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On-Call Crises in the Emergency Department

It is 2:00 a.m., your patient's family wakes you up because mom has CHF again and she has been waiting in the ED 4 hours before bed and they want to know why? Do you want to know why?

You are listening to ReachMD 160, The Channel for Medical Professionals. Welcome to the clinicians roundtable. I am Dr Shira Johnson, your host and with me today is Dr. Scott E. Rudkin. He is the Vice-Chair, Assistant Dean, and Associate Clinical Professor of Emergency Medicine at the University of California, Irvine School of Medicine. Dr. Rudkin has a study recently published in American Journal Of Emergency Medicine on the worsening of ED on call coverage in California and he has been an invited speaker at many medical conferences on emergency room overcrowding and the results in economic and medical impact. Today, we are discussing the ongoing and not yet resolved issue of emergency room overcrowding.

DR. SHIRA JOHNSON:

Welcome Dr. Rudkin

DR. SCOTT E. RUDKIN:

Thank you for having me here.

DR. SHIRA JOHNSON:

So we both heard more about emergency room overcrowding in the last 5 years than probably the entire 15 years in front of that. What are some of the reasons that it is not getting any better or is it?

DR. SCOTT E. RUDKIN:

Oh! I think what happen is roughly over the past decade, we have seen EDs closed. We had a 10% decrease at least in California, 10% close to 1999 to 2000. We also saw an increase in patients of approximately 20% from about 90 million up to 110 million. So that increase in patients decrease in beds as well as decrease in reimbursement of managed care stepped in, it becomes more and more difficult to get the patients cared for.

DR. SHIRA JOHNSON:

So what is some of history behind this ED overcrowding? Was not there a time when hospital administrators thought it was only a problem for the emergency room and now they realized it impacts everyone?

DR. SCOTT E. RUDKIN:

Really this issue comes in when input-throughput-output model. Really, it is supply demand. If the system gets overwhelmed with demand and supply can't keep up, you have a crunch point. For the input phase, you have a lot of patients to come in, lots of patients realize that what can take 6 months to be done in an outpatient's office, we can do in 6 hours. So you got the walk-in only we call them who come in with their insurance, even those without funding because in taller mandates we must care for all patients. Always patients come in. The throughout phase "we own this part", the ED can control that part. We can get the patients cared for rapidly, but its really the backdoor. If we cannot place our patients, we have to board them in the ED. There are frequently nights where I have to board half my ED. We have got patients willing to go upstairs. They have shown and actually patients await in the ED, they <_____> outcomes patient harm.

DR. SHIRA JOHNSON:

You mentioned EMTALA, remind our listeners what is EMTALA?

DR. SCOTT E. RUDKIN:

EMTALA is an emergency medicine treatment and active labor act. It was actually hidden away in the Cooper bill of 1986. Really this was a lot of signed good on paper. It was in a lot of trying to combat patient dumping. Back in early 80s, it restores the patients being driven around trying to find a local hospital that was open. It was actually a death case back in the mid west where the patients who have been seen earlier were brought back and their hospital refused to see the patients. What EMTALA says that if you receive medical fund which basing everything on hospital, you much accept all patients regardless their ability to pay and once you screened them take care of them, once you stabilize their emergent medical condition, you can then ask them for insurance of their cash, but until that point, you must care for them regardless of their funding. Again, on paper, it sounds great. The only problem was, it is called

the unfunded mandate, there was no money behind this to pay for it. So really the Federal have shifted their responsibility for this on to the states and on to the local ED docs.

DR. SHIRA JOHNSON:

Wasn't there some changes in the interpretation of EMTALA around 2003.

DR. SCOTT E. RUDKIN:

Unfortunately yes. We actually thought it was going to become stronger, but in their attempt to clarify, they actually weakened it. EMTALA is very simple and it says you must care for patients who <_____> the problem is as emergency physicians were the excerpts of the first 2 hours of your care. If you are really sick, we can keep you alive for the first 2 hours. The problem is we need specialty care to help us. When I called to have someone referring to the hand surgeon come in to help me, he or she may not want to come in and we thought the EMTALA was we are going to become stronger and really force used folks to come in and help out where really being soft and said, they don't have much <_____> is lost now, so there is less impact for them to come in.

