ER for the ER

Urban Institute, Barbara A. Ormond

Kojo Nnamdi: From WAMU at American University in Washington, this is Public Interest. I am Kojo Nnamdi.

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Read the newspapers, it doesn't matter where—Boston, Seattle, Ohio, in urban areas of Texas, Florida, New York, hospitals are temporarily closing emergency rooms to ambulance traffic and turning away patients who need help. And it's not just during flu season when hospitals in the Northeast find their ERs crowded with wall-to-wall sneezes; throughout the country, cities report hospitals are often on deferred status, too busy to take new patients, telling ambulances to go seek out another hospital. There simply don't seem to be enough emergency room services to go around.

Are the temporary closings a sign of a real crisis in our health care system, and are our urban areas simply the canary in the coal mine, telling us about the problem first before it spreads out to areas across the country?

In this next installment of our ongoing series with the Urban Institute, we look at the state of emergency care around the country. And, by the way, we are trying something new. You know, you've always been able to listen to this show through Real Audio at our Web site, www.wamu.org, but today you can listen to it live at www.kaisernetwork.org. It's a free online health policy Web-casting and news summary service. It is provided courtesy of the Kaiser Family Foundation. And, after the show, you'll find a written transcript of the show there as well as background research on this show and additional links to relevant sites that discuss emergency room issues. You should check it out.

And you can join us on the show by calling 1-800-433-8850, or e-mailing us at pi@wamu.org.

Joining us to discuss this issue is Barbara Ormond, research associate with the Health Policy Center of the Urban Institute. Welcome.

Barbara Ormond: Thank you.

Kojo Nnamdi: Joining us by telephone from California is Dr. Charles Cutler, chief medical officer for the American Association of Health Plans. Welcome to you, Dr. Cutler.

Dr. Charles Cutler: Thank you.

Kojo Nnamdi: Also in our Washington studio is Dr. Mohammad Akhter. He is the executive director of the American Public Health Association. Good to see you again, Dr. Akhter.

Dr. Mohammad Akhter: I'm glad to be here.

Kojo Nnamdi: And it's also good to see again Dr. Michelle Grant Ervin. She is chair of the department of emergency medicine at Howard University Hospital. Dr. Ervin, hi, again.

Dr. Michelle Grant Ervin: Hi, and thank you.

Kojo Nnamdi: Thank you for joining us.

Let's start out with some terms first, because we all know what an ER is. There's a television show every week with that name, and then all of a sudden, as I prepare for this show, "emergency department" crops up. What is an ED?

Dr. Michelle Grant Ervin: An ED is an ER. It's just a specialty has evolved that we really practice outside of one room. When you use the term ER, that's how we practiced in the 1970s: We were really confined to one

room, usually the back room of a hospital. We can use both terms if that's what you're comfortable with. But you will usually find "emergency department" being used by emergency medicine specialists and the academics, and ER being used by everyone else.

Kojo Nnamdi: Does that mean the television show is going to have to change its name to conform to this?

Dr. Michelle Grant Ervin: No. But I think the television show is doing a wonderful job of educating the public regarding the specialty of emergency medicine, and if that's the term that catches the public's mind, then that's the term they should use.

Kojo Nnamdi: Well, Barbara Ormond, a lot of hospitals have been downsizing the numbers of beds they have for at least the last 10 years. I guess the first question has to be, given what seems to be happening in emergency rooms around the country, did we simply go too far?

Barbara Ormond: I think it's interesting to notice that the downsizing of hospitals has been a much more recent phenomenon. But talking about crowding in the emergency room has been going on for at least a decade or more. So it's just a general mismatch in the number of people seeking care at the emergency department, or the emergency room, and the capacity of the emergency departments.

Kojo Nnamdi: Is there a specific relationship, Dr. Cutler, between managed care downsizing and the backup in emergency rooms?

Dr. Charles Cutler: Well, I think there are some relationships. The backup in the emergency room is in part due to the emergency room, but in part due to the availability of beds in the hospital, so that as people need to be transferred out of the emergency room to a hospital bed, the hospitals need to have the capacity to do that. One of the effects of managed care is to help stimulate the movement of some procedures from in-hospital to outpatient procedures. Common surgeries, like hernia surgery, for example, or tubal ligations, or cataract surgery, that used to be done in the hospital 15 years ago are now done in the outpatient setting. What that means is that there are fewer beds that are used for these discretionary kinds of surgeries that could be put off, and [the beds] could be made available to the kind of acute illnesses that people have when they come into the emergency room.

