Arizona College of Emergency Physicians®

ADVANCING EMERGENCY CARE

Hospital Emergency Department Crowding & Lack of Hospital Resources in Arizona

The Critical State of Emergency Care in Arizona

The Arizona College of Emergency Physicians hereby goes on record as stating that the emergency physician community has lost confidence in the emergency healthcare infrastructure in Arizona and that current resources supporting emergency care are inadequate to meet the needs of patients.

Arizona College of Emergency Physicians
Position Statement - March 2024

Observations:[1]

- The most dangerous procedure in healthcare is . . . **inter-hospital transfer**. Yet no one collects data on them, including outcomes.
- The most dangerous scenario in healthcare is . . . **a chronically crowded ED** (largely due to boarding of inpatients). Yet there are no reliable statistics & hospitals have successfully fought CMS imposing quality measures to gauge it.[2]
- The most dangerous resource shortage is . . . **a lack of critical on-call specialists,** especially surgical subspecialties (such as cardiovascular, neurosurgery, ENT, hand surgery, urology, trauma) & Psychiatry . . . Yet no one collects data or manages such resources on a regional basis.
- The most dangerous place for an admitted inpatient to be . . . **boarded in the ED**. Yet there are no reliable statistics & hospitals have successfully fought to keep it secret.[3]
- The most dangerous out-of-hospital place to be . . . **in an ambulance during regional wide-spread diversion**. There are some fairly reliable statistics for this, but rarely used to impact healthcare policy.
- **Knowing what to do is not the problem.** Many books & consultants that can tell hospitals what to do.[4] **Hospitals, in general, being willing (motivated) to do anything at all is the primary root cause.** They do not fix these issues because they are allowed to ignore them. And we know patients, and staff alike, suffer, even die because of it.[5] Emergency physicians have the 2nd highest rate of depression (38.3%) among specialties.[6]
- Labor shortages in healthcare are a reflection of every service industry & occur across the spectrum in healthcare, from home health, to nursing homes, physician offices & hospitals. Arizona ranks 15th in RN pay, yet is projected to have the worst nurse shortage in the country next year.[7] And we are a warm weather state.
- Arizona has the 8th highest median time spent in the emergency department (190 minutes).[8]
- "An overwhelming majority of emergency department physicians across the country say they have experienced boarding times in their facilities exceeding 24 hours, according to a 2022 survey from the American College of Emergency Physicians. Discharge delays due to a lack of beds in nursing homes and other long-term care facilities are {also} a key factor driving boarding challenges."[9]

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[1] Emergency Department Crowding: The Canary in the Health Care System - NEJM Catalyst - Sept 28, 2021

[2] The Risks of Being in Limbo in the Emergency Department - JAMA Internal Medicine - November 6, 2023

[3] Impact of ED-based intensive care unit on outcomes of decompensating boarding ED patients – JACEP Open – Aug 18, 2023

[4] Emergency Department Overcrowding: Understanding the Factors to Find Corresponding Solutions. J. Pers. Med. 2022, 12, 279

[5] ED boarding's impact on patient care and clinician well-being. The Joint Commission Journal on Quality & Patient Safety- Dec 2023

[6] Top 10 physician specialties with the highest rates of depression – AMA - Feb 20, 2024

[7] Analysis: Arizona will have largest nursing shortage in U.S. in 2025. National Center for Health Workforce Analysis, Feb 11, 2024

[8] ED visit times, by state– Becker's Hospital Review - February 1, 2024

[9] ED capacity issues nearing boiling point – Becker's Hospital Review - February 9, 2024

Solution? ***DATA***

The State (ADHS as a condition of licensure) must require automated & near real time reporting. We learned during COVID this saves lives & improves efficiency:

- Hospital & ED capacity, to include available inpatient beds vs unstaffed beds vs licensed beds; ED staffed beds; throughput metrics; waiting room census; & time, etc.; ED Nurse & clinician to patient ratio; Diversion metrics; and more.
- ED inpatient boarding (including psych) with thresholds that would require a sentinel event report to ADHS, e.g. psych patient held for more than 24 hours in the ED, critical care patient held for more than 4 hours, etc.
- Transfers, to include logistical metrics; medical conditions\situation (e.g. lack of on-call) requiring transfer; refusals to accept & by whom; Transfer outcomes.
- Create a hospital-by-hospital, bed & service availability system, made available to hospitals in need of patient transfer. See Oregon (Hospital) Capacity System
- Ideally a state-funded inter-hospital transfer coordination center. See AZ REACH with mandatory participation.
- Impact of EMS on ED Crowding including: Hospital Diversion, EMS off-load time (ED "Parking"), impact of inter-facility transports, ambulance transportation shortages, etc.

These data (for the most part) can be automatically collected by modern EHR & other systems minimizing the overhead to hospitals.

ADHS would collect\analyze this data automatically & monitor certain metrics in near real-time, with alert thresholds that feed into an escalation process.

ADHS would produce monthly 'Score Cards" for each hospital & reported publically in aggregate.

ADHS would have the authority to take action against any hospital found to exceed established threat parameters over a determine period of time & require a plan of correction.

An independent panel of healthcare experts would be responsible for developing & modifying these parameters.

The State would need to fund the necessary IT resources & analysts to manage the program.

Expected Outcomes

Hawthorne Effect: a type of human behavior reactivity in which individuals modify an aspect of their behavior in response to their awareness of being observed.

Healthcare is one of the most regulated industries in America. Yet, when it comes to emergency care, the lack of oversight is chilling. This fact allows hospitals to shift the burdens of other departments onto the emergency department & divert resources away from a service line often considered to be unprofitable. Hospitals often make "business decisions" to control such losses by choosing to not expand emergency services (space & staff) & employ constructive denial (diversion, transfer denial, waiting out the waiting room). This behavior is enabled by a near total lack of oversight & data related to serious issues faced by every emergency department in Arizona.

Obtaining even basic operational data from Arizona emergency departments will provide insight to regulators & policy makers to drive healthcare policy & resources. It will also motivate hospitals to address these needs & provide key performance indicators toward improvements.

Even on a limited basis, this approach has already been shown to be very effective in managing the crisis that is American's Emergency Department.[10]

Arizona's health care system is ranked third worst in America.[11] We must choose to do better.

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[10] An Actionable, Visual Dashboard Approach to Boarding. ACEP Now: Vol 42 – No 12 – December 2023

[11] Arizona's health care system is ranked third worst in America. The Center Square - May 24, 2021