Inside Out: Reversing the Focus on Emergency Departments to Enhance Efficiency

Adam Sharp, MD, MS; and A. Mark Fendrick, MD

"Who should go to the emergency department (ED)?" is a hotly debated question with no clear answer. There is no disputing that individuals experiencing acute life-threatening conditions such as trauma or myocardial infarction are best treated in the ED. Conversely, most agree that individuals needing an evaluation for chronic low back pain, displaying symptoms suggestive of an upper respiratory infection, or needing medication refills are more appropriately seen in non-ED settings. While the proper venue for certain clinical scenarios is clear, a great majority of patient complaints leading to ED visits fit somewhere in between the 2 ends of the spectrum. A systematic review by Uscher-Pines et al in this issue of *AJMC*[1] recognizes the challenge of classifying "non-urgent" ED visits; a different definition of "non-urgent" was used in each of the 26 articles included in the analysis.

ajmc.com © Managed Care & Healthcare Communications, LLC

The difficulty in categorizing non-urgent care is one of many reasons that healthcare stakeholders should shift their attention away from "Why do people go to the ED?" and instead focus on the question "Where do individuals go once the ED evaluation is complete?" A change of emphasis from "incoming" to "outgoing" paths of individuals using the ED would create a discourse to substantially enhance the value of emergency services for a variety of reasons. There is a lack of consensus regarding what encompasses "non-urgent" care, but this likely represents a small minority of ED visits.[2,3] The Centers for Disease Control and Prevention defines non-urgent visits as those requiring treatment in 2 to 24 hours; this represents only 8% of all ED visits.[4] A recent study of ED visits for Medicaid patients, using the CDC definition of non-urgent, concluded that only 10% of visits met this criterion.[5] This small number of ED visits also presumes that these individuals had an alternative source of care within 24 hours. Since other outpatient options are frequently unavailable in the current delivery system, a case can be made that the significant resources devoted to reduce non-urgent ED use may be better expended elsewhere.

In this article
Take-Away Points / p34
www.ajmc.com
Full text and PDF

Furthermore, the small proportion of overall healthcare expenditures attributable to non-urgent ED care reinforces the argument to deemphasize the intense policy focus on unnecessary ED visits. If a standardized definition of "non-urgent" were accepted and non-urgent visits were substantially reduced, the financial impact would barely be noticed in aggregate medical spending trends. All emergency care in the United States, estimated at over 136 million annual ED visits, contributes only 4% of total national healthcare expenditures.[6]

Given the relatively small amount that ED-related visits contribute to aggregate expenditures, the greatest opportunity for the ED to contribute to healthcare cost containment is by avoiding unnecessary admissions, not by diverting non-urgent visitors.[7,8] Nearly half of hospitalized patients are admitted through the ED and that proportion is increasing.[7] Inpatient services represent 29% of healthcare expenditures, nearly 6 times what is attributed to ED care.[6] Therefore, the allocation of funding to create evidence-based tools to decrease unnecessary inpatient admissions presents significantly higher potential for cost savings to the health system. Healthcare stakeholders already devote an impressive amount of resources to reduce unnecessary hospital readmissions, estimated to cost $17 billion annually.[9] Yet, few initiatives include a specific ED component, despite the ED's important gatekeeper function. Moreover, scrutiny of the ED's role in unnecessary admissions is likely to increase after recent articles in the lay press reporting that for-profit health systems use inappropriate admissions through the ED as a way to enhance profits.[10]

Thus, instead of implementing obstacles to ED care, we should consider innovative ways to take advantage of the existing ED infrastructure to enhance system efficiency. This is especially important given the time necessary to expand primary and urgent care to the level sufficient to support the needs of those who use the ED for non-urgent conditions. EDs are designed to identify and treat critical time-sensitive conditions, yet offer a convenient 24/7 model that many people prefer for less serious conditions.[11] It provides a portal of access to inpatient hospitalization, advanced diagnostic testing, and multiple specialists, regardless of ability to pay. This convenience is a major advantage in a health system that is cumbersome and difficult to navigate.[12]

Given the inherent benefits of the existing infrastructure and the current lack of an accessible primary care system for many individuals, the ED can be a key element of a patient-

Take-Away Points

The effort to identify and prevent low acuity ED visits would be better spent on eliminating variation in ED admissions. This is true for 2 simple reasons:

- ED care only accounts for 4% of US healthcare expenditures.
- Inpatient care accounts for 29% of US healthcare expenditures and the ED is the doorway to the hospital for nearly half of these patients.