So, in a way, by moving more of these surgeries appropriately to the outpatient setting, there may be a decrease in the reserve capacity that the hospitals had to accommodate the increases in demand.

Kojo Nnamdi: Dr. Ervin, I had a friend who last night had an emergency in which his mother went to one hospital in Washington where she had been going to the emergency room for treatment—his mother has cancer—and the ambulance could not go there and was diverted to another hospital in Washington, and sat in that emergency room for three hours because she could not be transferred to the other hospital because no beds were opening up there. What's going on?

Dr. Michelle Grant Ervin: There is a real capacity problem in the District of Columbia, especially this time of season, around the flu season. The capacity problem is not around just your hospital beds, it's around your acute care beds that are available. I can tell you that at my institution, we are often juggling between identifying intensive care unit beds so we can move patients from the emergency department upstairs into these acute care and step-down beds.

Kojo Nnamdi: Dr. Akhter, your experience?

Dr. Mohammad Akhter: I think what my friends have been describing here, and what you said is true not only here, but nationwide. I mean, this is the failure of our health policy. This has been—for the [last] 10 years, we've been sort of, "cutbacks, cutbacks, cutbacks," and no organized way of really taking care of the needs of the people. So here we find ourselves on the one hand with a large number of uninsured people who take this as the safety net, the emergency room. We find the people who are really needy need to be in the emergency room. And then, of course, a large number of people who are doing it as a matter of convenience, where they just simply go to the ERs and as a result these places are overwhelmed. And financially, no hospital has the capacity to really expand their services. So financially you're very tight, the demand is very high. And so it's not going to get better, it's really going to get worse.

Kojo Nnamdi: Barbara Ormond, a recent study in New York showed that some 75 percent of people in hospital emergency rooms were not there for what was considered a true emergency. Figures from San Diego say, 60 percent. And the problem seems to pervade the entire country. Obviously, the causes are complex, but can you tell us who these people are, and are they simply all uninsured?

Barbara Ormond: I think a large proportion of the people in the emergency rooms are uninsured. And the number of uninsured patients coming into the emergency rooms is increasing as the number of uninsured people in the country increases. A large proportion—

Kojo Nnamdi: They're now around 40 million, right?

Barbara Ormond: They're now around 40 million. A large proportion of these people have in the past been people who were insured under public programs, such as Medicaid, which is a public program providing insurance for low-income people. I think this kind of emergency room use is thought to be declining, as these people are moved into managed care programs. One of the reasons Medicaid people have often used the emergency room is that there are no other sources available to them. Private physicians have been reluctant to take on Medicaid patients for various reasons, reimbursement rates being one of them.

The other kind of people that are coming into the emergency room are privately insured patients, and these

are the people that the hospitals would like to see come into their emergency room—these patients have insurance, the hospitals will be well-paid for this.

But the question is, why are people coming in there, if the average wait in the emergency room is two hours for a non-urgent visit. Why would you go there if you had insurance, if you could go somewhere else? And so I think it's a question of looking at what the barriers to getting more appropriate sorts of care are in our system. Is it a question of the physicians offices are not open at convenient hours, or are not at convenient places? It's largely a question of, what are the alternatives to the emergency room.

Dr. Ervin, is your experience at Howard University Hospital similar?

Dr. Michelle Grant Ervin: My experience, not just at Howard University Hospital, but across the specialty of emergency medicine, is that we need to find what is "true" emergency. And in emergency medicine, the patient defines what the emergency is, regardless of the time of day or what the complaint is. At the time that they're presenting in the emergency department, for them, this is their reality, and this is an emergency for them. They may have insurance, they may have some type of HMO coverage, but they may not be able to have their needs, their concerns, addressed in what they consider a timely manner.

So, I would first like to define true emergency as the patient defines what the true emergency is. And often I have found that it is an access problem. They will present to the emergency department as their safety net, as their place of last resort, whether or not they have funding or other resources for health care, because this is where they're more than likely to get an answer or referral for an answer, or at least have someone hear what their question and concern is, as opposed to having to wait weeks.

