ALEXIAN BROTHERS
Medical Center

Illinois Legislative Task Force Testimony - December 1, 2011

Good afternoon, Chairmen and committee members. My name is Georgene Fabsits. I am an RN with a BSN degree who is the EMS/Emergency Preparedness Coordinator at Alexian Brothers Medical Center in Elk Grove Village. I have been in this role for 27 years; and for 4 years prior, I was a staff RN in the Emergency Department. I was also Alexian Brothers Medical Center's original Trauma Coordinator when we were designated as a Level II trauma in 1988.

Alexian Brothers Medical Center welcomes this opportunity to work collaboratively with members of the General Assembly, the Illinois Department of Public Health, our Regional and EMS partners and other stakeholders in a effort to support the advancement of Illinois' emergency health care system to provide safe, efficient, quality emergency care and optimal patient outcomes.

With this in mind, I respectfully submit the following testimony.

Illinois' EMS and Trauma Systems, though relatively young (31 & 23 years respectively), have advanced tremendously over that time. In EMS, we no longer "scoop and run" to the closest hospital, but rather, assess, identify time-sensitive patients, treat, stabilize and transport to the closest appropriate hospital.

In the field, patients with chest pain receive 12-lead EKGs to determine the presence of an acute myocardial infarction (AMI). Early notification to the emergency department allows us to activate our cardiac alert protocols. A cardiologist is available to assess these patients either, on arrival or shortly thereafter. If the patient is experiencing an ST-elevation MI (STEMI), they are rapidly transported to the cardiac catherization lab to undergo an angiogram, angioplasty (removal/decrease in the occluding plaque clot) and possible stent placement.

More cardiac arrest patients are having "return of spontaneous circulation" (ROSC) in the field, as a result of good CPR, early defibrillation with AEDs or pre-hospital defibrillators, the use of a resQPOD® (device that increases blood flow to the heart and brain during CPR); and, working that patient on the scene rather than in the back of a crowded, bumpy ambulance. At the hospital, they undergo therapeutic hypothermia and are rapidly transported to the cardiac catherization lab for angiography, to determine cardiac vessel occlusion/obstruction. More of these patients are being discharged and are able to lead productive lives.

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Patients suffering from stroke symptoms are rapidly assessed, identified as stroke victims, and transported to stroke centers where they quickly undergo a head CT scan to determine the presence or absence of a brain bleed. If the stroke is caused by a clot occluding one of the brain's vessels, they are quickly treated with either TPA (intravenous clot-busting medication); or, interventional radiology procedures, where a catheter is threaded through the arterial vessels to the location of the clot and administered TPA arterially, directly at the clot; or a device is used to manually remove that clot. It is "remarkable" to see a patient come into the emergency department (with facial droop, unable to speak, or move one side of their body) receive TPA and shortly have their stroke symptoms disappear.

Trauma patients are assessed, assigned triage criteria based on their injuries and/or physical condition, provided life-saving interventions and transported to the appropriate level trauma center, where they are often met by a team of specialized trauma healthcare workers. This trauma team quickly identifies their injuries, delivers stabilizing interventions and transfers them to the O.R. for repair of their injuries. Early rehabilitation needs are determined and therapies provided to assist them in regaining their pre-injury functioning, if able, or adaption to their disabilities.

As you can see, Illinois hospitals play a vital role in the provision of emergency services and EMS. The EMS System could not run without hospitals, as pre-hospital providers depend on hospital guidance and oversight, hospital supplies and hospital-trained personnel. Hospitals invest substantially in EMS by partnering with our providers and performing support activities to IDPH, for which no state reimbursement is received. The EMS Funding Task Force should seek to improve both pre-hospital and hospital services.

Alexian Brothers Medical Center is an Associate Hospital in one EMS System and a Participating Hospital in another. We are also certified as an Emergency Department for Pediatrics, a Level II Trauma Center, and a Primary Stroke Center.

As an active participant in an EMS System, Alexian Brothers Medical Center provides, but is not limited to, the following EMS activities:

1) Exchange medications and supplies that are used by the pre-hospital providers – Yes, we are able to charge the patient for these supplies, however, not on a per item basis; only able to charge based on the level of service provided in the Emergency Department;

2) Replace medications and supplies used by pre-hospital providers on non-transported patients – unable to charge for these since not hospital patients. Examples include, Dextrose for the hypoglycemic patient and resuscitations where the patient does not regain a pulse and is pronounced in the field;

3) Stock new ambulances at primary EMS agencies with medications and non-disposable supplies;

4) Conduct yearly ALS ambulance and ALS non-transport pre-hospital vehicle inspections. I am responsible for 5 EMS providers with 13 ALS ambulances and 9 ALS non-transport vehicles.

5) Make available clinical areas (Emergency Department, Pediatric Emergency Department, OR, ICU, Labor/Delivery) and hospital RN's who provide supervision and education to paramedic and EMT students;

6) Conduct 10-12 (2 hour) monthly EMS System provided continuing education classes to system agencies/providers and 3 (1.5 hour) monthly EMS system provided continuing education classes to ABMC's ECRN's (Emergency Communications RNs).

