

Emergency Department Crowding: A Call for Unity

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None

ED crowding is a global issue. It impact on millions of patient every day. Crowding must be seen as patient safety and quality issue and not just as an operational issue. The evidence suggests that, while there are many factors contributing to ED crowding, emergency physicians must adopt a definition that centers on quality. The definition must include the dimensions adopted by the Institute of Medicine and follow the guidelines discussed above. Likewise emergency physicians must argue that ED crowding must rise to the same level of importance as eliminating wrong site surgery, decreasing hospital acquired infections and the other goals listed in table 1. Emergency physicians must argue that national and regulatory standards addressing patient be implemented and adhered to by hospitals. The time has come to accept that the factors associated with crowding are not within the control of emergency physicians during their day to day activities. While adding resources to our emergency departments may be helpful, asking or demanding increased productivity form EPs and ED staff will not correct this problem. While multi-factorial the reason for ED crowding are not found in the influx of patients or the internal processes of the ED. The reasons are in the output; they are found within the processes of the organizations emergency departments support. Staffing critical care beds, allocating general acute care beds for ED patients and transporting these patients to those beds are the essential components to solving this global crisis. ED crowding has been present for over twenty years. The time has come for a unity of purpose, definition, research, solution and adherence following established guidelines for the delivery of quality care. [Emergencias 2011;23:59-64]

Key words: Emergency department. Crowding. Delivery.

Introduction

All citizens deserve equitable, lifelong, affordable and expedient health care. The goal of a national health care delivery system is to meet that challenge. Health systems should provide comprehensive primary care focusing on preventing illness with rapid access to evidence based acute care. There are many different national health care delivery models. One commonality is the cost of providing health care (Table 1).

For example, the Australian health care system is a mixture of public and private sector health service providers and a range of funding and regulatory mechanisms. Medicare and the Pharmaceutical Benefits Scheme cover all Australians and subsidize their payments for private medical services and for a high proportion of prescription medicines. In addition families or individuals that pay private health insurance premiums are eligible for the Federal Government 30% Rebate on pri-

vate health insurance¹. The Canadian health care system is a federally sponsored, publicly funded single payer system, with most services provided by the private sector with basic services are provided by private doctors, (since 2002 they have been allowed to incorporate), with the entire fee paid for by the government at the same rate. Some services such as prescriptions, optometry and dental care are not covered². In Taiwan, the national health insurance is a single payer, government sponsored program that promises access to all citizens. Patients incur a small out of pocket expense and the Bureau of National Health Insurance, through a global budget system, covers the balance³. The U.S model relies primarily on private insurance with social security based coverage for seniors (Medicare) and coverage for the poor (Medicaid). There is no national health care plan.

Health care systems should create a safe environment in which to provide patient care. Systems that provide quality care reduce unnecessary

Table 1. Changes proposed by the campaign “5 million lives”

- Deploy Rapid Response Teams.
- Deliver Reliable, Evidence-Based Care for Acute Myocardial Infarction.
- Prevent Adverse Drug Events (ADEs).
- Prevent Central Line Infections.
- Prevent Surgical Site Infections.
- Prevent Ventilator-Associated Pneumonia.
- Prevent Harm from High-Alert Medications.
- Reduce Surgical Complications.
- Prevent Pressure Ulcers.
- Reduce Methicillin-Resistant Staphylococcus aureus (MRSA) infections.
- Deliver Reliable, Evidence-Based Care for Congestive Heart Failure.
- Get Boards on Board.

variability, decrease error and harm and can decrease cost. The Institute of Medicine (IOM) has defined quality as: “The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge”. The IOM through its influential manuscript *Crossing the Quality Chiasm* has identified the need to improve processes and has articulated strategies and plans to develop a safe health care system. It has developed six aims for improvement that define health care as safe, effective, patient centered, timely, efficient and equitable⁴. It is a provocative definition challenging physicians to move away from the concept of one patient at a time, to incorporate and consider the patient’s desired outcome and do so while adhering to accepted evidence based guidelines.

The goal of the Institute for Healthcare Improvement is to improve the lives of patients. The Institute for Healthcare Improvement has launched the 5 million lives Campaign focusing on twelve changes (Table 1)⁵.