Kojo Nnamdi: Dr. Cutler, go ahead.

Dr. Charles Cutler: We're mixing a couple of issues. One issue is the crowding of the emergency room, and the other is the diversion of patients because no beds are available. And while they're linked, I think the issue that we were talking about, about beds, is slightly different from people coming to the emergency room for acute care. In the last case, as Barbara pointed out, one of the things that managed care has been trying to do is to offer patients alternatives for those acute visits where they're going to the emergency room because they know they can get acute care, and they don't know where they can get acute care otherwise.

What we've tried to do is arrange with our physicians, who are providing the primary care for these patients, [is for them] to be accessible, and as part of managed care contracts, for example, we would require that physicians have coverage 24 hours a day, that they at least be available by phone. And a number of managed care organizations have developed agreements with urgent care centers, or less acute care facilities that can provide care for patients with minor musculoskeletal problems or colds or sore throats.

Kojo Nnamdi: Dr. Cutler, your organization includes over a thousand health insurance plans, and represents health care plans for more than half of all Americans. As one such American, I have to say, I am completely unaware, outside of the emergency system, of physicians and clinics that make themselves available for that kind of care under managed care. And most people that I know are completely unaware of it.

Dr. Charles Cutler: Well, I'm surprised to hear that. In Washington, for example, one of the large health plans, Kaiser Permanente, operates urgent care centers at most of their health centers that are available to people with emergency room-like services. I'm not suggesting that people who have life-threatening emergencies call and go into those urgent care centers.

As Dr. Ervin stated, some people feel that they have life-threatening emergencies, and if they feel that they do, they should certainly go to the nearest emergency room. But for those people who have what they recognize as minor illnesses, such as minor musculoskeletal injuries, or sore throats, or colds, the first thing they should do is call their primary care physician, or if they belong to a group practice, like Kaiser—and it's not just Kaiser, there are other group practices—they should call those practices first. Because frequently they do have urgent care centers available.

Kojo Nnamdi: I call my primary care physician, and it is not an emergency, I have to wait at least two weeks before I can get into that office, even if I have a condition of illness.

Dr. Charles Cutler: Well, what I would suggest then is you might either take that up with your physician, or see about finding a physician who has same-day appointments available. Many physicians do arrange their schedules so that they have same-day appointments available for patients who have acute illnesses. And one of the things that our plans do is work with physicians to improve that kind of access. We certainly, through our consumer relations phones, get complaints and comments about physicians' offices, and we talk with them about being available for patients. That's one of the things we want to do: to avoid having people who don't have emergencies that need emergency room-kind of care go to emergency rooms when care could be provided in a more timely and more accessible way elsewhere.

Kojo Nnamdi: My own practice is, I simply walk into the physician's office, and sit down and pretend as if I had an appointment.

We've got to take a short break. Joining us by telephone from Delmar, California, you heard Dr. Charles Cutler; he is the chief medical officer for the American Association of Health Plans. In our Washington studio, Dr. Michelle Grant Ervin; she is the chair of the department of emergency medicine at Howard University Hospital. Dr. Mohammad Akhter; he is the executive director of the American Public Health Association. And Barbara Ormond is a research associate with the Health Policy Center of the Urban Institute.

We take your telephone calls at 1-800-433-8850, your e-mails at pi@wamu.org. We'll be right back.

(Commercial break.)

Kojo Nnamdi: Welcome back to our continuing series with the Urban Institute this month on emergency rooms. And speaking of the Urban Institute, Barbara Ormond of the Urban Institute, talk a little bit more about the reasons people seem to be choosing emergency rooms over the offices of their doctors.

Barbara Ormond: Well, even if a doctor's office will give them an appointment on the same day when they feel that they're sick and they feel that they need it, often people don't have the flexibility in their jobs or the flexibility with their children or their work schedule to be able to get into their doctor's office between the hours of nine and five, when they're generally open. And so what the emergency room offers that physician's offices don't—even the best physicians' offices—is immediate attention when you need it, and when you can go, when the other activities of your life and requirements of your life are not bearing on you.

