# CDC Report on ED Capacity

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The Centers for Disease Control and Prevention (CDC) recently released a report entitled ***Estimates of Emergency Department Capacity: United States, 2007***. This report is based on data from the CDC's 2007 National Hospital Ambulatory Medical Care Survey (NHAMCS). Inaugurated in 1992, the NHAMCS is now the longest continuously running national survey of hospital ED use.

The report notes that over the last several decades, the role of the ED has expanded from primarily treating seriously ill and injured patients. The report recognizes that EDs now also provide urgent and unscheduled care to patients unable to access their providers in a timely fashion and provide primary care to Medicaid beneficiaries and uninsured patients. As a result, EDs are frequently overcrowded with the most common contributing factor being the inability to transfer ED patients to an inpatient bed once the decision is made to admit them. "As the ED begins to 'board' patients, the space, the staff, and the resources available to treat new patients are further reduced," the report states. It continues, "A consequence of overcrowded EDs is ambulance diversion, in which EDs close their doors to incoming ambulances. The resulting treatment delay can be catastrophic for the patient."

According to the CDC survey, approximately 500,000 ambulances are diverted annually in the United States. The survey also shows that large EDs serving more than 50,000 patients each year represent just 17.7% of all EDs in the nation, but account for 43.8% of all ED visits in 2007. The implication, according to the report, is that small EDs with annual visit volumes of less than 20,000 patients may not experience crowding.

Other data from the survey show that about one-half of all hospitals with EDs had a bed coordinator or "bed czar," 58% had elective surgeries scheduled five days a week, and 66% had bed census data available instantaneously. Electronic medical records (EMRs), either all electronic or part paper and part electronic, were used in 62% of EDs. Basic EMR systems containing patient demographics, problem lists, clinical notes, prescription orders, and laboratory and imaging results were reported in 15% of EDs. However, the CDC could not accurately determine the prevalence of fully functional EMRs that also include features such as electronic transfer of prescription orders, warnings of drug interactions or contraindications, and reminders for guideline-based interventions.

Additional survey data show:

- Overall, 62.5% of EDs reported that they board admitted ED patients for more than two hours while waiting for an inpatient bed. Among EDs that board patients, 14.8% use inpatient hallways or other space outside of the ED when critically overloaded. A "full capacity protocol" that allows some admitted patients to move from the ED to inpatient corridors while awaiting a bed was used by 21.1% of EDs.
- EDs with more than 20,000 annual visits comprised more than 70% of EDs in metropolitan statistical areas (MSAs). When compared to EDs in rural areas, EDs in MSAs were more than twice as likely to board patients for more than two hours in the ED while waiting for an inpatient bed (77.4% versus 32.8%).
- More than one-third of EDs had an observation or clinical decision unit. About a third of EDs used a separate fast track unit for non-urgent care.
- In the previous two years, 24.3% of EDs increased their number of standard treatment spaces, and 19.5% expanded their physical space. Of those EDs that did not expand their physical space, 31.5% plan to do so within the next two years.
- Zone nursing was employed in 35.3% of EDs. "Pool nurses" that can be pulled to the ED to respond to surges in demand were available in 33.2% of EDs.
- Bedside registration was used in 66.1% of EDs, with 40% using computer-assisted triage. Electronic dashboards were utilized by 35.2% of EDs, and 9.8% used radio frequency identification tracking.

## GAO Study Finds ED Crowding Continues

According to a Government Accountability Office (GAO) report released June 1, hospital EDs continue to be overcrowded, with lack of access to inpatient beds continuing as the main contributing factor. The GAO first reported that most emergency departments experienced some degree of crowding in 2003 (*Hospital Emergency Departments: Crowded Conditions Vary among Hospitals and Communities*, GAO-03-460). The GAO was asked to revisit this issue in response to several studies that have associated crowded conditions in EDs with adverse effects on patient quality of care.

The GAO examined three indicators of ED crowding – ambulance diversion, wait times, and patient boarding – along with various factors that contribute to crowding. In doing so, the GAO reviewed national data, conducted a literature review of 197 articles, and interviewed individual subject-matter experts and officials from the Department of Health and Human Services (HHS) and professional and research organizations.