DR. SHIRA JOHNSON:

So, now you do not have to have a hand surgeon or plastic surgeon, etc. on call, is that correct even if you have them in your hospital?

DR. SCOTT E. RUDKIN:

Unfortunately yes. Luckily, I work at a level-1 trauma center, academic center, so I have got everything possible, but I see local hospital around me. We get transfer less than right and EMTALA is very clear too there is no boundary. As long as you are <_____> the US boundaries, you could be in Alaska and if they call me down here in Orange County, California I must accept the patient. It's kind of a screw law.

DR. SHIRA JOHNSON:

But they can delay in accepting the patient, correct?

DR. SCOTT E. RUDKIN:

Yes. It can happen they can delay, they can play games and stuff, and its really it is a broken system.

DR. SHIRA JOHNSON:

So looking at it naturally then, would you say ED overcrowding even over the last 5 years is getting worse?

DR. SCOTT E. RUDKIN:

Oh! there is no question. With fewer and fewer patients having access to care, again we think that this has been an uninsured problem that really if they caused and its really more than the ensured promise. The patients are more and upset with their ability to access care. They are coming to us and more and more <_____> like I said we have seen rapid increase in patients and those are really the patients who are funded. Overcrowding is coming to a point where we talk about the phasing that wear true your choke point. We are the last bastion of care for most folks and we have talked about this. If we have anything that could make system worse, symptom as <_____> or something, the system would come to a halt.

DR. SHIRA JOHNSON:

So, the payer does not make it better if you have more insured patients or privately insured patients, you still may back up?

DR. SCOTT E. RUDKIN:

Watching from our study in both 2000 and 2006, we looked this question and what we found was that if a patient got hurt in an area where the hospital has mostly unfunded patients and they are mostly black Hispanic, it does not make a difference what kind of insurance you have. It's very unlikely for them to have coverage. You could have the best insurance known to man and yet you get hurt in an area <_____> you driving cars in area where the hospitals pour, you may not get coverage.

DR. SHIRA JOHNSON:

Tell us more about hospitals closing their emergency room in California. Is that something that's at risk for being international trend?

DR. SCOTT E. RUDKIN:

Well, I think that we saw a phase of contractions which again from about 1992-2000, we did see about 10% closures because for the

longest time, hospital admin folks always thought about the ED as being the, you know, waste land, all those ER doc and what they are doing. What they found the less than 5 years or so is a tend that most hospitals want to have the admits come to the ED. They realize that actually emergency department can be a profit center if they are run well and they view this is a systems problem and start to cancel elective cases and really try to smooth their admits. The ED gradually becomes part of the whole system and those hospital have actually taken this and looked again to using <_____> model, but really it has been a system approach. The input phase is trying to control the patients who arrive, make outpatient appointments available for patients, who have come to us. The throughput phase give the ED doc the tools to get the patient in and out faster and really making sure that patients do not board both in the ED and making sure that the patient upstairs have beds to go to. That is the most important thing that could be done.

DR. SHIRA JOHNSON:

If you have just joined us, you are listening to ReachMD 160, The Channel for Medical Professional and I am Dr Shira Johnson, who is speaking with Dr. Scott E. Rudkin and we are discussing emergency room overcrowding as an issue that affects all of us. Tell us a little bit more about his model that you are referring to?

DR. SCOTT E. RUDKIN:

<_____> model which is very basic and you think about up <_____> powerful. There is a breakdown of whole approach into 3 phases. You got the input phase, throughout phase, and output phase. The input phase is anything that really usually demands your services. You've got clinic patients who can't see their doc, they don't want to come to the ED for care. You've got patients with no other extra care. If you can try to reduce the demand by giving the patients other options where to go, that can help a whole system out. The throughput phase is the part that is wait controlled. This is really how fast you can make the system expand. We've done a fairly good job at most EDs of making our processes efficient, we do a lot of parallel processing, we do multiple tests at one time, we don't wait for sequential testing. To try to get them worked up is <_____> possible. The problem becomes in the output phase. This is the backdoor. We can very efficient in a throughput phase, but if there is no push to put those patients, we quickly have our system backup and that's when we <_____> board patients in health, patients wait in the ED. We've had patients in the ED waiting as long as 2 to 3 days and it's unfortunate these patients who get inferior care in the ED because our nurse are not trained for inpatient care and these patients frequently are discharged from the ED after a 3-day stay.