Kojo Nnamdi: In 1986, Congress passed something called the Emergency Medical Treatment and Active Labor Act, EMTALA. This law giving every patient "the right to emergency treatment" regardless of their ability to pay. So, Dr. Cutler, is it Congress' fault that the ERs are overcrowded?

Dr. Charles Cutler: Well, what EMTALA provided, and I'm sure Dr. Ervin can speak to this better than I, is that anyone who showed up at an emergency room would at least be evaluated by that emergency room. And I believe Congress' concern was, at the time, well, what's called dumping. Which is patients who would show up at emergency rooms who were not insured, who would not be evaluated, and who would be sent to other emergency rooms, at sometimes considerable risk. So, I'm not sure that EMTALA per se caused some of the current issues that we have.

I think it's more likely that what happened [is related to] some of the other regulations that had to do with decertifying beds in hospitals that were unused. And by that I mean, a lot of states have regulations that control how many beds a hospital can have available. If the hospitals don't use those beds for some period of time, those beds are decertified. And what that does is, it decreases the reserve capacity at hospitals to take care of these peak demand times for people who need hospital admission.

Kojo Nnamdi: Dr. Ervin?

Dr. Michelle Grant Ervin: EMTALA did not cause overcrowding. If anything, EMTALA reinforced that there is a safety net for an individual to turn to if they feel that they will have what they call a wallet biopsy before they present to their health care biopsy. What EMTALA does, it says that when you present to an emergency department of an acute care facility—and it's now been expanded a little bit to also include outpatient centers, to hold them to the same standard—that you have the right to the minimum of a medical screening exam before anyone will ask you [whether you are] able to pay. And this has really be a tremendous safety net regarding health care across the country. It has not eliminated a wallet biopsy. Organizations have become a little bit more sophisticated in assessing how far they're going to go in stabilizing and evaluating patients, et cetera, but it has definitely saved lives.

Kojo Nnamdi: Dr. Akhter, what should we consider to be acute care?

Dr. Mohammad Akhter: The acute care is the kind of care that one needs: If it's not provided, one has the danger of losing their life, or limb, or really disease becoming progressively worse, does tremendous damage to the individual, or the disease gets spread to the others. So it is something that is time oriented, that one must be provided care.

Let me answer the first question, I think it's a very important question. We can take Congress off the hook. You know Congress passes a bill, and that's good, you can go to the emergency rooms so a patient wouldn't be dumped. But fundamentally, it's Congress' fault by creating this level of uninsured in the country. There's a tremendous number of uninsured. It's going up [because we don't have] universal coverage. It's Congress' fault to cut the hospitals and the institutions through their Medicare reimbursement to a point where they are bare-bones structures. These institutions are operating on shoestring budgets. If they want to expand, they can't expand. And I can tell you about D.C. hospitals. And last, but not the least, local governments have also pulled the rug from under us. When I was health commissioner here, we had 15 primary care clinics, today there are 4 or 5, but the number of uninsured has remained the same. So we have, by not really cooperating, not doing something that needed to be done for the public at large, which is provide universal coverage, have an alternative for primary care—we have created a situation where the ERs are unable to handle the load of patients.

Kojo Nnamdi: Barbara Ormond, I would like to hear your take on that.

Barbara Ormond: I think there are two issues why we need to provide more widespread insurance for people, and one is that we care about the people, and they need to get care in appropriate places before their illnesses get so serious that they turn to the emergency room.

But the other issue, and I hate to sound cold-hearted, is it's a money issue. The emergency room is a very expensive place to treat people. Charges in the emergency room—that's charges, not costs—can be two to five times higher for a non-acute care visit than they can in some other setting. If you're spending two to five times as much money on care than you need to, and that care is not available for public health measures for ambulatory care that's more appropriate, you're spending too much money for things you could get for a lot cheaper.

Kojo Nnamdi: Dr. Charles Cutler, it is my understanding that under EMTALA a patient is still responsible for the cost of care, and if you're uninsured and indigent, you've got to ask what happens then. But if you are

insured, does your HMO or insurance company have to pay? It's my understanding that some states have what is called a prudent layperson standard. Could you explain what that is?

