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The Overuse of America's Emergency Rooms

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I. INTRODUCTION

A hospital emergency room can be a patient's one-stop-shop for an array of healthcare services, day or night, regardless of their ability to pay, or the severity of their condition.¹ As a result, not only is emergency room use growing in general, but a larger number of people are turning to emergency rooms for non-urgent care and for conditions that could be treated or prevented by primary care physicians. In fact, it is estimated that more than half of the 120 million annual emergency room visits are avoidable.² This inappropriate emergency room use creates major inefficiencies in both care and cost. First, those with non-urgent symptoms often receive better care from their primary healthcare providers.³ Their use of the emergency room creates crowding, long waits, and added stress on hospital resources, thereby lowering the quality of care for those with true medical emergencies. Second, emergency room use costs vastly more than its alternative. Emergency room overuse is responsible for \$38 billion in wasteful spending in the U.S. each year.⁴ Therefore, reducing the overuse of emergency rooms will improve the care received by both urgent and non-urgent patients while cutting overall healthcare costs by billions of dollars each year. To do this the healthcare system must widen access to

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1. NEW ENGLAND HEALTHCARE INSTITUTE, A MATTER OF URGENCY: REDUCING EMERGENCY DEPARTMENT OVERUSE 2 (2010) http://www.nehi.net/uploads/full_report/pa_issue_brief_final.pdf [hereinafter NEHI].

2. NATIONAL PRIORITIES PARTNERSHIP, REDUCING EMERGENCY DEPARTMENT OVERUSE: A \$38 BILLION OPPORTUNITY 1 (2010) <http://www.nationalprioritiespartnership.org/PriorityDetails.aspx?id=598>.

3. Jeanne M. Lambrew et al., *The Effects of Having a Regular Doctor on Access to Primary Care*, 34 MEDICAL CARE 138, 143 (1996).

4. NEHI, *supra* note 1, at 1-2.

primary care and other alternatives to emergency room use, as well as create financial incentives to lower emergency room use for non-urgent conditions.

II. EMERGENCY ROOM USE IN THE UNITED STATES

The number of persons visiting the emergency room is increasing each year. From 1995 to 2005, the annual number of emergency room visits in the U.S. grew nearly 20 percent, from 96.5 million to 115.3 million.⁵ More importantly, the use of emergency rooms for non-urgent care has also grown, from 9.7 percent of visits in 1997 to over 12 percent in 2006.⁶ Shockingly, studies have shown that an estimated 56 percent of all emergency department visits are avoidable.⁷ This is because a majority of patient's issues are non-urgent, treatable by primary care physicians, or are preventable.⁸ This means that almost 67 million trips to the emergency room each year could be avoided.⁹

Although there is a widespread belief the poor and uninsured solely overuse the emergency room, research has shown that this is largely untrue.¹⁰ The overuse of emergency rooms is widespread across the entire American population regardless of insurance status.¹¹ In fact, the insured are responsible for a disproportionate increase in emergency room visits.¹² However, statistics present that the more income people have, the less likely they are to ever visit an emergency room.¹³ Also, African Americans and people over age seventy-five are most likely to visit emergency rooms.¹⁴

Those who do not have a regular doctor are more likely to use the emergency room for non-urgent medical needs, regardless of socioeconomic or health status.¹⁵ Although research shows most American adults reported having a primary health care provider, many are still using the emergency room for issues that could be treated by their general

5. *Id.* at 2.

6. *Id.*

7. *Id.*

8. *Id.*

9. NATIONAL PRIORITIES PARTNERSHIP, *supra* note 2, at 1.

10. NEHI, *supra* note 1, at 1-2; Maggie Fox, *Who's packing ERs? Not the uninsured*, RUETERS (May 19, 2010) <http://www.reuters.com/article/2010/05/20/us-usa-health-emergencies-idUSTRE64I78X20100520>.