National data showed that about one-fourth of hospitals reported going on ambulance diversion at least once in 2006. According to the GAO's analysis of 2006 data from the HHS's National Center for Health Statistics, average wait times continued to increase, with significant numbers of visits exceeding recommended wait times based on patient acuity levels, as summarized here:

- Patients needing immediate care (recommended maximum wait to see a physician of less than one minute) waited an average of 28 minutes to be seen by a physician. 73.9% of these patients waited longer than the one-minute recommendation.
- Patients with emergent conditions (recommended maximum wait of 14 minutes) waited an average of 37 minutes to see a physician. 50.4% of emergent patients waited longer than 14 minutes.
- Patients with urgent complaints (recommended to be seen within 60 minutes) waited an average of 50 minutes, with 20.7% of patients waiting longer than 60 minutes.
- Semi-urgent conditions (two-hour maximum wait recommended) had an average wait time of 68 minutes, with 13.3% of patients waiting longer than the maximum recommended timeframe.
- Non-urgent patients (24-hour recommended timeframe) had an average wait time of 76 minutes, with no ED reporting wait times to see a physician in excess of 24 hours.

Although national data on patient boarding is limited, the articles reviewed by the GAO and the experts interviewed reported that the practice is a continuing problem due to the lack of access to inpatient beds. In turn, the lack of access to inpatient beds is due to

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the competition for available beds between hospital admissions from the ED and scheduled admissions, such as elective surgeries, that can be more profitable for the hospital.

While the GAO found that studies on solutions to ED crowding are also limited, strategies have been successfully implemented in isolated cases. One solution found in case studies conducted at several hospitals was to streamline elective surgery schedules, thereby increasing the opportunity for ED admissions. Regarding ambulance diversion, some local communities have established policies that make diversion the last resort for any hospital, as it often leads to critical cases not receiving the immediate care they need. Other strategies include the use of on-call physicians to determine the best ambulance destination for each patient or state policy prohibiting hospitals from going on diversion unless under inoperable conditions.

Strategies to decrease ED wait times included increasing the speed with which laboratory results are available, accelerating care during the triage process by eliminating some of the administrative work associated with patients entering the ED, and implementing a system allowing non-urgent patients to be seen by a medical provider other than a physician. However, none of the strategies to address crowding have been assessed on a state or national level.

The GAO found that there are several other frequently reported causes for ED crowding, including a lack of access to primary care; a shortage of available on-call specialists; and difficulties in transferring, admitting, or discharging psychiatric patients. Less commonly cited causes of ED crowding included an aging population, increasing acuity of patients, staff shortages, hospital processes, and financial factors.

For the full report, go to http://www.gao.gov/new.items/d09347.pdf.

## Recent EMTALA Cases

## EMTALA Screening and Stabilization Claims Rejected

On May 28, 2009, the US District Court for the District of Puerto Rico dismissed claims alleging that a hospital and staff failed to examine, stabilize and treat a pregnant woman, thereby causing her to miscarry her pregnancy and later to suffer infertility (Vázquez-Rivera v. Hospital Episcopal San Lucas, D.P.R., No. 08-2223, 5/28/09).

### The Facts

Nora Vázquez-Rivera presented on October 27, 2006, at 6:59am at the Hospital Episcopal San Lucas' ED seeking emergency medical attention. Vázquez, sixteen weeks pregnant at the time, complained that she was experiencing vaginal bleeding and severe abdominal pain. A nurse took Vázquez's vital signs and urine and blood samples. Ultrasonography was also performed by a technician who informed Vázquez that "the baby looked fine." No further diagnostic tests or examinations were performed to determine the cause of the bleeding, nor was an attempt made to stop the bleeding.