In evaluating the ED, changing the dialogue from "Why did they come?" to "Where did they go?" provides a drastically better opportunity for improved efficiency.

centered, electronically integrated, high-performing delivery system. However, this will require significant changes in incentives for both ED providers and for individuals who prefer going to the ED even when other options are clinically desirable.[13-15] Innovative payment models such as global payment, episode-based bundled payments, accountable care organizations, and patient-centered medical homes that reward quality of care instead of the volume of care have shown to be effective at containing costs and maintaining quality.[16] Given the critical role of the ED in determining inpatient admissions, the active inclusion of emergency care providers in these payment strategies is crucial. Additionally, quality-driven financial incentives for providers must be aligned with consumer engagement initiatives, such as benefit design, shared decision making, and literacy programs. Financial barriers for consumers should be reduced for evidence-based, high-value ED services and potentially increased for those services that are harmful or of minimal benefit. Aligning value-driven payment reform with "clinically nuanced" consumer engagement strategies such as Value-Based Insurance Design with regard to ED care will incentivize both clinicians and patients to seek the right care at the right place at the right time.[17-20]

Lastly, in evaluating the efficiency of the ED, one must consider the perspective taken. From the societal perspective, despite the high ED fixed costs attributed to providing 24/7 high acuity services, the marginal costs are low.[21] The societal perspective also considers the benefits of unfunded care provided by EDs to the underserved. Since Americans are increasingly seeking emergency services for acute care already, ED care may be a better use of societal resources than incurring the high fixed costs necessary to keep clinics open 24/7.[3,6,13]

The ED demonstrates value by improving clinical outcomes through timely acute care services and filling the gaps in an imperfect healthcare safety net. Until there is sufficient primary care capacity, the ED can enhance the efficiency of other parts of the system by playing an increased role in coordinating care at the nexus of inpatient and outpatient medicine. Focus should be shifted from non-urgent ED use to more impactful opportunities, like reducing avoidable hospitalizations. Given their relative impact on both cost and quality outcomes, changing the dialogue from "Why did they come?" to "Where did they go?" provides a drastically better opportunity for improved efficiency. ED provider and patient initiatives that focus on outcome—not income—coupled with the inclusion of the ED as an essential part of an integrated delivery system will be pivotal to our health system achieving the highest value care.

Author Affiliations: From Department of Emergency Medicine (AS), Center for Value-Based Insurance Design (AMF), University of Michigan, Ann Arbor, MI.

Funding Source: None.

Author Disclosures: Dr Fendrick reports being a consultant for Abbott; ActiveHealth Management/Aetna; AstraZeneca; BlueCross BlueShield Association; Center for Medicare & Medicaid Services; Genentech; GlaxoSmithKline; Health Alliance Plan; Aon Hewitt; Highmark BlueCross BlueShield; Integrated Benefits Institue; MedImpact HeathCare Systems, Inc; Merck; National Business Coalition on Health; National Pharmaceutical Council; Pfizer; POZEN, Inc; Regence BlueCross BlueShield of Oregon; sanofi-aventis Pharmaceuticals; Thomson Reuters; TriZetto; and zanzors. He also reports that he is a speaker for Merck and Pfizer; and receives research support from Abbott; AstraZeneca; Eli Lilly; Genentech; GlaxoSmithKline; Merck; Novartis; Pfizer; and sanofi-aventis Pharmaceuticals. Dr Sharp reports no relationship or financial interest with any entity that would pose a conflict of interest with the subject matter of this article.

Authorship Information: Concept and design (AS, AMF); drafting of the manuscript (AS, AMF); critical revision of the manuscript for important intellectual content (AS, AMF).

Address correspondence to: Adam Sharp, MD, MS, Department of Emergency Medicine, University of Michigan, 2800 Plymouth Rd, Bldg 10/Rm G016, Ann Arbor, MI 48109-2800. E-mail: alsharp@med.umich.edu.