Emergency departments provide acute care, access to advanced technology and innovative protocols and procedures for all patients who enter through their doors. Despite the many different national public health models, efforts to improve quality and diminish error, rising cost of health care, and attempts to maintain access and deliver evidence based care we continue to experience crowding in our emergency departments. Evidence of severe crowding existed in 1991 among large teaching hospitals in the United States⁶. In 1990 the American College of Emergency Physicians (ACEP) published a list of measures to deal with crowding⁷. Sixteen years later ACEP published another policy statement dealing with crowding⁸. The question is why does this continue? Lack of a functional definition of crowding, increases in demand for ED services with de-

creasing supply, increasing complexity of ED patients, and disagreement on the influence of input vs. output all impact on patient outcomes.

Definition

The emergency medicine literature does not have one accepted and validated definition for crowding. Most emergency physicians would say their department is crowded when the demand exceeds the availability of ED beds. Others define it based on the ability to transport patient to inpatient beds. Mathematical models intended to identify and to predict ED overcrowding have been developed^{9,10}. The American College of Emergency Physician, in its 2006 policy statement, provides the following definition: “Crowding occurs when the identified need for emergency services exceeds available resources for patient care in the emergency department (ED), hospital, or both”¹¹. Lack of an accepted definition along with not having objective measures of ED quality and crowding have made it difficult, until recently, to assess the impact of crowding on the delivery of quality care¹¹. A more provocative definition, that potentially brings together the requirement for operational concepts and quality, is found in an editorial by Pines in which he states: “an ED is crowded when inadequate resources to meet patient care demands lead to a reduction in the quality of care”¹². Longo argues that the following should be considered in the selection of quality measures: 1. Conceptualize quality of care as multidimensional, 2. Assess and validate the reliability of measurements 3. Results must be statistically significant and clinically relevant 4. Quality measurement should assist in safeguarding the public trust¹³.

Supply and Demand

In the United States, from 1996 to 2006, annual visits to emergency departments increased from approximately 90 million to 118 million visits, a 31% increase (Table 2). The mean wait time to see a physician increased from 45.1 minutes in 2000 to 55.8 minutes in 2006^{14,15}. During this same period the number of emergency departments decreased from 4019 to 3833. In California, between 1990 and 1999 there was 12% decrease in ED beds¹⁶. Spain noted a 14.5% increase in ED visits from 2001 to 2005¹⁷. Increases in immigration have also resulted in increased utiliza-

tion of emergency hospital services¹⁸. Use of ED services by immigrants suggests different patterns of use with variations in gender and age and a lower cost than naturalized citizens; perhaps suggesting lower acuity¹⁹. Australian hospitals have noted a 15% increase in accident and emergency occasions between 2002-2003 and 2006-2007²⁰. In 2007 47% of surveyed hospitals in the United States reported being at or over capacity with 73% percent of teaching hospitals and 65% of urban hospitals reporting being at or over capacity. The most common reasons for ambulance diversion were lack of staffed critical care beds, ED overcrowding and lack of general acute care beds²¹.

Complexity

Infants less than 12 months old had the highest annual per capita ED visit rate with 84.5 visits per 100 infants (U.S. 2006), 75% of which were to general hospitals. Senior citizens over 75 years old had the second highest per capital ED visit rate with 60 visits per 100 persons. The most common complaints for children were fever, cough, vomiting and earache. For patients over 15 years of age the most common complaints were chest pain, abdominal pain, back pain, headache and shortness of breath. There were 1.9 million visits due to adverse effects of medical treatments and 2.2 million visits due to alcohol or drug use. Patient acuity, rated on a four level triage category using emergent, urgent, semi-urgent and non-urgent revealed modest changes from 2001 to 2006. Emergent visits accounted for 19-15.9% of visits with urgent visits accounting for 31-36% of visits. Semi-urgent visits increased slightly from 16% to 22% of all visits and non-urgent visits decreased from 20% to 12%. A higher proportion of patients age 65 and over were triaged as emergent or urgent¹⁵. This data supports the opinion that the overall complexity of ED patients has increased. An aging population with chronic disease and multiple co-morbidities will present to emergency departments more frequently and require intensive and time consuming evaluations. This population will require greater use of diagnostic technology. Young children too can challenge experienced providers and require extended periods of observation. It is clear that greater emphasis must be placed and increased resources made available to improve the care delivered to children in emergency departments²².

Demographics

It has been suggested that patients with non-urgent complaints have cluttered our waiting rooms. Frequent users of ED services have been studied as potential abusers of services and contributing to ED crowding. Finally, the uninsured have been held responsible for the increase in ED visits in the U.S. Recent research refutes these opinions.