Still bleeding and suffering from severe abdominal pain, at approximately 5:00pm on that same day, Vázquez was informed that she would be admitted to the hospital maternity ward. Vázquez was told by her regular obstetrician, Dr. Maryrose Concepción-Girón, that she was being admitted to the hospital to determine the cause of her bleeding, but that since Concepción would not be available to treat her, Vázquez would be under the care of Dr. Luis A. Acosta-García. Vázquez was brought to the maternity ward and left unattended. Early on October 28, 2006, Vázquez suffered a miscarriage. She was treated only by the nursing staff and was not examined by a physician until 6:00pm that day, at which time Acosta informed Vázquez that her condition would require curettage. This procedure was performed the following day, October 29, 2006, and Vázquez was discharged a few hours after the surgery.

In the days following the surgery, Vázquez began to feel ill. She saw another gynecologist who determined that the initial curettage had not removed all the placental and fetal remains. Vázquez had another curettage but acquired a serious, chronic infection requiring several life-threatening surgeries that rendered her sterile.

Nora Vázquez-Rivera and her husband filed suit pursuant to EMTALA, alleging that defendants Hospital San Lucas, Dr. Acosta-García, and Dr. Concepción-Girón failed to adequately screen, stabilize and treat Vázquez's condition. The plaintiff further alleged that as a result of the defendants' negligent acts and omissions, she suffered, and will continue to suffer, the loss of an unborn child, mental anguish, physical suffering and the loss of the ability to procreate. The defendants moved to dismiss the complaint, contending that the plaintiff lacked a viable claim under EMTALA and that Vázquez's supplemental medical malpractice claims should be dismissed for lack of jurisdiction.

### The Ruling

While the plaintiff alleged that the hospital's screening was inadequate and that no attempt was made to identify the cause of the plaintiff's bleeding, the federal court found that Vázquez's complaint did not survive a motion to dismiss on the screening requirement. Because the plaintiff did not claim that the "Hospital refused to screen Plaintiff Vázquez or that the screening that the Hospital provided to Plaintiff was inconsistent with regular screening procedures for similarly-situated patients," the court wrote, "…Plaintiffs have failed to state a claim under EMTALA's screening provision upon which relief can be granted."

Regarding the stabilization complaint, the court determined that Vázquez's allegations "satisfy the emergency medical condition element of EMTALA's stabilization requirement," insofar as the ED staff "identified Plaintiff's signs and symptoms as an emergency medical condition." However, the court found that once plaintiff Vázquez was admitted as an inpatient for further treatment, the defendants' statutory duty to stabilize under EMTALA was fulfilled.

For those reasons, the court granted the defendants' motion to dismiss Plaintiff Vázquez's EMTALA claims and refused to exercise supplemental jurisdiction over the plaintiff's claims alleging negligence under Puerto Rico law.

## EMTALA: Appropriate Medical Screening Claim

The US District Court for the District of New Jersey on April 15, 2009, ruled that records of other patients presenting to a hospital's ED are relevant to a patient's EMTALA claim that the patient did not receive an "appropriate medical screening examination." The court also granted the plaintiff's motion to compel production of the documents based upon the plaintiff's discovery request (Gonzalez v. Choudhary, D.N.J., No. 08-0076, 4/15/09).

### The Facts

On February 1, 2007, plaintiff Grisselle Gonzalez presented to the ED of defendant South Jersey Healthcare Regional Medical Center

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(SJHRMC) seeking treatment for a purported emergency medical condition. Gonzalez reported experiencing chest pain, "rating her chest pain as eight out of 10 in severity and associated with shortness of breath ... neck pain, throat pain, jaw pain, and pain radiating down her arm." Gonzalez was evaluated by a physician, who diagnosed extra-pyramidal symptoms and dystonia. Gonzalez alleged that SJHRMC, failing to perform "'adequate cardiac testing' or provide supplemental oxygen, nitroglycerine, or aspirin," discharged her from the ED the same day, only to return two days later "again seeking treatment for a complaint of chest pain, neck pain, throat pain, jaw pain, and pain radiating down her arm."