7) Provide the opportunity and financial support for ED nursing staff to obtain initial licenses as an ECRN (Emergency Communications Registered Nurse) and TNS (Trauma Nurse Specialist). Must also ensure that opportunities and financial support is available for these same nurses to obtain the necessary continuing education to maintain their licenses and the hospital's certifications (TNS – 64 hours trauma related education/4 years; ECRN – 32 hours EMS related education/4 years; EDAP – 8 hours pediatric education/year and Stroke Center – 8 hours stroke education/year.

Illinois' EMS system is built on maximizing the use of local resources to provide the highest level of pre-hospital emergency care possible. Communities across Illinois are diverse and have unique needs. We urge the development of workable solutions that are not one-size-fits-all approaches, but that allows for the incorporation of modern technology into the rural communities' training programs (e.g., distance learning), while maintaining the integrity and advancement of the EMS System and profession.

Illinois' EMS pioneers who established our current EMS education process laid the foundation upon which future generations can build. In order for EMS in Illinois not to become extinct, we need to evolve. Medical technology, protocols and medications have changed over time and we must be able to change with it, in order to continue to provide the highest quality pre-hospital patient care. We must be able to get the right patient to the right facility/resource in order to meet their needs and to maximize the use of local resources (e.g., trauma center, stroke center, STEMI center).

EMS educational programs need to become more consistent regionally and state-wide. We have to evolve away from a "don't teach me anything I don't need to know to pass the test" mentality. EMS education needs to keep up with all the medical advances in order to better serve the public. This educational consistency will help facilitate EMS provider reciprocity within Illinois and among states, and improve EMS provider professional mobility.

There are several good recommendations in the Task Force's strategic plan:

- Transitioning to the New Education Standards and adopting the National EMS Scopes of Practice Model - minimizes inconsistency in educational format, content and patient care approaches;
- Transitioning to the new levels and titles of EMS providers – current EMT-I's able to be transitioned to the "Advanced Emergency Technician "license level. Flexibility with these transition programs would minimize the conversion of these EMT-I's to EMT's, as well as, any corresponding reduction service level in small and rural communities, where patients have longer transport times and often require more emergency medical services;
- Requiring paramedic training programs to be recognized by a national accreditation program – ensures educational quality;
- Working with the EMS advisory Council's Education Subcommittee to develop minimum requirements for all continuing education programs – ensures consistency and currency with medical advances;
- Analyzing the costs, benefits and risks of transitioning EMS continuing education requirements to incorporate a competency-based approach – providing patient care is not just all about the book knowledge; but being able to correlate what you've learned from the books - with how the patient in front of you is presenting. Being able to demonstrate the skills necessary to conduct thorough assessments, identify the problem, and provide the appropriate treatment;
- Working with organizations representing rural communities to develop innovative and non-traditional EMS educational programs – allows for cultural variation, rural circumstances, increasing variability in EMS practice venues, and travel and time constraints;
- Development of a grant program to incorporate technology into education programs (to enable distance learning) – assists communities with decreased revenues and financial reserves in achieving/maintaining these educational standards ; and
- Establishment of separate requirements for reserve ambulances – poor use of resources to have these if-needed ambulances fully stocked. Supplies and medications expire, increasing the hospital's costs to replace.

Illinois hospitals cannot sustain the impact of funding cuts, particularly to EMS and trauma. Illinois hospitals already contribute substantially in dollars and personnel to the EMS and trauma systems.

You also must take into consideration that economics are more challenging these days. Reimbursements made on behalf of Medicare and Medicaid beneficiaries continue to be reduced; the number of uninsured or underinsured patients continues to increase. We endorse the addition of appropriate revenue streams to support EMS, but NOT in ways that would weaken the EMS or Trauma systems.

We (Illinois hospitals) have long raised concerns about the lack of adequate funding to support emergent trauma care. IDPH's strategic plan proposes a 25% cut in the Trauma Center Fund, which could jeopardize our ability to continue providing the highest-level trauma services. Historically, in Illinois, whenever there has been inadequate financial support, the number of trauma centers has dropped significantly. This fund allows us to upgrade our trauma equipment, obtain state of the art equipment and provide trauma training and continuing education to our personnel.

We recommend that the State avoid taxing entities that are part of the EMS System. We do not support a surcharge on trauma centers in the form of trauma center designation site visit fees, as noted in the IDPH strategic plan.

We do support the recommendation that EMS operations should be included in current grant funding opportunities, including the expansion of the EMS Assistance Fund grant program as recommended in the IDPH strategic plan.

In closing, we are truly at the crossroads of advancing EMS in Illinois. With minimal effort and a lot of willingness, we can continue to improve the EMS healthcare services in Illinois and our communities that will ensure that all residents in Illinois are afforded quality, safe and efficient emergency medical care.

I would like to thank the Chairmen and committee members for your time and willingness to hear my voice on this important issue facing the State of Illinois.

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