: Rapidly responding EMS

HP 2010 1-11: Increase the proportion of persons who have access to rapidly responding prehospital emergency medical services.

1-11c. Population covered by helicopter

1-11d. Population living in area with prehospital access to online medical

1-11e. Population covered by basic 9-1-1

1-11f. Population covered by enhanced 9-1-1

1-11g. Population living in area with two-way communication between hospitals

HP2010 Data Source: National Assessment of State Trauma System Development, Emergency Medical Services resources, and Disaster Readiness for Mass Casualty Events, HRSA.

Status: Archived due to lack of adequate data source.

The American College of Emergency Physicians believes this important objective should be retained and proposes a potential data source.

Many large EMS systems are stressed by budget cuts and increased utilization that may result in a delayed response for patients calling 911.(1-2) National data has been limited, but NHTSA through the National EMS Information System (NEMSIS) data project is in the process of compiling electronic data from all states.

NEMSIS stands for the National Emergency Medical Services Information System. NEMSIS is the national repository that will be used to potentially store EMS data from every state in the nation. (www.NEMSIS.org) ALL states have a memorandum of understanding signed to participate in the project. ACEP has been a supporter and partner in this project.

With the anticipated development of this large EMS data repository, analysis of EMS response times is now possible. As many acute illnesses and injuries require urgent medical treatment, timely access to EMS care can substantially improve the health of the population and result in increased survival.(3).

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Topic Area: Access to Health Services

HP 2010 Objective 1-12: Establish a single toll-free telephone number for access to poison control centers on a 24-hour basis throughout the United States.

Data Source: American Association of Poison Control Centers Survey, US Poison Control Centers.

Status: Archived because target has been achieved.

ACEP proposed new toxicology objective.

ACEP respectfully proposes a new draft objective to assure access to poison control center services and a data source.

ACEP Proposed AHS HP2020 Objective 1-12: Establish a stable funding mechanism to provide all US residents with 24-hour access to a poison control center that meets national quality standards.

Potential Data Sources: American Association of Poison Control Centers, HRSA.

Each year, more than 4 million callers seek telephone assistance from poison control centers (PCCs) throughout the United States.(1) Approximately 80% of callers to PCCs are able to safely manage their problem at home, avoiding unnecessary emergency department (ED) visits. As a result, every dollar spent on PCCs saves at least \$7 in health care costs.(2) For patients who are hospitalized, PCC consultation is associated with a median 3-day reduction in hospital length of stay, from 6.5 days to 3.5 days, with a cost savings of \$2,100 per case (2005 dollars).(2) In addition, PCCs provide important disease surveillance, pandemic response, professional education, and public information functions. The HP 2010 goal of establishing a single nationwide toll-free number for access to poison control center services was met. However, the success of this goal is in jeopardy, as poison centers in several states have had to close, or are in imminent danger of closure, due to funding cuts.(3-5) Adequate funding to support the PCC network should be a priority. In addition to providing guaranteed access to PCC services, a stable funding mechanism would allow PCCs to innovate and develop additional services to address pandemics and mass casualty incidents.

References

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Topic Area: Heart Disease and Stroke

Cardiac Arrest

HDS HP2020-10: (Developmental) Increase the proportion of out-of-hospital cardiac arrests in which appropriate bystander and emergency medical services (EMS) were administered.

Potential Data Source: The National Emergency Medical Services Information System (NEMSIS).

Status: Retained but modified Healthy People 2010 objective 12-4.

The American College of Emergency Physicians supports continued inclusion of this important objective, proposes modifications, and suggests a potential data source for HDS HP2020-10.

We propose the NHTSA created database on EMS information (NEMSIS) as the data source as it would capture the necessary times to track progress in this objective.

NEMSIS stands for the National Emergency Medical Services Information System. NEMSIS is the national repository that will be used to potentially store EMS data from every state in the nation. (www.NEMSIS.org) All states have a memorandum of understanding signed to participate in the project. ACEP has been a supporter and partner in this project.

