

Solutions to Misuse of the Emergency Department

Executive Summary:

- The number of patients visiting ED's is growing at a rate of 3% annually
- Those without insurance make up less than 20% of all visits to ED's for acute care
- There are several problems with using an ED when the visit could be handled at another site such as at one's personal physician
- Some hospitals are overcoming ED challenges posed by non-emergent visits by scheduling patients to clinics or by developing fast service lines to clear congestion
- Some are saving time in ED's by using Lean approaches to eliminate non-value added services

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The number of patients with acute care problems visiting the emergency rooms is steadily climbing. According to the article *Hospitals Work to Reduce ER Wait Times* posted on the ASQ website the rate is increasing at a 3% annual rate. This leads to several problems, including longer waiting time. An analysis of the growth reveals several trends in the demographics of patient visits and also the successful efforts of some ED's to reverse the negative outcomes from this surge in the number of visits.

First, let us characterize the present use of ED's. In September 2010 the journal *Health Affairs* had several articles which focused on the ED. The following statistics come from the articles *Where Americans Get Acute Care: Increasingly It's Not at Their Doctor's Office* and *Many Emergency Department Visits Could Be Managed at Urgent Care Centers or Retail Clinics*.

- Only 42% of acute care is rendered by a patient's personal physician
- 28% of acute care visits are to emergency departments
- 17.1% of all visits to ED's are by the uninsured
- 26.2% of all visits to ED's are by Medicaid patients
- 34.4% of all visits to ED's are by patients with private insurance

Visits to ED's are much more expensive than visits to private physicians, urgent care centers, retail clinics or Federally sponsored community health centers. According to the latter of the two articles above 13.7-27.1% of all acute care visits to ED's could be handled at urgent care centers or retail clinics with a cost saving of \$4.4 billion, or 0.2% of the total spending on national health care annually.

There are other problems associated with ED use for acute care when there are alternative choices. One is an increase in wait time for ED patients. According to the ASQ article, median wait time has increased from 22 minutes to 33 minutes from 1997 to 2008. For patients with serious medical problems this can have negative consequences. Also, the longer the wait, the more likely a patient is to walk away.

Some of the acute care visits are associated with misuse of the setting. Recently I was chatting with an ED nurse who told me of a Medicaid patient who came to her ED one morning complaining of menstrual cramps. The nurse asked her why she did not go to a local drug store for some over the counter medication. The patient insisted on seeing a physician. When she left she had a prescription for Darvocet. Last fall on KevinMD.com weblog an ED physician was complaining of pressure by the hospital administrators to please the ED patients so that they would give the hospital good marks on HCAHPS. The physician was against doing so but did because of the pressure.

One final problem I believe is important is the quality of continuing care that is absent in the ED. As has been well documented, especially in studies of patient-centered medical homes, acute and chronic care given by one's personal physician is more likely to have positive outcomes. Errors in medication are much less likely when handled by one's personal physician. Treatment based upon past history from the personal physician is likely to be more effective. Patients with personal physicians should only use the ED in times of true emergencies.

I have several suggestions that can help ED patients find the correct care in the correct setting. First, patients coming to the ED should first be triaged by a physician, nurse practitioner or physician's assistant in order to satisfy Federal rules. Then, patients who have non-emergent problems should be counseled to seek medical help in an outpatient setting. The Aurora Sinai Medical Center's ED in Milwaukee takes this process a step further. It not only counsels these patients about using the ED but also sends them to a scheduler to make a follow-up appointment with a primary care provider. They make every effort to schedule the patient with a provider that they are likely to visit. For instance, a patient who prefers a Spanish-speaking physician and who has Medicaid insurance may be scheduled to visit with a Community Health Center near his residence. Of course for this arrangement to work, the hospital must have close ties to community primary care providers.

Another approach to lessen ED wait time for hospitals that do not want to arrange for primary care service for non-emergent patients is to address ED processes using a Lean approach. Very often there are processes that add to wait time without adding any value. For instance, paper work done in the reception area could instead be done in an exam room after triaging using laptops or iPads. Some hospitals are creating fast service lines in their ED's for non-emergent patients, thus reducing wait time for all patients. Using value stream mapping with a Lean facilitator often creates solutions tailored to a specific ED setting that greatly reduce wait time and costs.

How can hospitals avoid pressuring physicians to bow to HCAHPS scores? John Black in his book *The Toyota Way to Healthcare Excellence* states that Park Nicollet Health Services, rated as a top 50 hospital for cardiac care by Thomson Reuters, has an administrative policy that it shall not interfere with any clinical decisions made by its clinical staff. I believe that they are successful in maintaining their excellent patient ratings because they realize that a few who may misuse the ED and give negative ratings

are far outweighed by the scores of those who benefit from the lack of interference by administration in clinical decisions.

Pressure on ED's will decrease as the numbers of certified patient-centered medical homes and accountable care organizations grow. The object of these organizations is to provide excellent primary care and to keep their patients out of the ED as much as possible. Demonstration projects have shown that these two types of organizations do have a major impact on ED use.

As the statistics show, ED overuse is not only due to those who are without insurance. A wide variety of patients with healthcare coverage use the ED for non-emergent acute care for a wide variety of reasons. Hospitals can overcome these challenges that negatively impact them with a variety of approaches, including patient education, scheduling patients for primary care visits in their community and by using Lean approaches to eliminate waste and create effective solutions.

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If you need a speaker to present at a meeting or conference, please contact me and I will consider doing so.

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