

agog dinner & discussion | Emergency Departments

Emergency Departments: The Canary in the Coal Mine for the Health Care System was the topic of conversation at a recent agog dinner & discussion on March 31 hosted by Lori Flexer and Jeff Sackett.

Community members gathered around the dining room table to learn more, share experiences and exchange ideas. The evening's conversation leaders were:

Dr. Robert Lowe, Professor, Departments of Emergency Medicine, Public Health and Preventive Medicine, and Medical Informatics and Clinical Epidemiology, OHSU; Senior Scholar, OHSU Center for Policy and Research in Emergency Medicine

Dr. Michelle Berlin, Vice Chair, Department of Obstetrics and Gynecology; Associate Director, Center for Women's Health; Director, National Center of Excellence in Women's Health, OHSU

Below is a brief synopsis of the evening's lively discussion and exchange of ideas, information, and questions.

Much of the literature about emergency department (ED) use begins with several false assumptions:

1. ED care is costly
2. Much ED use is unnecessary, for non-emergency conditions
3. It is easy to determine who needs ED care and who doesn't
4. "Inappropriate" ED use disrupts continuity of care and
5. "Inappropriate" ED use leads to ED overcrowding

Despite the common perception that ED use is costly, emergency department costs represent less than 2% of the US health care budget. ED costs for the poor are less than one half of 1% of the US health care budget.

There is little evidence about "unnecessary" or "inappropriate" ED use.

Some of the confusion on this topic stems from a misunderstanding about the time at which decisions are made. For example, chest pain from heartburn could be called "non-emergency" but there is nothing the patient could have done before the ED visit to distinguish heartburn from heart attack. Even in retrospect, experts have a hard time agreeing as to which ED visits were "necessary." Another part of the problem stems from **lack of alternative sites for care.** The mother of a 2 year old with fever in the middle of the night may realize that her child could be cared for in a primary care provider's office, but if the office is closed, or if the family cannot afford to see a primary care provider, then the ED may be the logical and appropriate choice. As another example, one of the participants described an incident where a young woman had fallen and possibly broken her ankle. Her father called her health care provider at 3:30 PM but the provider did not have an opening until the next day. The office staff suggested an urgent care center, where the young woman received substandard care from a provider who – as it turned out – had recently been censured by the Oregon Medical Board. The discussion participant stated that next time he would probably bring his family member to the ED.

It is not easy to determine who needs to be seen in an emergency department. Studies of patients who would have been triaged away as "non-emergency" show that a small but non-trivial proportion (0.25% to 5% in different studies) required hospital admission the same day. One might argue that this is a small risk, and that we need to ask patients to accept that risk in order to save money that can be used in better ways. However, the costs of ED care are such a small proportion of the healthcare dollar that this argument is not compelling.

It is not so clear that ED use disrupts continuity of care. Studies of frequent ED users show that they are generally frequent users of other medical care as well. Most have primary care providers whom they see often but



they also use the ED – because they tend to have one or more chronic diseases that can lead to emergency conditions.

ED over-use is not the commonest cause of ED overcrowding. Although volume of patients has some impact on crowding, the biggest cause of ED overcrowding in the US is lack of inpatient beds – so that patients who require hospital admission remain in the ED for hours or days, taking space and requiring staff time in ways that compromise the efficiency of the emergency department.

Discussion of possible solutions to the challenges posed by ED use included:

- **Extending primary care clinic hours, but would it reduce overall health care costs?** Staffing primary care settings evenings and weekends would be costly; perhaps it may be more cost-effective to use the ED, which is already open at these hours – if it is possible to create a fee structure within the ED to addressing non-emergent issues during non-clinic hours.
- **Advances in technology are helping bridge the discontinuity of care issue often associated with ED visits,** as more and more ED doctors are able to gain electronic access to patient medical records; however, continuity of care is still of great concern for many primary care doctors and concerned family members or close friends who feel responsible for playing the role of health advocate for their loved one and making sure pertinent medical history is communicated with multiple doctors.
- **The Patient-Centered Medical Home** is not a new concept, but one that has greatly expanded in recent years. It is an approach where each person has a primary doctor who heads a team of professionals, which might include a physician assistant, a nurse practitioner, a dietitian, a social worker, a pharmacist, and others, to provide round-the-clock access to care. Patients, doctors and families work together to make health care more effective and reduce its costs.
- **Of local interest:** In 2007, Multnomah County Health Department implemented an integrated clinical services (ICS) model that provides quality health services for people who experience barriers to accessing health care. The clinical services integrate physical and behavioral health and social services for the poor, uninsured and homeless populations. By integrating all these health care services under one organization, the goal of this model is threefold:
 1. provide clients a continuity of care
 2. improve operational efficiencies
 3. maximize opportunities for grants and programs for special populations.It is still too early to determine long-term results.

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