

SAFETY NET HOSPITAL EMERGENCY DEPARTMENTS: CREATING SAFETY VALVES FOR NON- URGENT CARE

By Laurie E. Felland, Robert E. Hurley and
Nicole M. Kemper

Hospital emergency departments (EDs) are caring for more patients, including those with non-urgent needs that could be treated in alternative, more cost-effective settings, such as a clinic or physician's office. According to findings from the Center for Studying Health System Change's (HSC) 2007 site visits to 12 nationally representative metropolitan communities, many emergency departments at safety net hospitals—the public and not-for-profit hospitals that serve large proportions of low-income, uninsured and Medicaid patients—are attempting to meet patients' non-urgent needs more efficiently. Safety net EDs are working to redirect non-urgent patients to their hospitals' outpatient clinics or to community health centers and clinics, with varied results. Efforts to develop additional primary, specialty and dental care in community settings, along with promoting the use of these providers, could stem the use of emergency departments for non-urgent care, while increasing access to care, enhancing quality and containing costs.

Busy Emergency Departments See More Non-Urgent Patients

Emergency department visits are rising, especially for patients with non-urgent conditions. Such conditions could include cold and flu symptoms, minor cuts and sprains, rashes, dental problems and prescription refills. The National Hospital Ambulatory Medical Care Survey found that total ED visits classified as non-urgent, meaning the patient should be treated in two to 24 hours, increased from approximately 10 percent of ED visits in 1997 to 14 percent of visits in 2005, with uninsured patients experiencing a slightly higher increase.¹ People with private insurance accounted for most of the overall increase in ED visits. However, low-income uninsured and Medicaid patients rely more on emergency departments than people with Medicare or private coverage.²

Low-income, uninsured and underinsured patients often turn to EDs for care because they lack timely access to outpatient care in other settings. The growing

reluctance of physicians and dentists to serve Medicaid and uninsured patients, along with shortages of primary care physicians and certain specialists, such as psychiatrists, in some communities make obtaining clinic or physician appointments increasingly difficult, according to findings from HSC's 2007 site visits to 12 nationally representative metropolitan communities (see Data Source).

Community health centers have expanded access to care in underserved areas but still struggle to respond to growing demand for primary care.³ Many safety net hospitals—the public and not-for-profit hospitals serving large proportions of low-income, uninsured and Medicaid patients—have primary and specialty care clinics that are key sources of care for low-income people, yet they too face capacity constraints, and waits for appointments can be several months. As one Boston ED director said, “We see people coming back to the ED two

to three times because they can't get an appointment with a specialist.”

Emergency departments are expedient sources of care because they are open 24 hours a day, cannot turn patients away without screening them and many are located in urban areas accessible by public transportation. At an ED in Lansing, a representative of a Medicaid health plan asked Medicaid enrollees why they chose the ED over their primary care provider—key reasons included difficulty obtaining appointments with network providers and lack of affordable transportation to other providers. Moreover, some ED directors and other observers suggested that safety net EDs have accommodated low-income patients and become the preferred provider of choice for some.

However, there are concerns about use of the ED for non-urgent care. EDs are often crowded with patients waiting to be admitted to the hospital. People with non-



Some safety net hospitals are expanding emergency departments to accommodate increased numbers of patients overall and attract more well-insured patients, but this is a costly response to caring for patients with non-urgent needs.

urgent needs may contribute to increased wait times for all patients, including those with emergent needs, which can adversely affect patient outcomes.⁴ In addition, ED capacity is costly given the range of stand-ready services and equipment EDs must maintain, and studies have found the costs of providing non-urgent care may be higher in emergency departments than in other settings.⁵ Interviews with ED directors at the main safety net hospitals in the 12 HSC communities spotlighted ways EDs are attempting to better manage the amount of non-urgent care they provide and improve access for people in the communities they serve.

