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Overcrowding and the HPG [Editorial]

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For years, we as individuals and as organizations have trotted out our Big List of Reasons for ED overcrowding, expecting our cries to be heard, and actions taken. My crazy eights list of causes include: the poor, the uninsured, EMTALA, unnecessary visits, the flu, understaffing, fewer hospitals, and lack of inpatient beds.Let's analyze these as causes of overcrowding. This is not a trivial exercise. We can't cure the patient without the right diagnosis and right treatment. We also would like the disease to be one that is treatable. With that in mind, let's look at the list.

First, let's take on the poor, the uninsured, and EMTALA. What evidence do we have that this has caused overcrowding? Answer: A lot, if your measure is the number of comments on this. However, if you use science, then the answer is not much. How could that be? Just think. If all of these patients had insurance, we would not be on the bandwagon to get them out of our emergency departments. We would see them, give them their unnecessary antibiotics and patient satisfaction surveys, and thank them for coming to see us. All of those patients would now participate in payment to provide necessary funding for adequate staff, equipment, and space. So let's put this list of problems under the right heading where they belong. The poor, the uninsured, and EMTALA create problems with underfunding, not overcrowding. If they all paid, we would call this being busy.

Let's move on to unnecessary visits. Because we seem to be the only group of physicians complaining about too much business, we should really take a look at this. First, what is an unnecessary visit? If we look at the science behind this banter, what we find is pretty straightforward. At every step along the way, from the patient's self-assessment to phone assessment, triage assessment, or initial physician assessment, there is an irreducible number of around five percent of patients in the nothing's wrong category who end up with something Bad Enough to Need Admission. No one has yet proposed a strategy to eliminate those visits and yet protect the five percent who have urgent problems, short of seeing the patient and making a diagnosis. As a gut check, would you leave it to a physician with a zillion hours of training (i.e., an intern) to decide who can be sent away? We can say sore throats don't belong here, but the patients with peritonsillar abscesses and epiglottitis will have to fend for themselves.

Another argument attached to the unnecessary visit is that they could be seen in another venue. Let's leave aside for a moment the annoying fact that another venue is most often not available to the patient. Otherwise, of course, this argument is true. Any patient could be seen in another venue. With the right equipment and personnel, you could run your codes in Aisle 6 of your local supermarket, and do your procedural sedations in the fruit section. What does that prove? If you want to make economic sense out of an emergency department, don't reduce its use. Use the heck out of it, which will reduce the cost per patient cost. What's the alternative? See 10 cardiac arrests a month, and bill them each $400,000? For acute, episodic care, what better place to be seen than the emergency department?

So why are we making such a crazy fuss about the unnecessary visit? Hint: Go look at the studies. What patient population are these studies always looking at? Mr. and Ms. Stock Option? No, their visits, of course, are always appropriate. Most of these studies focus on either Medicaid patients or the uninsured. Now doesn't that sound like an issue related to underfunding rather than overcrowding? Besides, are we really closing down and diverting ambulances because there are too many patients with insect bites in our waiting rooms?

I must admit that we've had success in one area as a result of these studies. In fact, rather phenomenal success. (Hurray for us! The good guys!) Thanks to our efforts at championing the unnecessary visit, we haven't reduced visits. But we certainly have provided a roadmap for insurers to deny payment for these visits that were previously covered without debate. Who knows whether they ever would have figured this out on their own? It's not like there are bunches of doctors in other specialties promoting that notion: Half my office visits are a waste of time; keep your money. Every time an emergency physician stands up and complains about unnecessary visits, you can subtract another few thousand bucks from your bottom line.

Championing the cause of overcrowding due to the flu or any other epidemic infection is silly and a waste of our good time. We know that entire regions are systematically overwhelmed all the time. Introducing the notion of episodic fluctuations leads directly to the notion that the problem will go away before a fix can be put in place. Therefore, no action is needed.

Let's move down the list. Do we have understaffing? Yes. Do we have fewer hospitals? Yes. Although this magnifies problems with

overcrowding, this is yet another issue related to underfunding.