The American College of Emergency Medicine suggests several modifications to this objective:

Increase the proportion of out-of-hospital cardiac arrests in which appropriate bystander and emergency medical services (EMS) were administered.

- a. Increase proportion of out-of-hospital cardiac arrest victims with effective bystander CPR
- b. Decrease time to first defibrillation for out-of-hospital cardiac arrest victims with shockable rhythms to 6 minutes or less.
- c. Increase the proportion of out-of-hospital cardiac arrest victims with rapid access to EMS care
- d. (Developmental) Improve functional status of out-of-hospital cardiac arrest survivors.
- e. (Developmental) Improve survival to hospital discharge for out-of-hospital cardiac arrest survivors.

Access to effective bystander CPR (1), rapid defibrillation (2), and decreased time to EMS arrival (1) can all improve survival. Additionally, therapeutic cooling has been proven to improve neurologic outcome for appropriate cardiac arrest candidates. (3) Although the original objective is a great starting point to achieve better outcomes in out-of-hospital cardiac arrests, the inclusion of specific goals (a-e) will help direct future efforts toward success.

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Topic Area: Injury and Violence Prevention

Increase functioning residential smoke alarm

Previous HP 2010 Objective 15-26: Increase functioning residential smoke alarms.

HP2010 Data Source: National Health Interview Survey (NHIS), CDC, NCHS.

Status: Archived due to lack of adequate data source.

ACEP respectfully proposes that this HP 2010 objective be retained and modified to include a data source.

ACEP Proposed Objective: Increase the proportion of states or jurisdictions that have a statute requiring working smoke alarms in all new residential construction, modifications of existing residential construction, and on all existing rental housing units.

Proposed Data Source: Annual survey of state Fire Marshals or Fire Safety Divisions. Data on Contacts for each state available (as of October 2009) at:

http://www.usfa.dhs.gov/downloads/pdf/campaigns/smokealarms/smoke_alarm_requirements_press.pdf

Background: Fire related deaths are the fifth most common cause of unintentional injury deaths in the United States (1) and the third leading cause of fatal home injury (2). Fatalities and injuries caused by residential fires have gradually declined over the past several decades, however many residential fire-related deaths remain preventable and continue to pose a significant public health problem and economic burden (\$7.5 billion each year (3)). In 2006, someone died in a fire every 3 hours, or was injured every 32 minutes (4). Additionally, 80% of U.S. fire deaths in 2005 occurred in homes (4), with half of home fire deaths occurring in homes without working smoke alarms (5). Evidence suggests that working smoke alarms can prevent fire related deaths.(6) According to the midcourse review of Healthy People 2010, there has been only a 10% improvement towards the target for working smoke detectors in residential homes.

Although many states have adopted the National Fire Prevention Association Codes and Standards for new construction, not all states have statutes requiring these standards in new construction. (7) Additionally, many states do not have statutes requiring working smoke detectors in existing rental housing units. (7)

Ensuring all homes have working smoke detectors can save lives. ACEP supports statutes requiring smoke detectors in all residential homes.

References

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Additional resources:

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Topic Area: Public Health Infrastructure

PHI HP2020 – Proposed New Objective and Data Source

Disaster: Injuries reportable to Public Health Department

ACEP proposed HP2020 Developmental objective: Improve measurement of the public health impact of disasters in all 50 states by: 1) classifying all injuries and illnesses directly related to officially declared disasters as reportable to public health, and 2) creating a database cataloging critical information on these victims and linking it to statewide EMS databases.

Data source: Survey of all states by the CDC to identify which states have succeeded in implementing this objective.