In the U.S. visits by patients with non urgent complaints from 2001 to 2006 have decreased from 20% to 12% of all visits. Others have estimated the frequency range to be 4.8% and 82%²³. The confusion rests on the variable definition of non-urgent. One recent Canadian study demonstrated that patients with non urgent complaints do not impact on the timeliness of care for acutely ill patients and that diverting these patients to other areas would have little impact on crowding. In an analysis of over 4 million visits the authors concluded that the impact of non urgent patients on the time to be seen by a physician and length of stay for non low complexity patients was not clinically significant²⁴. A study conducted in Portugal concluded that the majority of visits to the ED (68.7%) were appropriate and that inappropriate visits were not the main contributor to ED crowding²⁵. Researches in Sweden demonstrated that frequent users of ED services also used primary care services frequently and had a higher mortality, presumably because they were sicker than average²⁶. This observation was corroborated by researches in the U.S. who concluded that frequent users of ED are in poorer physical and mental health. The authors also noted that these patients had health insurance and a regular source of care²⁷. In Taiwan, factors associated with frequent ED use were: a regular source of care, alcoholism, higher clinic utilization and multiple markers for chronic disease²⁸.

Non urgent patients are similar to urgent and semi urgent patients. Seventy percent of non urgent patients have a primary care physician compared to 75% of semi urgent and urgent patients. Despite the availability of primary care physicians only 22% of non urgent patients and 27% of urgent and semi urgent patients contacted their physician prior to visiting the ED. Of equal interest was the fact that 22% of non urgent patients were referred to the ED by their primary care physician²³. Patients with non urgent complaints may see the ED as more convenient than making an appointment with their primary care physician. In addition, some physicians practice defensively

and send patients to the ED instead of having to deal with them in their office²⁹. McCabe provides clarity to the debate of the impact of non urgent visits to the ED when he states: "It was thought that patients arriving in the emergency department with simple complaints (e.g., ankle sprain, cold, medication prescription refill, etc.) were clogging up the system and were the cause of emergency department overcrowding. This was not true then and is not true now"³⁰.

The number of uninsured in the U.S. population has remained relatively stable. The rate varies within age groups, race and household incomes, but between 1995 and 2004 the national uninsured rate ranged from 15.4% and 15.7%³¹. In 2006 the rate was approximately 17.4%¹⁶. Weber and colleagues have provided evidence that between 1996 and 2004 the proportion of visits to the ED by the uninsured remained stable. They noted an increase in visits by more affluent patients and those with access to primary care physician³². It appears that most of the increase in ED visits in the U.S is due increased use by insured patients.

Input and Output

Factors affecting patient flow and impacting on ED crowding can be divided into two broad categories. Input factors include the impact of uninsured, non urgent and frequent visitors as well as the effect of seasonal illness on ED crowding. Output research focuses on the effect of ED boarding and hospital occupancy rates³³. It is clear that input factors are not the primary cause of the problem³⁴. Output factors, specifically the inability to transfer admitted patients to an appropriate inpatient hospital bed and institutional capacity, are the main reason for ED crowding^{14,35}.

Outcome

Emergency department crowding has been associated with poor service and delivery of medical care. As of December 2008, 4.5% of sentinel events reported to the Joint Commission occurred in emergency departments. Two recent studies have demonstrated a relationship between ED crowding, measured as ED volume, number of patients in the waiting room and mean length of stay for admitted patients, and the ability to comply with the timing of antibiotic administration for patients with community

acquired pneumonia. Timing of antibiotic delivery was chosen as it has been adopted by regulatory agencies as a measurement of ED quality. Both studies concluded that ED crowding had a negative impact on the timeliness of antibiotic administration^{14,37}. Adherence to accepted clinical guidelines is limited by ED crowding. Diercks and colleagues demonstrated that adherence to American College of Cardiology/American Heart Association guidelines for the treatment of non-ST segment elevation myocardial infarction was limited by the length of stay of the patient. Patients with long LOS were less likely to receive selected medications, and less likely to undergo cardiac catheterization and revascularization procedures. While mortality rates were similar, there was an increase in recurrent in hospital myocardial infarction in the group with a longer LOS³⁸. Patients presenting to a crowded Australian ED, defined as occupancy with patients under treatment, were less likely to begin treatment within established triage threshold times, more likely to leave without being seen and experienced a significantly higher 10 day in hospital mortality. The study showed that adjusting for triage differences did not diminish the mortality rate³⁹. Using hospital occupancy rate and ED occupancy by patients waiting for an inpatient bed, Sprivilis and colleagues noted an increase in patient mortality with increases in both indices. There was a 30% relative increase in mortality by day 2 and 7. This rate was independent of age, season, diagnosis and urgency⁴⁰. Inappropriate pain management occurs in the ED. It depends on race, gender, physician and it is related to crowding. Delays in administering pain medication or not receiving pain medication were related to number of patients in the waiting room and ED occupancy rate⁴¹.