Dr. Charles Cutler: Yes. I think it is in part what Dr. Ervin was describing earlier, which is that people go to the emergency room with a variety of complaints. And in the past, some managed care organizations in order to try to encourage the use of outpatient facilities, physician's offices, rather than emergency rooms, have limited payment for people who went to the emergency room based on the diagnosis that they received at the end of the visit. And, unfortunately, what happens in those instances is, someone can go to the emergency room with chest pain, thinking that they might be having a heart attack, which is perfectly appropriate, and then at the end of the visit really be diagnosed with stomach upset, or gastritis, which was not an acute emergency. And in some cases those claims were not paid.

What our members have adopted as part of our code of conduct, and what a number of states have mandated, is the prudent layperson standard, which is that if you, as a layperson, without any specific medical knowledge, think that you're having an event which is life-threatening or potentially hazardous to life or limb, you should go to the emergency room and have it evaluated, and the health plans will pay for it.

That's related, in a way, to the EMTALA standard, but it's different. And, as I said, you know, our members have adopted this standard of prudent layperson, so that anyone who feels that they're in severe danger, or they need emergency attention, should certainly go to the nearest emergency room, and we'll cover it.

Kojo Nnamdi: You can join us at 1-800-433-8850, our e-mail address, pi@wamu.org.

Allow me to go to the telephones, starting with Jason in Cleveland, Ohio. Jason, you're on the air, go ahead please.

Caller: Yes, I am a medical student here in Cleveland, Ohio, and planning on going into emergency medical. I'm halfway through my third year of clinical rotations, and I sort of think I have, maybe, an explanation for why emergency rooms are full and the hospitals are full. It's because—

Kojo Nnamdi: Jason, before you continue, you sound kind of hollow. Are you in an enclosed area?

Caller: I'm actually driving from the VA hospital to the large county receiving hospital where I have to go this afternoon.

Kojo Nnamdi: Okay. Go right ahead.

Caller: Okay. I think if we had preventive services, if we really, really were truly interested in making sure every American had preventive health care, then you'd have shorter hospital stays and fewer people who needed to go to the emergency room because they didn't know how to manage their illness. I think by educating patients in how to recognize signs and symptoms of their illness, of what's really a problem and what's kind of normal, I think you'd reduce—one, you'd reduce emergency room visits, and I think two you'd be able to reduce length of stay in the hospital, because you'd have less sick patients coming in who need more acute management.

Kojo Nnamdi: Jason, who is you, who do you see being responsible for the education to which you referred? Should it be the managed care industry, should it be the medical profession, should it be the government?

Caller: I think—personally, I think it's the responsibility of every person who comes in contact with a patient to be involved in education. I think it's the responsibility of medical students, of nurses, of physicians, of social workers, of physical therapists, of respiratory therapists. I think it's everyone's responsibility to say, hey, this is what I'm doing this is why I'm doing it, and this is what you yourself can do at home or when you're not in my office or in my clinic to take care of yourself, and make it a team approach. I think by empowering patients and educating them on how to take care of themselves, you're going to have: one, happier health care consumers; and two, fewer costs to the health care system.

Kojo Nnamdi: Well, Jason, the reason I raise that issue—and Barbara Ormond, Dr. Akhter, Dr. Ervin, Dr. Cutler, you can all respond—the reason I raise that issue is that people say that, look, nobody pays for preventive health care in the United States, nobody is willing to pay for that.

Dr. Cutler?

Dr. Charles Cutler: Well, as you may remember, before the term managed care, managed care organizations were called health maintenance organizations. And they were called that because that was the name used in the HMO Act, the Health Maintenance Organization Act of 1973. One of the major changed that managed care instituted over traditional insurance is that managed care actually does pay for preventive care. Traditional insurance does not pay for preventive care visits, screenings, pediatric immunizations, and so on, but managed care organizations do pay for that. In fact, most managed care organizations have outreach programs for preventive care. And there's a wide range of preventive care services which are measured and reported nationally called the quality compass that's available on the web, and I could give your listeners the reference later if you like.

Kojo Nnamdi: Sure.