Background: By their very nature, disasters affect large populations and adversely impact all aspects of society, including the health of individuals. Optimizing the management of these events is critical to meeting the goals of HP 2020 and requires substantial outcomes research. However, one of the biggest impediments to disaster research is access to outcomes data on disaster victims. Without timely review of such data, it is impossible to establish whether disaster interventions are effective and where improvement is needed. Currently, most hospitals are reluctant to permit access by investigators to patient medical information due to concerns such activity would violate the Health Insurance Portability and Accountability Act (HIPAA). This negatively impacts research not just by physicians, but also seriously restricts the investigative activities of many disciplines, including public health, sociology, and psychology. A solution to this significant problem is to classify all injuries and illnesses directly related to officially declared disasters as reportable to public health. Such a ruling would alleviate the liability risk to hospitals associated with HIPAA and provide researchers with access to critical outcomes data. Public health professionals have decades of experience in protecting patient confidentiality while investigating other reportable diseases and would be an effective steward of such information. Both the American College of Emergency Physicians and the Society for Academic Emergency Medicine have endorsed this concept.(1,2) Linking this data with other statewide EMS databases would prevent duplication of effort and improve overall data collection.

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ACEP provided comments on the following Healthy People 2020 Objectives.

Topic Area: Access to Health Services

Health Insurance

AHS HP2020-1: Increase the proportion of persons with health insurance.

Data Source: National Health Interview Survey (NHIS), CDC, NCHS.

Status: Retain Healthy People 2010 objective 1-1.

The American College of Emergency Physicians supports the continued inclusion of this important objective: AHS HP2020-1.

Background: Lack of health insurance is a major barrier to accessing preventive, diagnostic and therapeutic health services. Although having health insurance does not guarantee access to affordable health care, individuals who lack health insurance are more likely to not obtain needed care; more likely to not fill a prescription because of cost; more likely to have no regular source of care; and more likely to postpone care due to cost.(1) The uninsured are more likely to die early and more likely to have poor health status;(2) they are diagnosed at later stages of disease and get less treatment than those with insurance.(3)

Emergency departments, which are an essential component of the health care safety net, treat all persons regardless of their insurance status or ability to pay. Because of their unique availability, emergency departments are often used by the uninsured and the underinsured, both for non-urgent visits that could be seen in a less acute setting and, more importantly, for true emergencies that could have been avoided by appropriate care days, weeks or months before the emergency department visit.(4,5) Increasing the proportion of patients with health insurance would improve access to appropriate and timely care. We agree with previous comments that an appropriate goal would be 100% and would support strengthening the objective by identifying universal insurance coverage as the target.

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Topic Area: Heart Disease and Stroke

Awareness of early warning symptoms of stroke.

HDS HP 2020-9: Increase the proportion of adults aged 20 years and older who are aware of and respond to early warning symptoms and signs of a stroke.

- a. Increase the proportion of adults who are aware of the early warning symptoms and signs of a stroke and the importance of accessing rapid emergency care by calling 911
- b. Increase the proportion of adults age 20 years and older who are aware of the early warning symptoms and signs of a stroke
- c. Increased the proportion of adults aged 20 years and older who are aware of the importance of accessing rapid emergency care by calling 911

The American College of Emergency Physicians supports continued inclusion of this important objective: HDS HP 2020-9.

Background: Stroke is the third leading cause of death in the United States and a leading cause of serious, long-term disability.(1) Although major advances have been made in prevention, treatment, and rehabilitation, stroke continues to be a significant cause of morbidity and mortality in the US. New interventions such as fibrinolytics have evolved in the past decade for the treatment of strokes.(2) however, these treatments are time sensitive. Delivering the earliest possible definitive treatment for acute ischemic stroke is a major goal. Studies have shown that shorter time to fibrinolysis substantially improves clinical outcome.(3) Patient delay in seeking treatment for acute coronary syndrome and stroke symptoms is one of the major factors limiting delivery of definitive treatment. Significantly longer delay times occurred when patients or patient's families did not recognize the symptoms of a stroke, and did not use the 911 activation system after the onset of stroke symptoms.(3)

References

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3. Zerwic J, Hwang SY, Tucco L. Interpretation of symptoms and delay seeking treatment by patients who have had a stroke: exploratory study. *Heart Lung*. 2007;36(1):25-34.