Maintaining that on February 3 she developed severe difficulty breathing and suffered a cardiac arrest while in the ED triage area, Gonzalez claimed that SJHRMC violated EMTALA by failing to provide her an "'appropriate medical screening examination' on February 1 because of her lack of insurance, indigency, appearance, race, gender and/or age." Furthermore, Gonzalez alleged that in addition to providing negligent and reckless care and treatment on February 1, SJHRMC "deviated from appropriate standards of medical care in a manner that purportedly proximately caused injury."

Gonzalez filed a complaint alleging that SJHRMC violated EMTALA when she presented to the ED on February 1, 2007. In the motion considered by the district court, the plaintiff sought to compel SJHRMC to produce redacted medical records of all patients with a chief complaint of chest pain who presented to the ED during a two week period contemporaneous to her February 1 visit to the defendant's ED. The plaintiff asserted that she needed the records to support her claim that defendant failed to provide an "appropriate medical screening examination."

Opposing the motion, the defendant represented that 96 charts fell into the category of documents identified by the plaintiff, but that the records are not discoverable because the plaintiff received from them her February 1, 2007, admission chart. The defendant also contended that the 96 charts were not discoverable because the plaintiff took depositions of the triage nurse and ED physician, at which time the plaintiff had the opportunity to inquire of the policies and procedures followed when SJHRMC ED physicians see patients.

SJHRMC contended that they had "a number of written policies and procedures, albeit none that specifically addressed the screening of a patient who presented to the ED with a complaint of chest pain." The defendant further disputed the relevancy of the medical records on the grounds that patients do not present to the ED with identical symptoms and that this case is one of "faulty medical screening" rather than a case of "inadequate medical screening."

**The Ruling**

The court rejected the various arguments offered by the defendant, finding no basis to limit or preclude the plaintiff from obtaining further discovery on the issue. The court, disagreeing with SJHRMC's argument that the medical records are not discoverable because Plaintiff's claim is for "faulty medical screening" rather than an "inadequate medical screening" claim, instead noted that the "same evidence that supports a medical malpractice claim under state law may, in some circumstances, also constitute evidence of differential treatment sufficient to support a claim for failure to give an 'appropriate medical screening' under EMTALA."

Citing federal civil procedure where relevancy is more liberally and broadly construed at the discovery stage than at trial, the federal court determined that, in meeting the EMTALA burden to present evidence that a hospital treated a patient differently than any other patient who came to the ED with similar injuries and symptoms, a plaintiff may look to sources other than the express standard policies of the hospital.

The court also stated that in regard to hospital policies, the defendant produced the hospital's general written policies for screening patients who present to the ED rather than any documents setting forth a particular screening procedure for patients complaining of chest pain. Thus the court found the plaintiff's discovery request seeking medical records of other patients with similar injuries and symptoms presenting at the ED is "relevant to the EMTALA claim for failure to provide an 'appropriate medical screening examination.'"

## OTHER REGIONAL NEWS

# Missouri's Emergency Medical System is Expanding to Better Treat Trauma, Stroke and STEMI

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Missouri nurses, physicians, paramedics and other emergency medicine specialists will be introducing a new emergency medical system statewide in 2010. The Time Critical Diagnosis (TCD) system uses the trauma system model for emergency treatment of stroke and ST elevation myocardial infarction (STEMI).

More than 250 medical professionals, healthcare leaders and emergency medical care providers from across the state, including members of the American Academy of Emergency Medicine (AAEM), have been meeting regularly since September 2008 to formulate regulations and guidelines for the TCD system. The regulations are currently in draft form and will go through professional and legal reviews before they are filed with the Secretary of State's Office in 2010.

While the TCD system will be adopted statewide, participation by hospitals is completely voluntary. The regulations will outline standards for centers providing four distinct levels of care for stroke and STEMI patients. Hospitals must meet these standards including staffing, equipment, specialized services and hours of availability to become designated as stroke and STEMI centers.

Health professionals were invited to attend one of six public meetings being held throughout the state in late September and early October 2009. These meetings provided an overview regarding the TCD system and reviewed the key standards being proposed for stroke and STEMI centers. Attendees were encouraged to provide feedback on the draft regulations and to share their thoughts.

For more information, please visit www.dhss.mo.gov/TCD_System/Implementation.html.