Redirecting Non-Urgent Patients

Some safety net hospitals are expanding emergency departments to accommodate increased numbers of patients overall and attract more well-insured patients, but this is a costly response to caring for patients with non-urgent needs. While some hospitals are trying to provide non-urgent care more efficiently—for example using a “fast-track” approach where mid-level practitioners provide care in a setting separate from the ED—such strategies may attract even more non-urgent patients. For example, an Orange County hospital that created a small area in its ED for a physician to quickly treat patients with minor conditions has noted an increase in patient volume and more people traveling from longer distances.

Rather than attempting to serve more non-urgent patients, many safety net EDs are attempting to help patients establish “medical homes” that provide preventive and primary care for both episodic medical needs and chronic conditions, with coordination of follow-up visits and tests. Such providers, which include hospital outpatient clinics, community health centers and individual primary care practitioners, may provide less costly care, reduce reliance on the ED for non-urgent conditions and diminish the likelihood of a non-urgent problem going untreated and becoming more severe.

Some safety net hospitals are adding primary care capacity and working more closely with hospital specialty clinics to

treat more patients needing follow-up care. For example, an Orange County hospital recently built an internal medicine clinic to serve uninsured patients, a Boston hospital added more family medicine clinics and an Indianapolis hospital added a clinic for Spanish-speaking patients. In Miami—where a quarter of the population is uninsured—a safety net hospital restructured its clinics to make them more efficient and enable more patients to be seen, with a visit going from being an “all-day experience” to average waits of 75-90 minutes. That hospital also has added school-based clinics and mobile vans to deliver care in the community without the overhead costs of full-scale clinic facilities.

To encourage the use of outpatient clinics and community health centers, some EDs—after screening patients as required by the federal Emergency Medical Treatment and Labor Act (EMTALA)⁶—help patients with non-urgent conditions identify other providers and schedule appointments. A Miami ED added a nurse practitioner to determine which patients could be treated in a clinic setting and administrative staff to schedule appointments with primary care or dental clinics on the same day or within three days, depending on appointment availability and urgency of the patient’s condition. Over the course of 18 months, ED staff referred an average of 50 patients a day to clinics—almost double what they initially expected and approximately 15 percent of total ED volume. The hospital also placed posters around the hospital and clinics to educate patients on the types of conditions that can be treated in a clinic rather than the ED.

Another approach used in some communities is to dedicate ED staff to work with patients prior to arrival—in some cases targeting patients with frequent visits—to direct them to primary care settings for non-urgent needs. A Greenville ED added a nurse to serve as a patient advocate to help patients establish a medical home in the community by linking them to private physicians, free clinics and community health centers for care. The advocate also focuses on patients with frequent ED visits to ensure that they obtain appointments with their medical home. Similarly, a Seattle ED identifies patients—many with mental

health conditions—with 14 or more visits in a year and creates a patient care plan, referring patients who lack a medical home to the hospital's clinics or community health centers.

When an ED treats a patient for a non-urgent need, ED staff in some communities work to inform the patient about other care options to keep their condition from escalating into a more serious problem and requiring a return visit. As a Boston ED director remarked, "Once we see a patient, it's very important that there is good access to primary care, so patients don't come back many times because their diabetes or blood pressure is out of control."

Community Clinic Linkages

Involvement of community health centers and other primary care clinics is important to safety net hospital efforts to control the amount of non-urgent care provided in emergency departments, particularly for hospitals without their own clinics. The national associations representing community health centers and Medicaid health plans encourage efforts to provide a continuum of care through a medical home to mitigate the need for patients to turn to EDs for non-urgent care.⁷ Health center directors are largely supportive of such efforts to take on more patients diverted from the ED, and some have adopted same-day scheduling or walk-in appointments to enable patients to be treated more quickly.

