

## Report Examines Recession's Impact on EDs

To determine what impact the recession is having on hospital EDs, the Kaiser Family Foundation's Commission on Medicaid and the Uninsured conducted a set of interviews last month with ED heads and officials of groups representing emergency physicians and nurses. The EDs in which they practiced reflected a broad spectrum of settings and represented the four major regions of the United States. The product of those interviews, a policy brief entitled *Emergency Departments Under Growing Pressures*, indicates that the recession may have pushed EDs to their breaking point.

### Key Findings

#### Strained ED Capacity and Rising Volume

While ED capacity has been strained for some time, nearly all the EDs surveyed reported rising volume. The recession, with its negative impact on health coverage and patients' ability to afford needed care, was widely viewed as the cause of the volume increases. To deal with such increases, EDs are raising the number of patients doctors see per hour, and adding to work shifts and staff. The situation is worrisome, as the pressure on staff to do more in less time increases the risk of errors.

#### Economic Pressures Produce New "Recession" Population

ED doctors and nurses report seeing more people who lost their jobs and became uninsured. They also report higher numbers of insured patients seeking primary

care in the ED because they can no longer afford to pay deductibles and out-of-pocket costs at their doctor's office.

#### No Other Options for Uninsured People

Except for one ED, which was part of a large area health care system that included clinics for poor and uninsured people, all others surveyed cited sharp inadequacies in access to primary care in their communities, giving uninsured patients no other options. They reported that few private practices accept uninsured patients and waits for new-patient appointments at community health centers and clinics range from four to six weeks to four to six months. Also, when they have no other access to physician care and have run out of their medicines, uninsured adults come to the ED to get a refill, often having gone without for weeks. The visit is likely to be repeated a month later, as few ED doctors will prescribe for more than a month. Several interviewees said that doctors' offices in their communities had directed uninsured clients, clients with Medicaid, and insured clients whose benefits had run out to the ED for care.

#### No Access to Timely or Affordable Care

Faced with full primary care practices or unacceptably long waits for appointments with private physicians, insured patients turn to the ED for primary care. For some, their deductible or the co-pay required up-front in doctors' offices is a deterrent, and they come to the ED instead where they receive needed care, but do not have to pay right away.

#### Long Waits

Whether insured or uninsured, patients face long waits due to ED overcrowding. In one large, urban hospital the wait was 18 to 24 hours. One ED physician said, "It is only a matter of time before people are dying in the waiting room." It is expected that patients who give up waiting and leave will come back in worse shape.

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## CMS Clarifies EMTALA Obligations in the Event of H1N1 Resurgence

In response to concerns from hospitals and public health officials, the Centers for Medicare & Medicaid Services (CMS) issued an August 14, 2009, fact sheet to its State Survey Agency Directors clarifying options that are permissible under EMTALA in the event of a resurgence in H1N1 flu this fall. According to CMS, “many stakeholders perceive that EMTALA imposes significant restrictions on hospitals' ability to provide adequate care when EDs experience extraordinary surges in demand.”

The fact sheet notes that

- ▶ Hospital EDs can set up alternate screening sites elsewhere on campus, with personnel stationed outside the ED to log in and redirect patients seeking care to that alternate site. This triage system is acceptable as long as the personnel are qualified physicians, nurse practitioners, physician's assistants, or RNs trained to perform medical screening exams (MSEs) and acting within the scope of their State Practice Act.
- ▶ Hospitals may set up screening at an off-campus site if it is controlled by the hospital.
- ▶ Hospitals and community health officials may encourage the public to go to those sites instead of the hospital for influenza screening.
- ▶ The required medical screening exam does not need to be an extensive work-up in every patient's case.

However, there are some important caveats. A hospital may not tell individuals who have already come to the ED to go to the off-site location for the exam. And the hospital cannot announce or advertise the off-site location as a place that provides care for general, urgent, unscheduled emergency medical conditions, other than those involving influenza-like illness. For a copy of the memo and fact sheet, go to [http://www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/SCLetter09\\_52.pdf](http://www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/SCLetter09_52.pdf)

## AHRQ Report on ED Use and Payers

According to the most recent *News and Numbers* report from the Agency for Healthcare Research and Quality (AHRQ), Americans made a total of 120 million visits to hospital EDs in 2006. Of that number, more than 40% (about 50 million) were billed to Medicare and Medicaid. The uninsured accounted for 18% of the visits, 34% of the visits were billed to private insurance companies, and the rest were billed to workers compensation, military health plan administrator Tricare, and other payers.