The number of patients leaving without being seen by a physician is another measure of ED quality. In addition these patients represent a source for medical legal risk as approximately one third of them may conditions that require admission to a hospital. Rates of patients who leave without being seen have been relatively stable in the U.S. Reasons for leaving without being seen include urban hospitals, non urgent complaints, and lack of insurance⁴². Patients tend to leave without being seen more frequently when ED occupancy rates reach 140%. Of interest is the association between leaving without being seen and lack of emergency residency training of the attending physician on duty⁴³.

Results

ED crowding is a global issue. Its impact on millions of patients every day. Crowding must be seen as a patient safety and quality issue and not just as an operational issue. The evidence suggests that, while there are many factors contributing to ED crowding, emergency physicians must adopt a definition that centers on quality. The definition must include the dimensions adopted by the Institute of Medicine and follow the guidelines discussed above. Likewise, emergency physicians must argue that ED crowding must rise to the same level of importance as eliminating wrong site surgery, decreasing hospital-acquired infections, and the other goals listed in table 1. Emergency physicians must argue that national and regulatory standards addressing patient care be implemented and adhered to by hospitals. The time has come to accept that the factors associated with crowding are not within the control of emergency physicians during their day-to-day activities. While adding resources to our emergency departments may be helpful, asking or demanding increased productivity from EPs and ED staff will not correct this problem. While multi-factorial, the reasons for ED crowding are not found in the influx of patients or the internal processes of the ED. The reasons are in the output; they are found within the processes of the organizations' emergency departments' support. Staffing critical care beds, allocating general acute care beds for ED patients, and transporting these patients to those beds are the essential components to solving this global crisis. ED crowding has been present for over twenty years. The time has come for a unity of purpose, definition, research, solution, and adherence following established guidelines for the delivery of quality care.

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La saturación de los servicios de urgencias: una llamada a la unidad

Flores CR

La saturación de los servicios de urgencias hospitalarios (SUH) es un problema global que afecta a millones de pacientes cada día. Debe considerarse como un problema que afecta a la calidad y la seguridad de los pacientes, y no sólo como un asunto que afecte a la organización. La evidencia sugiere que mientras que hay muchos factores que contribuyen a la saturación de SUH, los médicos de urgencias deben adoptar una definición que se base en la calidad. La definición debe incluir las dimensiones adoptadas por el *Institute of Medicine* y seguir las guías recomendadas. Asimismo los *urgenciólogos* deben argumentar que erradicar la saturación de los SUH debe alcanzar el mismo nivel de importancia que eliminar errores quirúrgicos, disminuir el número de infecciones nosocomiales y otros objetivos destacados. Los *urgenciólogos* deben defender que los estándares reguladores nacionales dirigidos al paciente sean implantados y tenidos en cuenta por los hospitales. El tiempo ha venido a demostrar que los factores asociados con la saturación de urgencias no están dentro del control de los médicos de urgencias durante sus actividades diarias. Mientras que aportar recursos a nuestros SUH puede ser de ayuda, pedir o demandar un incremento de la productividad de los *urgenciólogos* y de los SUH no corregirá este problema. Aunque que hay múltiples razones que explican la saturación de los SUH, éstas no se encuentran en la entrada de pacientes o en los procesos internos de los servicios de urgencias. Las razones están en las salidas, dentro de los procesos de los departamentos que dan soporte a los SUH. La provisión de camas de cuidados críticos, la asignación de camas para pacientes agudos de urgencias y el traslado de estos pacientes a estas camas son componentes esenciales para resolver esta crisis global. La saturación de los SUH ha estado presente durante más de 20 años. Ha llegado el momento para un consenso en el objetivo, la definición, la investigación, la solución y la implantación de ésta siguiendo las guías establecidas para proporcionar calidad en la atención médica. [Emergencias 2011;23:59-64]

Palabras clave: Servicios de urgencias hospitalarios. Saturación. Calidad.