Let's summarize. Everything on the list so far (OK, maybe not the flu) has to do with underfunding. There are two very important conclusions that follow from this. One: Were it not for underfunding, we would not say we were overcrowded; we would say we're busy, and probably be quite happy for it. The second conclusion is that tying the overcrowding solution to underfunding makes any hope for relief nonexistent in our lifetime. Is it not clear that we do not have the political wherewithal to provide universal coverage to all patients? I'm not saying that these are hopeless pursuits, but I'm not sure they'll have much impact on overcrowding for years to come.

Let's move in our final step to the one thing that unequivocally socks us in, shuts down our emergency departments, and brings the system to a halt - the bunking of innumerable admitted patients in the emergency department. If you have no space left, you have no ED left. Go to Aisle 6 of your supermarket, please. The 2B3A inhibitors are on the shelf right next to the extra large half-filled bag of Fritos.

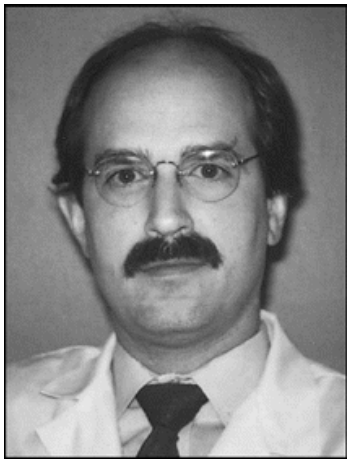

Figure. Dr. Peter Viccellio

Virtually all of the recent studies on ED overcrowding have confirmed that admitted patients held in the ED are grinding the system to a halt. Let me put it a different way. Our business is brought to a halt by a group of patients who really are someone else's business. This is a bad business plan, not to mention the fact that it really stinks for the patient having an emergency. (By the way, I hope none of you object to my using the old fashioned term patient rather than customer.) So if we want to implement an evidence-based solution to ED overcrowding, here's where the focus should be. To fix the problem, one must understand its true causes. So let's do a step-by-step analysis here.

Step one: A patient is admitted, but there is apparently not a readily available inpatient spot for the patient. Step two: Because there's not a normal spot for the patient, we've got to put them in an abnormal spot. Now, before we move to step three, this abnormal spot really could be anywhere in the hospital. I personally like Nuclear Medicine myself. Step three: Let's pick the emergency department as the abnormal spot for this patient. In spite of a gazillion square feet in the rest of the hospital and a zillion more staff who incidentally are actually trained in inpatient care, let's stuff all the overflow into the tiniest, busiest, and most critical and chaotic space in the hospital. This is health care planning as a fraternity stunt.

How has such insanity become the prevailing way of doing business? It's lousy for the admitted patient, and dangerous in the extreme to the guy in the waiting room with the pulsatile mass in his abdomen. Understanding how this happened, how we were elected to be the abnormal spot, may lead us toward how to make it unhappen. The evolution of this process is not difficult to understand, unless your entry into emergency medicine is more recent, in which case you might think this is happened by some unfathomably wise design. Here goes.

It's 1980. Hospitals are starting to fill up. The emergency department has the clout of a wet noodle within the HPG (hospital power grid [I just made that up]). A patient needs a bed. There is a bed. The staff upstairs has not yet achieved that Zen-like center of calm that will prepare them to take the patient, and besides, they're in their two-hour change of shift report. The physician staff is tied up in pontification rounds; they are not to be interrupted. You call, berate, involve administration, send in the Marines. You threaten to not think kindly of them. They quietly refuse. The refusal is effortless, smooth, almost graceful in its disdain for the emergency department. From their point of view, you aren't even on the HPG.

You keep the patient. You do the work for the inpatient staff. They are happy. Because the entire inpatient staff would have resigned en masse if you had so cruelly hoisted the patient upon them prior to them becoming mentally centered, you have kept the hospital afloat yet another day. And because you haven't interrupted the Important Doctors upstairs, you get to keep your job. You have just been introduced to the HPG. The view from the bottom is not pleasant. They have learned that they can refuse, and that you can't do squat about it. Clarity is achieved. When too many patients come, we won't have hospital overcrowding. We'll just have ED overcrowding. How nice and simple!