11. NEIH, *supra* note 1, at 3.

12. *Id.*

13. Fox, *supra* note 10, at 1.

14. *Id.*

15. Laura A. Petersen et al., *Nonurgent Emergency Department Visits: The Effects of Having a Regular Doctor*, 36 MEDICAL CARE 1249, 1252 (Aug. 1998).

doctor.¹⁶ This can be attributed to a lack of access to primary care physicians. A rise in patient demand due to the aging population and an increase in chronic diseases currently outpace the supply of primary care providers.¹⁷ Long wait times in the physician's office, limited availability of appointments, or difficulty getting through to the physician on the telephone, all increase a patient's likelihood of turning to the emergency room despite having a primary doctor.¹⁸

III. COSTS TO THE HEALTHCARE SYSTEM DUE TO EMERGENCY ROOM OVERUSE

Inappropriate use of emergency rooms has significant financial and quality implications.¹⁹ In terms of quality, the implications are two fold, affecting both the non-urgent and urgent patients' quality of care. Moreover, reducing emergency department overuse could lower overall healthcare costs by billions of dollars.

First, people who use a regular doctor for non-urgent care generally have better access to quality health care.²⁰ This is because emergency rooms are not optimal settings for the delivery of non-urgent care.²¹ The episodic nature of emergency care lacks continuity and is rarely coordinated with care that occurs elsewhere.²² Patients that receive continuous care by a regular healthcare provider benefit from enhanced clinical diagnostic accuracy and treatment, disease prevention, and higher rates of patient adherence to treatment regimens.²³ Higher continuity of care is also associated with decreased hospitalization due to better management of medical problems.²⁴ Regular doctors are also more likely to take preventative measures such as screening for cancer.²⁵ For instance, women with a regular source of care were approximately one-third more likely to have been screened for cancer than those without.²⁶ Additionally, individuals

16. George Rust et al., *Practical Barriers to Timely Primary Care Access*, 168 ARCHIVES INTERNAL MED. 1705, 1705 (2011).

17. NEIH, *supra* note 1, at 5.

18. Rust et al., *supra* note 16, at 1708.

19. Petersen et al., *supra* note 15, at 1252.

20. Lambrew, *supra* note 3, at 143.

21. NEHI, *supra* note 1, at 7.

22. *Id.*

23. *Id.*

24. See James M. Gill et al., *The Effect of Continuity of Care on Emergency Department Use*, 9 ARCHIVES FAM. MED. 333, 333 (2000).

25. Lambrew et al., *supra* note 3, at 143.

26. *Id.*

with poor to fair health are twice as likely to see a doctor if they have a regular doctor.²⁷

Second, the increase in emergency room use for non-urgent care is overloading hospitals' resources, making it harder for those with urgent conditions to receive the care they require.

Treating an increased amount of non-urgent patients crowds hospital emergency rooms, creates longer wait times, and stresses hospital resources, lowering the quality of care for those truly in need of emergency care. Many hospitals cannot handle the increased number of emergency patients. A national survey in 2002 showed that 62 percent of all hospitals surveyed reported operating their emergency rooms at or beyond capacity.²⁸ Further, nearly one-third of all hospitals have experienced periods of "Emergency Department Diversion," having to divert some or all ambulances to other hospitals.²⁹ In 2003, emergency room overcrowding forced half a million ambulances to be diverted; averaging one ambulance rerouted every minute.³⁰ Some hospitals, like Chicago's Provident Hospital, have been forced to stop accepting ambulance runs to their emergency rooms.³¹ Hospitals only have so many beds in their emergency departments and if non-urgent patients occupy them, they are unavailable for those with acute medical needs whom the emergency room was designed for in the first place.

Finally, researchers have estimated that the difference in costs between emergency departments and private physician's offices or similar locations account for billions of dollars nationwide.³² In 2007, it was estimated that the average emergency room visit costs \$767; \$580 more than the cost of an office-based visit.³³ When multiplied by 67 million people who choose to use the emergency room instead of an office-based doctor, avoidable emergency department use results in \$38 billion dollars of wasteful health care spending each year.³⁴

If the American healthcare system is able to minimize the use of hospital emergency rooms for non-urgent, primary care physician treatable, and preventable healthcare needs,

27. *Id.*

28. Rust et al., *supra* note 16, at 1705.

29. *Id.*

30. *Id.*

31. Monifa Thomas, *Provident to turn away emergency ambulances*, CHICAGO SUN-TIMES, Feb. 14, 2011, at 10.

32. Petersen et al., *supra* note 15, at 1252.

33. NEHI, *supra* note 1, at 6.

34. *Id.*

it will not only increase access and quality of care for millions of patients, but also save billions of healthcare dollars spent each year.

