EDITORIAL

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Overcrowding: Something New for the New Year?

Currently in many—perhaps most—of the nation's urban hospitals, up to 80% of their emergency departments' capacity is taken up by admitted patients waiting for available inpatient beds, while the hours of their ED lengths of stay are typically recorded in double digits. The most significant contributors to ED overcrowding and, where permitted, ambulance diversions are the lack of sufficient inpatient beds and the increasing utilization of EDs for all types of care, particularly during off-hours. With millions of additional patients possibly seeking health care as a result of the Patient Protection and Affordable Care Act, and with no provisions for additional health care practitioners, overcrowding in the nation's EDs is likely to get even worse before it gets better.

But you've heard and experienced all of this before. So what's new? On January 1, 2012, CMS began requiring all hospitals to add to their core quality measure reports data on ED lengths of stay and throughput for both admitted and discharged patients, along with ED walkout rates. Benchmarks for these measures are scheduled to be issued in the third quarter of this year, after which a hospital's record in meeting the benchmarks may become part of the "value-based purchasing" used by CMS to determine reimbursement rates. Currently, three core-measure benchmarks that involve ED care are being used in this way: 90-minute "door-to-needle" PCI times for STEMI patients and, for community-acquired pneumonia patients, obtaining blood cultures in the ED and selecting correct antibiotics within 6 hours of patient arrival.

That it should require federal legislation to fix the overcrowding problem is shameful but understandable. It is *shameful* because no hospital organization, county, or municipality has managed to effectively deal with a serious patient care problem that has increased steadily for decades. On the other hand, their inaction is also *understandable*, since no hospital that has somehow managed to avoid closure and remain functional could possibly afford the additional resources necessary to address this problem. Exacerbating the situation, some state legislatures remain determined to continue reducing inpatient bed numbers or to close hospitals.

However, before EPs begin to leap for joy over the prospect that the government will ultimately solve this problem, we should consider the results of similar past corrective actions. First and foremost is EMTALA—characterized by some as one of the greatest unfunded mandates of all time.

EMTALA was enacted to correct the truly terrible practices of denying basic emergency health care to people who couldn't afford to pay for it. Yet, for all of the good that EMTALA has done, consider too, how many well-intentioned EPs have been snared by the accompanying regulations—by losing or incorrectly completing transfer attestations and other infractions. Once regulations are written and become law, the penalties are the same regardless of the practitioners' intent, and too often the road to regulatory hell is paved with good legislative intentions. Also, some malpractice attorneys have seized on EMTALA as a possible means of obtaining free "discovery" or of achieving monetary judgments exceeding state-imposed caps.

Added to these concerns is a new and even more serious problem of identifying appropriate follow-up care to ED visits as accepting-referral sources disappear at an alarming rate. Many free clinics have closed or have been transformed into pay clinics, and an increasing number of private practitioners are opting out of accepting all health plan coverage—including Medicare.

But something has to be done, and it has to be done now. During the 1980s, an ED director of a public hospital called national attention to patient-dumping practices and championed the cause that became EMTALA. Ironically, that hospital too has been cited for EMTALA violations and more recently has had to divert patients because of overcrowding. **EM**