Over time, you get used to this. You become the tragic hero of Sisyphean proportions. The battle has been lost, and prisoners have been taken. A generation of physicians is trained knowing that this is the Way of Things. Of course, it's a problem, so you go to meetings, write memos about the meeting, have a luncheon about the memo, and a memo about the luncheon. If there's a problem, then data must be collected! Once the data is collected, analyzed, and discussed, a memo must be written! The memo must say, Data must be collected! A committee of the hospital is formed called We Really Want To Fix This Problem So You Don't Have To Do All Our Work For Us. A report is expected from them within two years. They, of course, are sympathetic and appreciative. Sometimes, you get tired of collecting data that leads to no changes. You quit collecting data. This is a sign to others that the problem has gone away. The Fix This Problem committee is dissolved.

Then the day comes when you finally hit upon a solution. We have too many admitted patients in the ED, so let's try to stop our own patients from coming here! Thus an entire industry of ambulance diversion (so what if it doesn't work) and triage of patients away from the ED begins. An ambulance ride becomes a tour of the city. This is the Let's Send Our Own Business Away plan which, for some reason, has not caught on in other areas of industry. Ford seems unwilling to shut down their assembly line so they can serve as a garage for GM. Most unfortunately, our committed efforts to shoot ourselves in both feet without a gun have done nothing to reduce the crowd. Obviously, more data needs to be collected.

Now let's fast-forward to today. The number of hospital patients often will exceed the number of inpatient beds. Sometimes this is actually because there are too many patients, and not because too few doctors are discharging their patients or too many beds are being hidden from the system until change of shift. Today, everyone knows that admitted patients just belong in the ED until someone on the inpatient side undergoes a mood change. They really want to fix the problem, but it's ours until they do. It doesn't seem like that builds a lot of motivation on their part.

The emergency department had the clout of a wet noodle within the hospital power grid

I actually am lucky enough to work in a Reasonable Place where all the players involved understand that square feet are square feet, and hallways are hallways. We've discovered that there's not something special about ED hallways, unless having so little hallway would be deemed special. Overcrowding is viewed as a hospital problem, not an ED problem. Solutions are driven by what's best for all the patients, not to help the ED. They understand that we provide emergency care, and no one pretends anymore that we can provide even marginally adequate inpatient care in the ED.

We actually do move admitted patients to the inpatient service, even if there's not a normal bed for them, up to two per nursing station. Their hallways are actually pretty nice and quiet. There have not been massive resignations. In fact, this practice is now sort of viewed as a What was the big deal all about? By moving the patient upstairs shortly after admission, we reduced the length of stay for those patients by almost a day (which, by the way, represents zillions of dollars to the hospital's bottom line). This didn't happen overnight, but through a long and devoted process, everyone came to the conclusion that this was best for all of the patients.

The ED needs to fulfill its mission to provide timely emergency care to patients coming through the door, and not be the sewer for all the problems of the hospital. Our mission as physicians is to fight like junkyard dogs to make sure this happens. From a business aspect, if you provide a lousy service and long waits, then you'll lose everyone who has a choice, and be left with those that don't. This usually means the hospital and physicians are footing the bill. There go your staff and equipment.

Unfortunately, at many institutions, the value of the ED goes completely unappreciated. In large part, this is driven by misinformation, and the fact that historically we have been downstream from the HPG. Changing this is much like a chess game. It requires careful strategy, multiple moves on the board, looking several moves ahead, and always expecting (and hoping for) a draw, not checkmate. But it does require, as the first step, understanding that all of this has been dumped on us not because it makes sense (because obviously it doesn't), but because our profession, when it began, was not given a seat on the HPG.

Hospital overcrowding is a big problem, and it needs to be dealt with within the hospital, not within the emergency department. They need to do it like the OB department does it. Step one: We have a patient in active labor. The OB suite is overwhelmed, has no beds, no space. What happens? Step two: Life is tough. Rock and roll. Quit messing around and send us our patient. I really like those folks.

Moral of the story: Limit the blame for overcrowding. If you do, you can actually make progress. Twenty years of the Fix the Ills of Society Strategy have not worked. It's about time we tried something else. As the philosopher Rowdy Yeats said: Head 'em up! Moooove 'em out!