Managing Emergency Department Overcrowding

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OVERCROWDING

The issue of emergency department (ED) crowding and ambulance diversion first received national attention with sporadic reports in the late 1980s. It has been an increasingly significant national problem for more than a decade. Surveys of hospital directors have reported overcrowding in almost every state in the United States. Daily overcrowding has been reported by 10% to 30% of the hospitals surveyed. More than 90% of hospital ED directors reported overcrowding as a problem resulting in patients in hallways, full occupancy of ED beds, and long waits occurring several times a week.[1] Overcrowding has many other potential detrimental effects including diversion of ambulances, frustration for patients and ED personnel, lower patient satisfaction, and most importantly, greater risk for poor outcomes. Poor patient outcomes then create potentially significant risk management implications for providers. The combination of unhappy patients and adverse outcomes breeds an environment ripe for litigation. There is no evidence at present that ''the ED was just too crowded'' is a valid defense for medical malpractice claims.

Initial position statements from major organizations, including the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the General Accounting Office (GAO), suggested that the problem of overcrowding was a result of inappropriate use of emergency services by those with nonurgent conditions, probably cyclical, and needed no specific policy response.

More recently, these and other organizations have more forcefully highlighted the problem of overcrowding and focused on the inability to transfer emergency patients to inpatient beds as the single most important factor contributing to ED overcrowding.

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Standard-of-care treatment for specific disease entities certainly lowers the risk to patients and providers. But to successfully combat overcrowding, it must be looked at as an overall hospital issue, not as a problem of the ED. To quote a leader in overcrowding research, Brent Asplin,[2] "if you want to fix crowding, start by fixing your hospital." ED leadership must work in concert with hospital senior management to make substantive changes. This article gives a basic blueprint for successfully making hospital-wide changes using principles of operational management. The causes, significance, and dangers of overcrowding are discussed briefly and then specific solutions are provided.

HOW DID IT HAPPEN?

The 1980s and 1990s saw a steady downsizing in hospital capacity. American Hospital Association data showed 1.36 million hospital beds in 6933 hospitals in 1981, 927,000 staffed beds in 5370 hospitals in 1991, and 829,000 beds in 4950 hospitals in 1999. There were 4547 hospital EDs in the United States in 1991, and only 4177 remained by 1999.[3]

The most reliable data on ED visits come from the National Hospital Ambulatory Medical Care Survey (NHAMCS), which has been conducted annually since 1992 by the Centers for Disease Control's (CDC) National Center for Health Statistics (NCHS). During the period from 1992 to 1999, the number of ED visits rose by 14%; from 89.9 million annual visits in 1992 to 102.2 million in 1999.[4] More than half of this increase came between 1997 and 1999. The 2006 CDC NCHS survey documented a continuing increase in the number of hospital ED visits even as other data showed a further decline in the actual number of hospital EDs. In 2006, Americans made 119.2 million visits to hospital EDs, a 32% increase over the 90 million visits made in 1992. During the same period, the number of hospital EDs decreased by more than 10%.[5]

During this time period, a number of laws, programs, and other factors contributed to increased volume with a simultaneous decrease in reimbursement:

1. The 1986 Emergency Medical Treatment and Active Labor Act (EMTALA),[6] the law upheld by the United States Supreme Court, guarantees emergency medical care as a civil right extended to all US residents. The Act requires screening and stabilization to be provided for all who seek emergency care, regardless of the ability to pay, and threatens physicians and hospitals with explicit legal and financial penalties for noncompliance. There are no accompanying requirements for payors, public or private, to support such a mandate. There is no guarantee of payment for hospitals, emergency physicians, or on-call specialists who provide these services.
2. The Balanced Budget Act of 1999 cut net Medicare reimbursement.
3. The number of uninsured and underinsured persons in the United States has increased steadily during the same time period; in 1990 there were 35.6 million nonelderly uninsured patients, whereas in 1998, about 43.9 million nonelderly were uninsured.[7]
4. There is limited availability of off-hour services by primary care physicians.
5. Increased use of technology has led to referrals to the ED for computed tomography (CT) scan, magnetic resonance imaging, ultrasound, and other new technologies. Even well-insured patients are increasingly using EDs when primary care physicians are unavailable and the urgency and complexity of the problems do not allow for a scheduled, elective evaluation.