Metric Madness

Name Withheld Per Request

Some years ago, a friend of mine who is a family counselor told me, "You have high expectations in an unrealistic environment." She meant working in an emergency department. She meant being a physician. I have heard this several times over the years from people in other industries.

Most emergency physicians treat their patients like family. We would want our spouse, sibling, child, or parent to be treated exceptionally well in the emergency department. This aspiration leads us to have high expectations of ourselves and to strive for excellence.

The emergency department **is** an unrealistic environment. It may seem normal to us, but what we do is crazy compared to other jobs and to other settings in the medical world. We do not work in an office or operating room, which is typically elective, linear, and for the most part controlled. Our environment forces us to be multitasking efficiency experts, faced with numerous variables out of our control, overwhelming information flow, interruptions and personal interactions — all at once! And the pressure keeps building: CMS, the Joint Commission, ABEM, state and hospital requirements, etc.

One for-profit hospital chain has now placed even more demands on its physicians and nurses: metrics (beyond those now required by the federal government). A "metric" is a time-based measurement related to the documentation of an activity by a clinician. A metric is either within arbitrarily set limits or outside those limits, and if outside the limits is printed in red on the report sent to the hospital administrator each month. Many of the metrics used by this hospital chain conflict with each other, making it impossible to meet all of them simultaneously and adding to the unrealistic demands placed on the emergency department. Hospital administrators may use the failure to meet metric standards as a reason to discipline or fire emergency physicians.

Here are some examples of those metrics. I now have to see patients in ten minutes or less from the time of their arrival in the ED — not from the time they arrive in an exam room, but from the time they walk up to reception. And even if more than one patient arrives at the same time, I am not allowed to sign up for more than one at a time on the EMR (electronic medical record). There must be at least two minutes between sign-ups. Try complying with those conditions in a 40,000 patient/year department!

Next is the "push to fill" rule. I am responsible for eight rooms, and if three of the rooms empty and fill again, I remain responsible for the ten minute metric on those patients and subject to the two minute lockout. If I am in a room working on a septic patient and cannot leave when those three rooms fill, that's just too bad for me and my statistics.

But that is just the beginning. There is also a thirty minute metric, measured from the time of patient arrival to the ordering of laboratory and radiology tests. There is a thirty minute metric from patient arrival to the administration of pain medicine for a suspected long bone fracture — not the **ordering** of pain meds, but the **reception** of those meds by the patient. Distal fibula fractures that look like a sprained ankle and buckle fractures in a child's forearm are included in this metric. If the nurse cannot give pain medicine or draw blood within the thirty minute window, at the end of the month that metric is highlighted in red under my name.

Last is the length of stay (LOS) metric, set at three hours. It does not matter why the patient is still in the department after three hours. Whether it is related to my management or circumstances beyond my control, I am responsible for the LOS.

In 2012, a boarded emergency physician in my hospital system was asked to resign from a very high acuity, high volume emergency department because of bad LOS metrics. There was no discussion with the hospital CEO about delays in getting patients to the floor. It was the physician's fault entirely. The CEO took no responsibility for the functioning of his inpatient units.

Since violating LOS has become a firing offense, other metrics are undoubtedly fair game too. I am an independent contractor and have no recourse, since I am sure the corporate contract management group (CMG) I work for isn't watching my back. Since the hospital chain and the CMG have monopolies in the region, I may well have to move if I am fired. Or maybe I'll become a travel doctor — Texas is sounding pretty good right now.

The use of metrics is not inherently unreasonable. It is one way to establish parameters for tracking the passage of time in relation to volume and acuity. Metrics give us a quantitative way to think about our efficiency and

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performance. However, in this system the metrics actually conflict with each other, making them impossible to achieve. They do, however, satisfy the data-dependent manager who mistakenly equates good patient care with an isolated number. Not surprisingly, as far as I know, no practicing emergency physicians or nurses — the true efficiency experts in the ED — were consulted on choosing or implementing ED metrics.

What **would** be useful is a daily database of information to review and evaluate. Data related to surges, staffing at the time of surges, timing of ancillary services ordered and completed, the acuity level associated with the number of patients per hour, LOS, and other multivariable data points. These data could be evaluated and used to develop a "trigger" system that responds to the needs of the ED, as well as the needs of a variety of other departments.

A simple example: if five admitted patients remain in the ED for more than four hours, then the house supervisor activates hallway beds on inpatient units. Although establishing such a policy does not require researching a database, imagine how such information would help justify that kind of rule and assist in ED management. With this approach, and with emergency physicians' involvement, a more relevant and productive system of triggers and metrics could be designed — and used for management improvement rather than as a threat. This type of database is possible: I have seen one in action.

One additional note on this situation: the CMG I work for is now sharing its profits from my hard work with the hospital chain through a joint venture — a win-win for them, and another blow to morale for me. The current situation is extremely discouraging. Many of my colleagues feel the same way. We are watching our industry consolidate into regional monopolies, with decisions that have huge impacts on clinical quality made by nonphysicians who are clueless as to what constitutes good patient care, while emergency physicians become economic pawns with less and less power — even in their own departments. ■