Recognizing that community clinics can take pressure off of EDs, a number of safety net hospitals—in such communities as Seattle, Phoenix and Miami—are collaborating with health centers. For example, one hospital is in discussions with an area health center to help the center extend hours to evenings and weekends to see more patients diverted from the ED or those who otherwise would have gone to the ED. However, without sufficient assistance to community health centers in the form of direct funding or the potential to generate additional revenue from treating more insured patients, taking on more patients would create a financial strain for health centers. One health center director noted a previous arrangement with a for-profit hospital where the ED sent the health center uninsured

patients but few insured patients.

In a number of communities, health information technology enables scheduling appointments with other providers and/or sharing a patient's clinical information between the EDs and other providers. In Boston, Cleveland, Indianapolis and Lansing, some clinics and physician offices can connect to the electronic medical record system in EDs to schedule appointments and better track a patient's condition and previous tests and treatments, although many systems provide read-only access and cannot transfer information back and forth. In Greenville, safety net providers and community organizations have developed an electronic referral system to transfer clinical and insurance information from the ED to the community clinics. Eventually this system is intended to facilitate referrals from the clinics to the hospital's clinics as well.

States, as part of Medicaid and other insurance coverage reforms, also are interested in encouraging the use of primary care providers instead of emergency departments. The Massachusetts universal coverage reform legislation included funding for Medicaid health plans to establish strategies to divert non-urgent patients away from EDs. These funds have helped community health centers expand operations to offer appointments outside normal business hours. And Florida funds health centers to help cover the costs of treating uninsured patients, with some of the funding directed toward initiatives that encourage the use of health centers over EDs for non-urgent care.

Ongoing Challenges

Safety net hospitals' efforts to limit ED use for non-urgent conditions face a number of challenges. The amount of primary care available through clinics and health centers varies by community, and overall demand for care typically exceeds supply. Even as primary care capacity for low-income people has expanded across some communities in recent years, ED directors reported significant waits for appointments at health centers and clinics, particularly for new patients and those needing specialty care.

Also, the challenge of redirecting patients is more complex than expanding health center and hospital clinic capacity. Some

health centers' extended hours have not been utilized as predicted: a health center in Miami started a pediatric clinic on Saturdays but discontinued it because too few patients presented for care, and a health center in Boston noted similar concerns about new Sunday hours. The reasons for low demand are not always clear, but community respondents pointed to limited transportation and child care, and they suggested it takes time to inform people about health center and clinic options and encourage them to use those providers. Some low-income people still consider the ED their medical home. The director of a community clinic in Greenville lamented, "The uninsured do still continue to go to the EDs as much as we try to offer alternatives; many have a mindset that the ED is where they go." Additionally, adding staff to redirect patients to outpatient settings and investing in health information technology stretches safety net providers' limited funds.

Furthermore, expanding access to primary care through community health centers and clinics often does not address the need for specialty, mental health and dental care, and prescription drugs, so many EDs continue to treat those needs on site. EDs often rely on specialists employed by the hospital or who are paid a stipend to serve on call to treat non-urgent patients while they are still in the ED. As a Miami ED director explained, "We call the same doctor who wouldn't see the patient on the outside, and that doctor consults for the patient here."

Implications

Emergency departments provide important access for people whose conditions do not require immediate treatment but who cannot access a community provider in a timely manner. However, EDs are not designed to treat ongoing, chronic needs and wait times to receive care can be long. Strategies and policies that help direct patients to other outpatient settings could increase access, enhance quality and contain costs if there are community providers willing and able to treat more low-income people.

Findings across the 12 HSC communities suggest that a combination of approaches could help stem ED use for non-urgent care, including expansion of community health



Data Source

Approximately every two years, HSC conducts site visits to 12 nationally representative metropolitan communities as part of the Community Tracking Study to interview health care leaders about the local health care market, how it has changed and the effect of those changes on people. The communities are Boston; Cleveland; Greenville, S.C.; Indianapolis; Lansing, Mich.; Little Rock, Ark.; Miami; northern New Jersey; Orange County, Calif.; Phoenix; Seattle; and Syracuse, N.Y. The sixth round of site visits was conducted between February and June 2007 with 453 interviews. This Issue Brief is based on responses from CEOs and emergency department directors at the communities' main safety net hospitals, as well as directors of community health centers, local health departments, Medicaid agencies and consumer advocates.