Topic Area: Injury and Violence Prevention

Nonfatal poisonings

IVP HP2020-1: Reduce nonfatal poisonings.

Data Source: National Electronic Injury Surveillance System-All Injury Program (NEISS-AIP), CDC, NCIPC.

Status: Retained Healthy People 2010 objective 15-7.

The American College of Emergency Physicians supports the continued inclusion of this important Objective IVP HP2020-1.

Background: Unintentional poisoning was second only to motor vehicle crashes as a cause of unintentional injury in 2005.(1). Additionally, in 2006, almost 2 million ED visits were associated with drug misuse or abuse.(2) Efforts to improve education regarding the dangers of non-medical use of prescription medications, programs to decrease illicit drug use, along with research to determine effective means to decrease all poisoning related injuries or death are needed.

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Topic Area: Injury and Violence Prevention

Homicides

IVP HP2020-2: Reduce homicides.

Data Source: Vital Statistics System (NVSS), CDC, NCHS.

Status: Retained Healthy People 2010 objective 15-32.

The American College of Emergency Physicians supports continued inclusion of this important Objective IVP HP2020-2.

Background: In 2003, Homicides accounted for 11% of all injury deaths and are the 15th leading cause of death.(1) The National Violent Death Reporting System (NVDRS) collects and links data regarding violent deaths obtained from death certificates, coroner/medical examiner reports, and law enforcement reports. NVDRS began operation in 2003, and currently only 17 states report this vital information. This information is key in identifying high-risk groups and circumstances, provides information for developing, implementing and evaluating programs and policies aimed to reduce this burden in our communities. For example, a recent analysis of homicide-followed by suicide in the NVDRS found a substantial link between intimate partner conflicts and homicide-suicide incidents highlighting a new avenue to address homicides.(2) The continued development and expansion of NVDRS is essential to reduce the personal, familial, and societal costs of violence. Further efforts are needed to increase the number of states participating in NVDRS, with an ultimate goal of full national representation.(3)

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Topic Area: Injury and Violence Prevention

Child Fatality Review

IVP HP2020-5: Increase the number of states and the District of Columbia where 100% of deaths to children aged 17 yrs and under that are due to external causes are reviewed by a child fatality review team.

Data Source: Michigan Public Health Institute; National Vital Statistics System (NVSS), CDC, NCHS.

Status: Retained Healthy People 2010 objective 15-6.

The American College of Emergency Physicians supports continued inclusion of this important Objective IVP HP2020-5.

Background: Child fatality review teams evolved in response to the recognition of the significant violence against children in the US.(1) The Arizona child fatality review program found that child mortality data based on death certificate information is frequently incorrect, and that a comprehensive review, including information not available to the coroner or medical examiner, may help identify a preventable cause of death.(2) Unfortunately, not all states mandate this type of insightful comprehensive review. Expanding the program so that all states have a comprehensive child fatality review team will help identify high-risk families and circumstances, opportunities for evidence based prevention programs and policies to reduce mortality and the ability or monitoring trends to evaluate interventions.

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Topic Area: Injury and Violence Prevention

Increase Seat Belt Use

IVP HP2020-8: Increase use of safety belts.

Data Sources: National Occupant Protection Use Survey (NOPUS), DOT, NHTSA; Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP.

Status: Retained Healthy People 2010 objective 15-19.

The American College of Emergency Physicians supports the continued inclusion of this important Objective IVP HP2020-8.

