

THE CONNECTICUT COLLEGE OF EMERGENCY PHYSICIANS SUPPORTS SECTIONS 6 & 7
OF HB 7293:

"AN ACT CONCERNING EMERGENCY DEPARTMENT OVERCROWDING"

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Because of Representative Sayer's leadership, Connecticut has made great strides in the past year defining emergency department overcrowding. We have convened the task force on emergency department overcrowding. We have held a town hall meeting with legislative, physician, nursing, and hospital thought leaders. The media has highlighted the issue, as depicted this month, on the front page of the Hartford courant. Today we gather to debate this bill, HB 7293, and begin the road to solving this crisis. If we fail, Connecticut's emergency departments will be unable to provide quality and compassionate emergency care to patients who need it most.

In order to facilitate this discussion, we must understand the process through the emergency department. The process is divided into three parts: input, throughput, and output. Experts throughout the country as illustrated in the institute of medicine's report, *Hospital-Based Emergency Care: At the Breaking Point*, last year believe the cause of crowding is output. In many arenas, including language in this bill, the implication is crowding is caused by input.

There is no doubt emergency department visits are climbing at a rapid rate. Many of these patients are truly ill and require admission into the hospital. Others do use the emergency department for less urgent matters. However, these patients have a very short throughput and they are discharged quickly, if there is an available stretcher for the evaluation.

The process comes to a halt when the sick patients remain in the emergency department because the hospital does not have any staffed in-hospital beds. This practice is called "boarding" and is the immediate cause of emergency department crowding. As more patients occupy emergency department beds, there are fewer resources to offer the nonstop input of patients. One solution is to go on diversion. The CDC reports that one ambulance is diverted every minute from its originally intended destination in the United States. This is the current solution in many hospitals throughout the state. Emergency departments board as many patients as possible until they are overwhelmed and then go on diversion. We, as emergency physicians, feel boarding is unfair to our communities and are saddened that we cannot provide quality and safe care.

Emergency nurses are excellent at providing rapid assessment and treatment of emergency patients. However, the practice of "boarding" patients that are already "tagged" for admission in the emergency room compromises our nurses ability to deliver emergency care to the ongoing flow of critical patients. Furthermore, hospital divert to institutions outside of their community. This practice results in prolonged pain and suffering and a decrease in patient safety.

Section 1 of this bill proposes defining emergency and nonemergency visits. Implementing this practice would violate the prudent layperson standard and cause serious harm to many people. For example, I see many patients with sore throats. Many of you would say this complaint does not belong in the emergency department and would qualify as a nonemergent visit. The majority of the time you would be correct. However, I will give two scenarios to demonstrate that apparent trivial complaints might be only the tip of potentially dangerous icebergs. Over the past four months, two of my patients presented with what might be perceived as simple complaint of sore throat. The reality was that they needed to be emergently intubated to protect their airways from closure as the result of the serious conditions epiglottitis in one patient and fungal infection in the other. Should they have not come to the emergency department for their sore throats? Likewise, we have made great strides in the public awareness of heart disease. The standard of care is for the patient who is suffering a heart attack is to emergently open their blocked coronary artery within ninety minutes of arriving at an emergency department. It is not uncommon for some patients who think they have indigestion but actually have a heart attack. Are the actual patients discharged with indigestion nonemergent because they were not having a heart attack? The Connecticut College of Emergency Physicians opposes section 1 and proposes it is removed from this bill.

On the other hand, we strongly support sections 6 and 7. Without measuring the problem, Connecticut will be unable to fully grasp the issue and work towards a solution. The proposals in these sections create a platform to begin addressing the issue of overcrowding from the global perspective it deserves. Each hospital will be able to develop strategies that work best for the institution. These sections also highlight the importance the entire hospital has in responding to emergency overcrowding. In fact, emergency overcrowding is a misnomer and the correct term should be hospital overcrowding. For hospitals, the emergency department is the canary in the coalmine. The status of the emergency department reflects the condition of the entire hospital. As long as there is inefficient output of emergency patient, the department cannot run effectively.

The Connecticut College of Emergency Physicians recognizes the complexity of this issue, but long term solutions do not help are patient now. We are advocating for our patients for immediate change. We want the ability to provide safe, compassionate and quality emergency care to all our patients. For this to happen, the practice of boarding must end and then we can address the other factors contributing to the process.