ISSUE BRIEFS are published by the Center for Studying Health System Change.

600 Maryland Avenue, SW, Suite 550
Washington, DC 20024-2512
Tel: (202) 484-5261
Fax: (202) 484-9258
www.hschange.org

President: Paul B. Ginsburg



centers, community clinics and hospital clinics and strategies to improve their accessibility. Alignment of hours of operation and available services among existing providers could increase people's care options at lower costs. Since transportation is a significant barrier for some, bringing services to low-income neighborhoods through mobile vans and school-based services could improve access in a cost-effective way. Furthermore, incentives to improve communication and coordination among community providers and ED staff could facilitate referrals so care is provided in the most appropriate setting. Development of information technology among health care providers could improve communication among providers and ultimately reduce costs.

To prompt private practitioners to treat more low-income people, incentives such as enhanced Medicaid reimbursement appear essential. With the growth of Medicaid managed care, there is an increasing onus on Medicaid health plans to establish adequate networks of practitioners willing to treat Medicaid enrollees, but this too is impeded by the fact that low payment rates to health plans lead to low payment rates to physicians. Funded through the Deficit Reduction Act of 2005 (DRA), the Centers for Medicare and Medicaid Services recently awarded \$50 million over two years to 20 state Medicaid programs to help develop capacity and programs to encourage primary care use over ED use.

Moreover, low-income people need to be informed about alternatives to the ED. Previous research shows that most uninsured people are unaware of providers that offer relatively low-cost care in their communities.⁸ Media campaigns and other outreach efforts could help raise awareness of health centers and hospital clinics, as well as the services offered and hours of operation.

Incentives, such as transportation vouchers and ensuring that patients pay less out of pocket for non-ED providers than they would in the ED, could also encourage people to use other providers. The DRA allows state Medicaid programs to permit EDs to charge copayments for non-urgent treatment, but the impact on ED use and whether needed care is obtained has yet to be determined. ■

Notes

1. Nawar, Eric W., Richard W. Niska and Jianmin Xu, *National Hospital Ambulatory Medical Care Survey: 2005 Emergency Department Summary*, Advance Data from Vital and Health Statistics No. 386, National Center for Health Statistics (NCHS), Hyattsville, Md. (June 29, 2007).
2. Cunningham, Peter J., and Jessica H. May, *Insured Americans Drive Surge in Emergency Department Visits*, Issue Brief No. 70, Center for Studying Health System Change, Washington, D.C. (October 2003); NCHS (2007).
3. Hurley, Robert E., Laurie E. Felland and Johanna Lauer, *Community Health Centers Tackle Rising Demands and Expectations*, Issue Brief No. 116, Center for Studying Health System Change, Washington, D.C. (December 2007).
4. Wilper, Andrew P., et al., "Waits to See An Emergency Department Physician: U.S. Trends and Predictors, 1997-2004," *Health Affairs*, Web exclusive (Jan. 15, 2008).
5. Institute of Medicine, *Hospital-Based Emergency Care: At the Breaking Point*, Washington, D.C. (June 14, 2006).
6. EMTALA requires hospitals to screen for emergency medical conditions, stabilize patients before transfer and transfer only upon determination that the transfer benefits outweigh the medical risks.
7. Association for Community Affiliated Plans and National Association of Community Health Centers, *The Impact of Community Health Centers and Community-Affiliated Health Plans on Emergency Department Use*, Washington, D.C. (April 2007).
8. May, Jessica H., Peter J. Cunningham and Jack Hadley, *Most Uninsured People Unaware of Health Care Safety Net Providers*, Issue Brief No. 90, Center for Studying Health System Change, Washington, D.C. (November 2004).