Background: Motor vehicle crashes are the leading cause of teen deaths, accounting for more than 1 in 3 deaths.(1) Evidence reveals seat belt use can reduce deaths and injuries from motor vehicle collisions.(2) According to NHTSA, jurisdictions with stronger belt enforcement laws continue to exhibit higher rates of seat belt usage.(3) Unfortunately, in 2006, seat belt use nationwide was only 81%.(3) Primary enforcement safety belt laws, which allow a police officer to stop a motorist solely for not wearing a safety belt, can contribute to increased safety belt use, resulting in decreased injuries and fatalities.(4,5) Efforts to increase the proportion of states with primary enforcement safety belt laws would save lives and reduce health care costs.

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Topic Area: Injury and Violence Prevention

Motorcycle Helmet Use

IVP HP2020-9: Increase the proportion of motorcyclists using helmets.

Data Sources: National Occupant Protection Use Survey (NOPUS), DOT, NHTSA;
Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP.

Status: Retained Healthy People 2010 objective 15-21.

The American College of Emergency Physicians supports continued inclusion of this important Objective IVP HP2020-9.

Background: A recent Cochrane Systematic Review of the effects of helmet use in motorcyclists found that motorcycle helmet use decreases the risk of death and head injury in motorcycle crashes. (1). Other studies have estimated use of a motorcycle helmet can decrease the chance of a fatal crash by 37-39% (2,3), with no change in the incidence of spinal injuries. (4). Additionally, studies have found that states with helmet use laws have decreased fatalities. (5,6) Unfortunately, after Congress lifted federal sanctions against states without helmet use laws, many states have repealed these laws. If all states were to enact a primary motorcycle helmet use law, helmet use would increase dramatically while the number of motorcyclists head injuries and fatalities would decrease. (7)

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Topic Area: Injury and Violence Prevention

Reduce unintentional injury deaths.

IVP HP2020-22: Reduce unintentional injury deaths.

Data Source: National Vital Statistics System (NVSS), CDC, NCHS.

Status: Retained but modified Healthy People 2010 objective 15-13.

The American College of Emergency Physicians supports the continued inclusion of this important Objective IVP HP2020-22.

Background: In 2006 acute injuries (including poisoning) accounted for almost 25% of ED visits.(1) Unintentional injuries are the 5th leading cause of death in the US and the leading cause of death in ages 1-40.(2) Emergency physicians are on the front line caring for these patients, witness these tragic preventable injuries and deaths and can improve critical leadership in reducing this burden. Research into ED based secondary prevention initiatives has revealed success at decreasing injuries and violence.(3,4) We need to continue to work towards injury prevention and control through research, surveillance, and evidence-based programs and policies.(5)

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Topic Area: Injury and Violence Prevention

Violence by intimate partners

IVP HP2020-31: Reduce violence by current or former intimate partners.

- a. Reduce physical violence by current or former intimate partners.
- b. Reduce sexual violence by current or former intimate partners.
- c. Reduce psychological abuse by current or former intimate partners.
- d. Reduce stalking by current or former intimate partners.

Data Source: National Intimate Partner and Sexual Violence Surveillance (NISVS) System, CDC, NCIPC.

Status: Retained but modified Healthy People 2010 objective 15-34.

The American College of Emergency Physicians supports continued inclusion of this important Objective IVP HP2020-31.

Background: Intimate Partner Violence (IPV) is the most common cause of violence related injury to women in the United States (U.S.)(1), and greater than one-third of all female homicide victims in the U.S. were killed by the victims' husband or partner.(2) The health consequences for IPV victims have been well documented.(3-5) EDs are often the entry point for individuals experiencing IPV,(6) and play a vital role in IPV screening.(7-9). Although numerous ED based screening programs are successful, the ideal means to decrease future IPV has not been fully determined. Future efforts at research, education, and health care policy initiatives are important to address this important objective.

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Topic Area: Injury and Violence Prevention

Emergency Department surveillance systems

IVP HP 2020-33: Increase the number of states and the District of Columbia with statewide emergency department data systems that routinely collect external-cause of injury codes for 90 percent or more of injury-related visits.

Data Source: Healthcare Cost and Utilization State emergency department data sets (HCUP SEDDS).