III. SOLUTIONS TO AVOIDABLE EMERGENCY ROOM USE

Barriers to timely access to primary care and a lack of alternatives create excess emergency department use.³⁵ This problem is so widespread that no one solution can prevent the 67 million unnecessary emergency room visits per year. The healthcare system must widen access to primary care, provide alternatives to the emergency room, and create financial incentives in order to lower emergency room overuse.

The first solution requires the healthcare system to provide better access to primary care physicians. This is especially important because those who do not have a regular doctor are more likely to use emergency care for non-urgent medical needs³⁶ and people who use a regular doctor for non-urgent care generally have better access to quality health care.³⁷

Recognizing the need for expanded primary care, the Patient Protection and Affordable Care Act (PPACA) of 2010 has created several programs, which promote access to primary care providers. This includes programs to support workforce education and training and provide funding to expand primary care capacity.³⁸ The PPACA reauthorized programs that support residency training in primary care, provide need-based financial assistance for physicians in training and practicing primary care physicians, and supporting faculty and curriculum development.³⁹ Additionally, the PPACA requires residency programs to redistribute at least 65 percent of unfilled spots in non-primary care programs to primary care or general surgery residency programs.⁴⁰ Financial incentives for primary care physicians under the PPACA include a 10 percent increase in Medicare payments for primary care encounters starting in 2011.⁴¹ The law also provides for the testing and implementing of new primary care delivery models and

35. Rust et al., *supra* note 16, at 1709.

36. Petersen et al., *supra* note 15, at 1252.

37. Lambrew et al., *supra* note 3, at 143.

38. John D. Goodson, *Patient Protection and Affordable Care Act: Promise and Peril for Primary Care*, ANNALS OF INTERNAL MED. 2 (2010) <http://www.annals.org/content/early/2010/04/15/0003-4819-152-11-201006010-00249.full>.

39. *Id.*

40. Robert B. Doherty, *The Certitudes and Uncertainties of Health Care Reform*, 152 ANNALS OF INTERNAL MED. 679, 680 (May 2010).

41. *Id.*

financial reimbursement methodologies to primary care physicians who improve outcomes for patients with chronic illnesses.⁴² These programs may help to meet the increasing demand for primary care in the long term.⁴³

However, due to barriers to primary care, many patients with a primary care physician still visit the emergency room for non-urgent care.⁴⁴ These barriers include long wait times in the physician's office, limited availability of appointments, or difficulty getting through to the physician on the telephone.⁴⁵ Luckily, most barriers are considered to be, at least partially, under the control of the primary care practice.⁴⁶

Answering the telephone on time and the availability of timely and convenient appointments are just some of the ways primary care providers can break down barriers to care.⁴⁷ Further, providing patients with access to after-hours physicians or telephone consultations with nurses have been proven to reduce emergency room use.⁴⁸ One program showed that after implementing a call system, inappropriate emergency room visits were reduced from 41 percent to 8 percent.⁴⁹ Also, patients who receive care at primary care practices that offer evening and weekend hours are less likely to turn to the emergency room.⁵⁰

Having a regular source of primary medical care is necessary but not sufficient to lower the risk of emergency room over usage. Primary care providers must provide continuity in their care. A continuous relationship with a physician allows a patient to develop trust in the physician's knowledge and medical judgment.⁵¹ Therefore, whenever it is unclear whether a patient needs to go to the emergency room, they are more likely to defer to the physician's advice.⁵² Further, patients under continuous primary care are less likely to be hospitalized because of better management of chronic issues, better screening for diseases, more comprehensive medical care and a higher

42. *Id.*

43. *Id.*

44. Rust et al., *supra* note 16, at 1705.

45. *Id.* at 1708.

46. *Id.* at 1709.