REFERENCES

1. Uscher-Pines L, Pines J, Kellermann A, Gillen E, Mehrotra A. Emergency department visits for nonurgent conditions: systematic literature review. *Am J Manag Care.* 2013;19(1):47-59.

2. Lowe RA, Bindman AB. Judging who needs emergency department care: a prerequisite for policy-making. *Am J Emerg Med.* 1997;15(2): 133-136.

3. Diverting Non-urgent Emergency Room Use: Can it Provide Better Care and Lower Costs? Washington, DC: Health, Education, Labor and Pensions Committee; 2011.

4. Garcia T, Bernstein A, Bush M. Emergency Department Visitors and Visits: Who Used the Emergency Room in 2007? http://www.cdc.gov/nchs/data/databriefs/db38.pdf. Accessed December 2, 2012, 2012.

5. Sommers AS, Boukus ER, Carrier E. Dispelling myths about emergency deparment use: majority of Medicaid visits are for urgent or more serious symptoms. *Res Brief.* 2012;(23)1-10, 1-3.

6. Kashihara D, Carper K. Medical Expenditure Panel Survey: National Health Care Expenses in the U.S. Civilian Noninstitutionalized Population, 2008. Vol Statistical Brief #301. Agency for Healthcare Research and Quality; 2010.

7. Schuur JD, Venkatesh AK. The growing role of emergency departments in hospital admissions [published online July 11, 2012]. *N Engl J Med.*

8. Smulowitz PB, Honigman L, Landon BE. A novel approach to identifying targets for cost reduction in the emergency department [published online July 12, 2012]. *Ann Emerg Med.*

9. Jencks SF, Williams MV, Coleman EA. Rehospitalizations among patients in the Medicare fee-for-service program. *N Engl J Med.* 2009; 360(14):1418-1428.

10. Creswell J, Abelson R. A hospital war reflects a bind for doctors in the U.S. *New York Times*, November 30, 2012. http://www.nytimes.com/2012/12/01/business/a-hospital-war-reflects-a-tightening-bind-for-doctors-nationwide.html?ref=todayspaper&_r=0. Accessed December 2, 2012.

11. Sempere-Selva T, Peiro S, Sendra-Pina P, et al. Inappropriate use of an accident and emergency department: magnitude, associated factors, and reasons--an approach with explicit criteria. *Ann Emerg Med.* 2001;37(6):568-579.

12. Chen FM, Rhodes LA, Green LA. Family physicians' personal experiences of their fathers' health care. *J Fam Pract.* 2001;50(9):762-766.

13. Pitts SR, Carrier ER, Rich EC, et al. Where Americans get acute care: increasingly, it's not at their doctor's office. *Health Aff (Millwood).* 2010;29(9):1620-1629.

14. Tang N, Stein J, Hsia RY, et al. Trends and characteristics of US emergency department visits, 1997-2007. *JAMA.* 2010;304(6): 664-670.

15. DeLia D, Cantor JC, Brownlee S, et al. Patient preference for emergency care: can and should it be changed? *Med Care Res Rev.* 2012;69(3):277-293.

16. Song Z, Safran DG, Landon BE, et al. The 'alternative quality contract,' based on a global budget, lowered medical spending and improved quality. *Health Aff (Millwood).* 2012;31(8):1885-1894.

17. Fairman KA, Curtiss FR. Still looking for health outcomes in all the wrong places? misinterpreted observational evidence, medication adherence promotion, and value-based insurance design. *J Manag Care Pharm.* 2009;15(6):501-507.

18. Fendrick AM, Chernew ME, Levi GW. Value-based insurance design: embracing value over cost alone. *Am J Manag Care.* 2009;15(10 suppl): S277-S283.

19. Robinson JC. Applying value-based insurance design to high-cost health services. *Health Aff (Millwood).* 2010;29(11):2009-2016.

20. de Souza JA, Ratain MJ, Fendrick AM. Value-based insurance design: aligning incentives, benefits, and evidence in oncology. *J Natl Compr Canc Netw.* 2012;10(1):18-23.

21. Williams RM. The costs of visits to emergency departments. *N Engl J Med.* 1996;334(10):642-646. ■