Status: Retained but modified Healthy People 2010 objective 15-10.

The American College of Emergency Physicians supports the continued inclusion of this important Objective IVP HP2020-33.

Background: External Causes of injury Codes (E-Codes) numerically categorizes injuries by cause and. For example, if a patient suffers a femur fracture, the traditional N code is for the fracture. The E-code will identify the cause of the femur fracture, such as an unintentional fall from a ladder. E-codes define the manner of the death or injury, the mechanism, and the place of occurrence. This type of injury data can assist EDs, trauma centers and local and state public health agencies in identifying and tracking patterns and trends in external causes of injuries.(1) Additionally, this information can help in the development of prevention strategies targeting specific causes of injury in specific population at risk.(2) However, not all states report external causes of injury. In 2007, 26 states and District of Columbia mandated E-code collection, and some states collect information, but are not mandated.(1) In many of the state databases, E-coding is incomplete,(1) leading to challenges in the data interpretation.

Universal coding for external causes of injury provides essential data to guide public health decisions and ultimately reduce morbidity and mortality from injuries.

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Topic Area: Mental Health and Mental Disorders

Reduce the Suicide Rate

MHMD HP 2020-1: Reduce the Suicide Rate

Data Source: National Vital Statistics System (NVSS), CDC, NCHS.

Status: Retained Healthy People 2010 objective 18-1.

The American College of Emergency Physicians supports continued inclusion of this important objective MHMD HP 2020-1.

Background: Every year more than 32 000 people die by suicide in the United States (www.cdc.gov/ncipc/dvp/Suicide/SuicideDataSheet.pdf). Estimates suggest that, every day, there are approximately 2000 suicide attempt-related injuries and up to 10,000 suicide-related visits to US emergency departments (EDs). (1-3) Rates of presentation to EDs for suicide-related reasons increased almost 50% from 1992-2001 and show no sign of declining. (3) These figures reflect Emergency Medicine's increasing burden of responsibility and care for suicidal patients.

The closure of psychiatric inpatient facilities, reductions in inpatient beds, transition to outpatient treatment and increased costs of general practitioner visits have coincided with, and likely contributed to, increased attendances to EDs by psychiatric and suicidal patients who would previously have been admitted or seen in primary care. The ED is now the default option for urgent and acute contact for suicidal patients. The need to have ED based brief screening, early identification, intervention, facilitated referral, safety planning, and motivational enhancement to seek additional care are part of a multimodal approach to prevent suicide and suicide-related behaviors. Multiple emergency medicine investigators have developed different yet successful suicide screening and intervention initiatives. (4-8) Given the crowded ED environment, challenges remain regarding the ideal methodology for improved suicide screening and intervention. Support, research, and ultimately implementation of the most successful and efficient ED based suicide prevention programs are needed to address this important public health problem.

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Topic Area: Mental Health and Mental Disorders

Homelessness and mental health

MHMD HP 2020-3: Increase the proportion of homeless adults with mental health problems who receive mental health services.

Data Source: Projects for Assistance in Transition From Homelessness (PATH), SAMHSA.

Status: Retained Healthy People 2010 objective 18-3.

The American College of Emergency Physicians supports continued inclusion of this important objective: MHMD HP 2020-3.

Background: Homelessness and mental illness are risk factors for frequent emergency department (ED) visits.(1,2) ED visits for these populations have been increasing.(3,4) Additionally, homelessness may be a consequence of a break in contact with mental health services for many homeless individuals with psychosis.(5) According to the midcourse review of HP2010, only 26% of homeless individuals with mental health needs were able to receive access to mental health services in 2003, and this represents a movement away from the target of only 30%!