The report is based on AHRQ's *Nationwide Emergency Department Sample* – a database nationally representative of ED visits in all non-Federal hospitals. Other findings include:

- About 38% of the 24.2 million visits billed to Medicare ended with the patient being admitted, compared with 11% of the 41.4 million visits billed to private insurers, 9.5% of the 26 million visits

billed to Medicaid, and 7% of the 21.2 million visits by the uninsured.

- The uninsured were the most frequent users of EDs. Their use rate was 1.2 times greater than that of individuals with either public or private insurance (452 visits per 1,000 population vs. 367 visits per 1,000 population, respectively).
- The uninsured were also the most likely to be treated and released (a possible indication that EDs are their usual source of care). Their “treat and release” rate was 421 visits per 1,000 population vs. 301 visits per 1,000 population for those with insurance.

In view of these findings, many policy experts say that reducing the number of ED visits billed to public insurance plans would be an important way to lower the high, and growing, expense of U.S. health care.

## Arizona Enacts Law Raising ED Malpractice Standard

On July 13, **Arizona** Governor Jan Brewer (R) signed into law SB 1018, a bill that raises the burden of proof for medical malpractice lawsuits against ED doctors from “preponderance of evidence” to “clear and convincing evidence,” the highest burden of proof in civil cases. Senator Carolyn Allen (R-Scottsdale), who sponsored SB 1018, said the law will encourage more doctors to practice emergency medicine in the state.

Doctors and hospital groups have been supporting such a measure for some time, and their statements echoed Allen’s. Chic Older, executive vice president of the **Arizona** Medical Association, said that ED doctors often see patients with little or no knowledge about the patient’s medical history and, therefore, “We’ve got to make some allowances for the fact that things can go wrong in these situations.” He added that the law still allows patients to sue if they are injured during emergency treatment, but they just need to prove a higher

evidentiary standard to win such actions.

Critics of the new law say the measure unnecessarily raises the burden of proof for ED doctors above that of other physicians, who are still held to the “preponderance of evidence” standard in malpractice suits. The standard of care used for malpractice cases already takes into account whether a physician was familiar with a patient’s history so a doctor would not be punished for making mistakes based on that lack of information. These critics say that the elevated burden of proof will simply make it harder for plaintiffs who were injured out of negligence to prove their already-difficult claims.

According to a 2006 report by the **Arizona** Emergency Medical Services Access Task Force, however, such malpractice reform would make more physicians and specialists willing to treat patients in EDs. The new law goes into effect on September 30.

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No inpatient capacity for those who need admissions leads to boarding.

### Repeated Visits and Sicker Patients

Patients not getting primary care come to the ED repeatedly as problems flare or they get sicker. As a result, the ED is burdened and the patient faces higher costs and possibly more difficult treatment.

### Costs Lead Patients to Decline Recommended Care

The interviews elicited numerous accounts of both insured and uninsured patients choosing not to follow medical advice because of the cost, including the cost of missing work. Such decisions put patients’ health in jeopardy, leading to repeated ED visits and even costlier treatment.

### ED Visits Linked to Stress from Job Loss/Financial Worries

Interviewees reported increases in complaints of anxiety, depression, and stress due to joblessness and financial worries. When no physical cause can be found for such somatic complaints as stomach or chest pains, the

symptoms are most likely stress-related.

### Follow-up Care Unlikely

Interviewees described follow-up care for uninsured patients as an enormous problem, with fees and long waits for referred appointments the impediments. When ED doctors realize their patients are unlikely to get follow-up care, they practice differently to ensure the patient’s safety – doing more extensive and costly work-ups, or admitting them in some cases. The effects of no follow-up – e.g., worsened conditions – are seen at intake.

### Inadequate Resources to Meet Mounting Pressures

In order to handle the increasing volume, EDs need additional staff, ancillary services capacity, and greater inpatient capacity. If the H1N1 pandemic hits, EDs will have even more pressure. That could be more than EDs can handle.

The complete policy brief (publication #7960) is available at [www.kff.org](http://www.kff.org).