DR. SHIRA JOHNSON:

From a county hospital and problem is not isolated to California, was the same in our facility, Miami. So, in the past, we know why administrators weren't more responsive. They viewed it as an ER problem, not as their problem, but now in this day and age, why aren't administrators getting more responsive?

DR. SCOTT E. RUDKIN:

It's a chestnut to crack. I think what happened is you need to have our local champion, I <_____> who have had several times we

met and it's really about culture change. It's breaking down barriers to say this is not an ED problem or an inpatient problem. It's a systems problem. We need to share this issue. We and our hospital have only recently come to grips <_____>, because it took us 2 years of really bringing folk to the table, inpatient/outpatient folks have one and the same lesson. How we are gonna fix it through the system? Once you can an inpatient <_____> nurses, docs to believe that this is a systems issue, not just an ED issue, that's #1. Once you can break the most barriers, you can look at how often do you have patients who go upstairs, how often do they affect the high beds as <_____> nurse would be very nice to kind of slowly quit the bad. You will have to get a new patient.

DR. SHIRA JOHNSON:

Spies to go up and look on the floors to see where are their beds?

DR. SCOTT E. RUDKIN:

Exactly.

DR. SHIRA JOHNSON:

What are the numbers on ED diversion and remind our listeners what diversion is and what you have at your facility? How does that input the model you just referenced?

DR. SCOTT E. RUDKIN:

Exactly. ED diversion happens and actually in our county where we actually look at <_____> of going to no diversion <_____>. Actually, the patients do <_____> divert, but diversion is a case where when you are in an ED and you are about to go down, which means basically every bed as almost full, may be they have 1 or 2 more beds. What you will do is you will tell the ambulances we've no more capacity, so please go elsewhere. Once they make patients go, you know, 5 to 10 miles further to a different hospital, and occasionally it may not be their home hospital which makes it very hard to care for these patients. So, ED diversion can run from anywhere from 10% in some hospitals up to 70%, some hospitals reported being down, 70% of the time that they can fit new patients, they are chronically constipated.

DR. SHIRA JOHNSON:

Does your fire rescue have permission to override diversion for a cardiac arrest or certain critical situations?

DR. SCOTT E. RUDKIN:

If there is an airway issue, they can go to local host regardless because they need to get the airways cured. We are actually in our county were the first kinds to have a trauma system. We initially had different tiers. We frequently will go down from more basic medical <_____> to stay open as a level 1 tertiary care center, will stay open for more advanced cases, which kind of creates <_____> issue too because we are selectively open ourselves up which can create an issue for us. So, it's are real sticky issue because we are up for trauma which means multisystem traumas, if someone is having a stemming, we can take those folks; if they are having a stroke, we can take them. That is creating a very weird thing where you ought to be sick enough to override this diversion status and actually our counties look in carefully <_____> no divert policy saying everyone is just up, you can't go down.

DR. SHIRA JOHNSON:

What are the numbers, what can we share with our listeners on mortality associated with overcrowding?

DR. SCOTT E. RUDKIN:

This is tougher enough to crack. I have heard of anecdotal reports about patients harm <_____> from a divergence status. I don't have any concrete numbers to share.

DR. SHIRA JOHNSON:

Well there is always the anecdotal reports of somebody who is in the triage are too long, chest pain was thought to be atypical, the didn't get back, and they had a cardiac arrest, correct?

DR. SCOTT E. RUDKIN:

Oh, that is common. We've got a local sister hospital here recently. They had a patient who got an EKG in a waiting room, wasn't <_____> with doctors were backed up, died, I mean there has been case in New York that is unfortunately <_____> common occurrence. We almost tuned out now.

DR. SHIRA JOHNSON:

You tell me where our listeners may go for more information?

DR. SCOTT E. RUDKIN:

There are just a couple that they can go to, one them is acep.org. ACEP, the American College of Emergency Physicians, has several white papers on this topic. It's a great reference.

DR. SHIRA JOHNSON:

Our thanks to Dr. Scott Rudkin, who has been our guest. We have been discussing emergency room overcrowding, how it affects our practice of medicine? I am Dr. Shira Johnson, you've been listening to the clinicians' roundtable from ReachMD 160, The Channel for Medical Professionals. Please visit our website at reachmd.com which features our entire library through on demand podcast and thank you for listening.

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