Emergency department homeless patients needing mental health services may wait long periods in EDs awaiting access to mental health services. This not only increases ED crowding, but also delays care for these patients. As mental illness is often a chronic condition among the homeless, it is better managed in established long term programs by providers with expertise in psychiatric disorders. Recent data suggests that access to an integrated care clinic for homeless veterans with serious mental illness resulted in increased preventive and primary care as well as reduced use of emergency services.(6)

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Topic Area: Older Adults

OA HP 2020-9: Reduce the rate of emergency department visits due to falls among older adults.

Data Source: National Hospital Ambulatory Medical Care Survey, CDC, NCHS.

Status: New to Healthy People 2020.

The American College of Emergency Physicians supports this important new Objective OA HP2020-9.

Background: The US population is growing older, and falls among this older population are a substantial problem.(1) Falls are the leading cause of injury deaths and the most common cause of nonfatal injuries.(2) The risk of being seriously injured from a fall increases with age.(3) Efforts to reduce falls in older adults are an important public health initiative. In fact, the Joint Commission has made reducing the risks of falls one of its patient safety goals for 2009. The American College of Emergency Physicians supports the development and inclusion of this important objective.

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Topic Area: Respiratory Diseases

Asthma

RD HP2020-2: Reduce emergency department visits for asthma.

- a. Children under age 5 years
- b. Children and adults aged 5 to 64 years
- c. Adults aged 65 years and older

Data Source: National Hospital Ambulatory Medical Care Survey (NHAMCS), CDC, NCHS.

Status: Retained Healthy People 2010 objective 24-3.

The American College of Emergency Physicians supports the continued inclusion of the objective RD HP2020-2.

Background: Approximately 34.1 million Americans have been diagnosed with asthma during their lifetime.(1) There are approximately 217,000 emergency room visits in the US each year due to asthma.(2) Having an asthma attack that necessitates a visit to the emergency room may indicate severe or poorly controlled asthma, inadequate access to health care or inappropriate use of emergency services.(3,4) Independent predictors of high ED use (six or more visits a year) have been shown to be nonwhite race, Medicaid, other public, and no insurance, and markers of chronic asthma severity. Patients with six or more ED visits were responsible for 67% of all prior ED visits in the past year.(5) The key to reducing visits to the ED for asthma is better longitudinal care, prevention, and patient education.

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Topic Area: Respiratory Diseases

COPD

RD HP2020-14: Reduce chronic obstructive pulmonary disease (COPD) related hospital emergency department visit rates.

Data Source: National Hospital Ambulatory Medical Care Survey (NHAMCS), CDC, NCHS.

Status: New to Healthy People 2020.

The American College of Emergency Physicians supports this important new objective RD HP2020–14.

Background: In the United States, COPD is the fourth leading cause of death and is projected to become the third leading cause of death by the year 2020.(1) There are more than 16 million persons living with COPD in the U.S; however, it is estimated that there may be an additional 16 million or more persons still undiagnosed.(1,2) There are approximately 214,000 ED visits per year due to COPD.(3,4) A recent study has shown that patients with COPD who are at high risk for emergency room visits from exacerbations or complications benefit from simple low-intensity case management. In this study, with implementation of low-intensity case management, emergency room visits for COPD decreased by more than 50%.(5) The key to reducing visits to the ED for COPD is not only improved longitudinal care, but also better patient education and prevention.

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Topic Area: Substance Abuse

ED visits

SA HP2020–3: Reduce drug-related hospital emergency department visits.

Data Source: Drug Abuse Warning Network (DAWN), SAMHSA.

Status: Retained Healthy People 2010 objective 26-4.

The American College of Emergency Physicians supports the continued inclusion of this important Objective SA HP2020-3.