47. *Id.*

48. NEHI, *supra* note 1, at 8.

49. *Id.*

50. *Id.*

51. Gill, *supra* note 24, at 337.

52. *Id.*

likelihood of properly following treatment plans.⁵³ Therefore, not only will wider access to continuous primary care divert some emergency room use to doctor's office, it will also prevent future needs for the emergency room.

Secondly, the healthcare system needs to provide alternative sites for treatment of non-urgent conditions. Although they are small players in the health care arena,⁵⁴ retail-based clinics, like Walgreen's Take Care Clinic and CVS's MinuteClinic, present a great alternative to emergency room use. Retail based clinics are a straightforward model; they offer a limited menu of mainly acute and simple medical services on a walk-in basis, provide care through nurse practitioners or physicians assistants with lower salaries, and are located in small, relatively inexpensive retail spaces for easy consumer access.⁵⁵ Their inclusion in insurance coverage has allowed retail clinics to enter the mainstream healthcare system.⁵⁶ They also help alleviate emergency room overuse by those without a regular physician or insurance coverage. In one survey, thirty-three percent of respondents did not have a primary care provider and twenty-two percent reported being uninsured at the time they used the retail clinic.⁵⁷ Also, retail clinic visits cost one-fifth of emergency room visits.⁵⁸

Hospitals themselves are also adding creative solutions to traditional emergency rooms to help relieve overcrowding. Some hospitals are using the InQuickER system to allow patients with issues that are not life threatening to sign-in online, wait at home, and come in at a specified time.⁵⁹ This is a viable option for hospitals without the ability to expand their emergency department in response to its ever-increasing use. Twenty-three emergency rooms in eight states have implemented this system.⁶⁰ Other hospitals have set aside nurses and doctors to treat patients with minor issues and non-urgent conditions.⁶¹ Creating a separate track for patients who can be treated relatively quickly may reduce wait times and improve the overall flow of patients through the emergency

53. See *id.* at 333.

54. Margaret Laws & Mary Kate Scott, *The Emergency of Retail-Based Clinics in the United States: Early Observations*, 27 HEALTH AFFAIRS 1293, 1294 (2008).

55. *Id.*

56. *Id.* at 1294.

57. *Id.* at 1295.

58. NATIONAL PRIORITIES PARTNERSHIP, *supra* note 2, at 2.

59. Brian Indrelunas, *ER patients can wait at home instead, for a price*, THE DESERT SUN, Feb. 10, 2011, at B5.

60. *Id.*

61. *Id.*

room.⁶²

Finally, insurance companies can create monetary incentives for patients who use their primary care providers. Health insurance plans can include financial penalties in order to deter those who use the emergency room for non-urgent care. For example, several of Aetna's small-group HMO plans do not cover emergency room care that is deemed "non-urgent."⁶³ Insurance companies can also institute policies that encourage continuity of care, for example, offer lower co-payments for patients and higher reimbursements for physicians when visits are made to one's regular provider and higher copayments for non-urgent emergency room visits.⁶⁴

IV. CONCLUSION

As the American population ages and the prevalence of chronic conditions rise, the barriers between primary care physicians and their patients increase. As a result, millions of people turn to hospital emergency rooms for non-urgent and primary care physician treatable and preventable illnesses each year. This has profound effects on our healthcare system. This increase in inappropriate emergency room use lowers the quality of care for both urgent and non-urgent patients, and wastes \$38 billion healthcare dollars each year.⁶⁵ In order to solve the problem, the American healthcare system must widen access to continuous care by primary physicians and to emergency room alternatives like retail clinics must be widened, as well as create financial incentives by insurance companies. Lowering unnecessary emergency room use will not only save billions of dollars every year, but also, Americans will gain better access to quality health care.

62. NEHI, *supra* note 1, at 9.

63. Sarah Miller, *The Effect of Insurance on Outpatient Emergency Room Visits: An Analysis of the 2006 Massachusetts Health Reform* 5 (University of Illinois, 2010).

64. NATIONAL PRIORITIES PARTNERSHIP, *supra* note 2, at 1.

65. NEHI, *supra* note 1, at 1-2.