

## The Unraveling Safety Net: A Research Agenda

**I**t was well past lunch time in Atlanta on the last day of the Society for Academic Emergency Medicine annual meeting, yet a group of animated and enthusiastic emergency medicine researchers, clinicians, and teachers sat in a room, postponing their meal to brainstorm about research ideas and the need to help solve the problems of emergency department (ED) crowding. Crowding that may be leading to gaps in care not only for the vulnerable patients for whom we may be the only access to health care, but for each and every one of us who may someday need emergency care as a result of an unexpected incident or serious illness. We present here a synopsis of some of those ideas, hoping that they will inspire us to find innovative ways to keep emergency care available for all persons when and where they need it.

Early in the discussion Dr. Sandra Schneider focused us around the purposes of research in this area.<sup>1</sup> She suggested considering research in a number of areas: 1) research as the search for the shock story; 2) research seeking the root causes of crowding; 3) research as pure science; or 4) research into interventions. As she noted, sometimes research is done to find the sensational story that will shock the public and policymakers into taking note of the problem. Research can be seen as a means of advocacy or a means of searching for the root causes of a problem. Both may be important. The Institute of Medicine recently published a report on the nation's safety net institutions, yet it never considered EDs as safety net institutions. Do we need the shock story to make policymak-

ers aware that the nation's EDs are indeed a part, a big part, of that safety net?

Soon it also became apparent that there is no uniform definition of the problem of crowding in the ED. Without such a definition, it was hard to frame the research questions. As in many areas of research, such as cardiac arrest, we cannot study the process without standard definitions of the relevant process and outcome variables. We have done this with the Utstein criteria in cardiac arrest and it is time to do this in crowding. In this special issue, Reeder and Garrison offer at least one definition of crowding.<sup>2</sup> They suggest a number of approaches to measuring patient density, acuity levels, and provider staffing to determine whether crowding is currently a problem. Adopting these or similar definitions would go a long way toward a uniform standard that would allow us to study the questions facing us.

During the morning session, problems of crowding were viewed as problems of input, problems of throughput, or problems of output.<sup>3</sup> The group found this a good way to categorize the areas that need to be considered. Input issues in crowding revolve around the increased numbers of patients coming to EDs for care. There may be many reasons for this. Some areas that need to be explored are: barriers to accessing primary care, lack of insurance, patient motivations such as perceived convenience, the aging of the population, and population growth. Throughput questions relate to our efficiency while patients are in the ED. In this area we might consider delays related to laboratory and radiology studies, and any other

factors that cause delays in the care of patients. The final area of study is related to output. Many of the participants saw this as one of the primary factors leading to overcrowding. Output focuses on our inability to move patients to their new level of care once a decision has been made. Specifically, this usually involves holding patients in the ED who need inpatient or intensive care unit care because the hospital is full. Many in the group saw this as a recipe for disaster.

Having focused on the need for a definition and a research agenda surrounding questions of input, throughput, and output, the group wanted to think about the steps necessary to implement such an agenda. It was clear that a number of essential activities should be undertaken immediately. As previously mentioned, standardized definitions and criteria must be developed and agreed upon; regional variation and differences in individual hospital characteristics must be carefully considered during this process. It was suggested that many hospitals have been collecting data and tracking various aspects of this problem; it might be useful to collate and analyze whatever administrative data are available. Like all retrospective studies, this would suffer from a lack of complete and consistent data across institutions, and have the advantage of yielding useful results for relatively little expense in a short period of time. Such a review of administrative data from multiple sources would undoubtedly help to refine the standardized definitions and criteria. However, it was also clear that ongoing prospective data collection will be necessary. The most effective approach would be the development of a consortium of emergency researchers and EDs to address these questions. We therefore recommend developing such a consortium, and call for a

meeting of interested stakeholders to facilitate an in-depth analysis of the issues and a focused plan for further study.—TERRI A. SCHMIDT, MD (schmidt@ohsu.edu), *Department of Emergency Medicine, Oregon Health Sciences University, Portland, OR*; and LYNNE D. RICHARDSON, MD, *Department of Emer-*

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**Key words.** safety net; research agenda; emergency departments; overcrowding.

### **References**

1. Lewin ME, Altman A (eds). *America's Health Care Safety Net: Intact but En-*

*dangered.* Institute of Medicine, Washington, DC: National Academy Press, 2000.

2. Reeder TJ, Garrison HG. When the safety net is unsafe: real-time assessment of the overcrowded emergency department. *Acad Emerg Med.* 2001; 8:1070–4.

3. Gordon JA, Billings J, Asplin BR, Rhodes KV. Safety net research in emergency medicine: proceedings of the *Academic Emergency Medicine* consensus conference on "the unraveling safety net." *Acad Emerg Med.* 2001; 8:1024–9.

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## Call for Photographs

### Deadline for receipt: February 15, 2002

Original photographs are invited for presentation at the SAEM 2002 Annual Meeting in St. Louis. Photographs of patients, pathology specimens, gram stains, EKG's, and radiographic studies or other visual data may be submitted. Submissions should depict findings that are pathognomonic for a particular diagnosis relevant to the practice of emergency medicine or findings of unusual interest that have educational value. Accepted submissions will be mounted by SAEM and presented in the "Clinical Pearls" session and/or the "Visual Diagnosis" medical student/resident contest.

No more than three different photos should be submitted for any one case. Submit one glossy photo (5 x 7, 8 x 10, 11 x 14, or 16 x 20) and a digital copy in JPEG or TIFF format on a disk or by email attachment (resolution at least 640 x 480). Radiographs should be submitted as glossy photos, not as x-rays. For EKG's, send an original and a digital image. The back of each photo should contain the contributor's name, address, hospital or program, and an arrow indicating the top. Submissions should be shipped in an envelope with cardboard but should not be mounted.

Photo submissions must be accompanied by a case history written as an "unknown" in the following format:

1. Chief complaint
2. History of present illness
3. Pertinent physical exam
4. Pertinent laboratory data
5. One or two questions asking the viewer to identify the diagnosis or pertinent finding.
6. Answer(s) and brief discussion of the case, including an explanation of the findings in the photo.
7. One to three bulleted take home points or "pearls"

The case history must be 250 words or less with at least one blank line between sections. The case history **MUST** be submitted as an email attachment to [saem@saem.org](mailto:saem@saem.org). If accepted for display SAEM reserves the right to edit the submitted case history.

Submissions will be selected based on their educational merit, relevance to emergency medicine, quality of the photograph, the case history, and appropriateness for public display. Contributors will be acknowledged and photos will be returned after the meeting.

Photographs must not appear in a refereed journal prior to the Annual Meeting. Appropriate masking of recognizable patients or written consent is the responsibility of the contributor. Documentation of written consent, where necessary, must accompany submissions and include a release of responsibility.

All submissions will be considered for publication in *Academic Emergency Medicine*. In addition, SAEM reserves the right to post selected images and case histories on the SAEM website for teaching purposes. Submitters will be acknowledged. SAEM will retain the rights to use submitted photographs in future educational projects, with full credit given for the contribution.

**Send submissions to SAEM at 901 North Washington Avenue, Lansing, MI 48906 or [saem@saem.org](mailto:saem@saem.org).**