Background: Drug abuse is a major public health problem that can have multiple social and health consequences. According to data from the National Institution for Drug Abuse (NIDA), drug use is a risk factor for injury. Injury patterns can be associated with particular drugs; alcohol and cocaine use are associated with violent injuries and opiates associated with nonviolent injuries and burns.(1) Other serious medical consequences include the transmission of infectious diseases such as HIV and viral hepatitis, cardiac events such as arrhythmias, aortic dissection and myocardial infarctions, as well as neurologic events such as cerebrovascular accidents. Data suggests that substance abuse is a risk factor for frequent use of ED resources, particularly if associated with mental illness.(2-4) Illicit users of prescription medications has become a significant issue, with 6 million users aged 12 and older in 2002.(5). Education regarding the hazards of illicit prescription drug abuse, and interventions to decrease diversion of these drugs from medical purposes to the illegal market are needed.(5)

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Topic Area: Substance Abuse

Follow-up

SA HP2020–15: (Developmental) Increase the proportion of persons who are referred for follow-up care for alcohol problems, drug problems after diagnosis, or treatment for one of these conditions in a hospital emergency department.

Potential Data Source: National Hospital Ambulatory Medical Care Survey (NHAMCS), CDC, NCHS.

Status: Retained but modified Healthy People 2010 objective 26-22.

The American College of Emergency Physicians (ACEP) supports continued inclusion of this important Objective: SA HP2020-15.

Background: Objective SA HP2020-15 is a very important HP 2020 Objective. Emergency departments (EDs) attend to more than 115 million visits annually and address the health and social consequences of the chronic disease of addiction. Based on the findings published by the Academic ED SBIRT (Screening, Brief Intervention and Referral to Treatment) Research Collaborative in *Annals of Emergency Medicine* in 2007, 26% of patients screened positive for at risk and dependent drinking.(1) Many of the SAMHSA funded SBIRT ED sites report similar rates (See *Drug and Alcohol Dependence* 2008) and demonstrate need for substance abuse referrals. According to SAMHSA less than 10% of people diagnosed with abuse or dependence are receiving the treatment they need.

Trauma patients who screen positive for alcohol and substance use in the ED are at much higher risk of future traumatic injuries.(2) ED visits have been identified as a key opportunity for prevention and intervention of alcohol-related morbidity and mortality.

An additional potential data source (besides the NHAMCS, CDC, and HCHS) that could support this objective includes SAMHSA's ED Drug Abuse Warning Network (DAWN) which currently reports national and metropolitan area rates on drug abuse referrals to detox/treatment. The DAWN, if used as the data source, would need to expand from capturing alcohol only rate <21 populations to all ages in order to be more useful.

The ACEP and the Emergency Nurses Association endorse SBIRT and both have on line education programs for physicians with support from NHTSA.(3) Furthermore, Level I and II Trauma Centers require Screening and Brief Intervention for certification by the Committee on Trauma of the American College of Surgeons. New reimbursement SBI codes have been adopted by AMA (CPT codes) and CMS G&H codes for these clinical preventive procedures.

We have an excellent opportunity to improve the care of patients presenting to our Nation's EDs with at risk and dependent drinking and drug use. HP 2020 Objective SA-15 can track progress, promote change and inform public policy. ACEP encourages efforts to develop a definitive data source to track success.

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Topic Area: Substance Abuse

SBI

SA HP2020–18: Increase the number of level I and level II trauma centers that implement evidence-based alcohol screening and brief intervention.

Data Source: National Trauma Verification Registry, American College of Surgeons.

Status: New to Healthy People 2020.

The American College of Emergency Physicians supports this important new Objective SA HP2020–18.

Background: The American College of Emergency Physicians and the Emergency Nurses Association endorse SBI and both have on line education programs for physicians with support from NHTSA. Furthermore, Level I and II Trauma Centers require Screening and Brief Intervention for certification by the Committee on Trauma of the American College of Surgeons (ACS). New reimbursement SBI codes have been adopted by AMA (CPT codes) and CMS G&H codes for these clinical preventive procedures.

Despite the requirement by ACS that all Level I and II trauma centers implement SBI, there is still some variability in implementation among these trauma centers, and there is room for improvement of.(1, 2) Future directions for this objective include systematic training and evaluation of SBI practices as well as initiatives to develop sustained implementation of SBI.

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