Dr. Charles Cutler: The second point is that I absolutely agree that we all have a responsibility to educate patients more. And managed care organizations have really taken an aggressive approach to identify patients who—especially those patients who have chronic illnesses, who are at higher risk of having acute events and using emergency rooms. And the classic example is asthma, where a number of managed care organizations

have provided outreach programs for their patients with asthma, using nurses and nurse educators, educating patients on how to care for their asthma, how to use their inhalers appropriately, making sure they're on the right medications. And they've demonstrated that the emergency room use when these programs are in place can decrease as much as 80 percent. And hospital admissions also decrease for those patients involved in the programs.

So I agree that we all have a responsibility to educate patients. And there certainly are a number of good demonstrations that those kinds of programs empowering patients to provide better care for themselves can decrease the use of health care services.

Kojo Nnamdi: Jason, thank you for your call.

On to Bill in Indianapolis, Indiana. Bill, you're on the air, go ahead please.

Caller: Yes, I'm a board-certified emergency physician who has been practicing for approximately 18 years. I agree with Dr. Ervin that the problem is multi-factorial, but part of it is exactly as she says, the patient defines the emergency. And despite the claims of one of the other physicians on your panel today, I can't recall the name, I continue to see patients presenting who have a same-day appointment, even an hour or two away, but they couldn't wait to have someone take care of their viral sore throat. And it unfortunately happens to be, in many cases, the Medicaid population.

In our particular state we are stuck; we cannot and certainly we would never refuse to see a patient. We are required to ask them if they've contacted their physician for approval—if they haven't, we have to contact that physician—and then if the physician says no, we don't get paid. But we've already rendered the service, yet the patient bears no responsibility there. There is no education—if you try to educate them then they feel that they are being put down, and they can complain about it, and you really have no resource. I would like to hear the panel's response as to what types of things really can be brought to have the patient bear some responsibility for appropriate utilization.

Kojo Nnamdi: This is Public Interest. I'm Kojo Nnamdi.

Bill, let's get an answer to your question. Dr. Ervin?

Dr. Michelle Grant Ervin: Well, I would like to, before I directly answer his question, I would like to address the issue regarding under funding, period. You mentioned preventive health services are not funded. Emergency care is not adequately funded across this country. You see the cost of when a patient presents into an emergency department, but that's because an emergency department has to be able to handle the acute MI, the stab wound, the gunshot wound, as well as the sore throats. And because of Intella, we are required to rule out the life threats first, whether that means doing the initial EKG, lab, screening, observing—all of that is built into the cost. Whereas, in the preventive setting they tend to go from the back end, as opposed to starting with what is the worst possible thing this could be.

To emphasize what Dr. Akhter brought up, health care across the country is underfunded, both preventive and emergency. And I just wanted to bring that point across. Regarding education, the Medicaid population, I think the entire population needs to be educated. And I think emergency medicine does take that on. I know here in the District of Columbia, a campaign was started several years ago regarding making the right call, educating the public on when to call 911 for an emergency for transport versus the patient is stable, you only have a sprained ankle, you don't need to call an ambulance to take you into the emergency department. I think education is ongoing, I think it needs to be done across all socioeconomic levels, not just the Medicaid population.

Kojo Nnamdi: But what Bill seems to be talking about—he's mentioned individuals who have a doctor's appointment on the very same day that they have the sore throat, and hours before the doctor's appointment showing up at the emergency room. Is that what you were saying, Bill?

Caller: Yes, Kojo, I've taken care of patients at 6:00 a.m. who have an 8:00 a.m. appointment, or they will have called their doctor, their assigned physician, we have an HMO type set up here for our Medicaid population—

Kojo Nnamdi: Bill, I find it difficult to believe that that is a common problem; is it?

Caller: I see at least two to three patients a night for that.

Dr. Michelle Grant Ervin: Kojo, if I could respond. Yes, you see patients like that, but on the other side of the coin you see patients that present with a sore throat, they do have a same-day appointment, and that sore throat is their throat is closing up, their airway is closing up, they're not able to breathe.

Kojo Nnamdi: Finding it difficult to breathe.

Dr. Michelle Grant Ervin: They're getting worse, they're not able to wait. So there are abuses in patients waiting too long, and there are abuses on patients not waiting long enough, and it's hard to determine who to make the call on. And I believe that as emergency medicine we need to keep advocating the patient has to make the determination to make the right call.

Kojo Nnamdi: Bill, thank you for your call.

It is my understanding that the so-called continuum of care model has been touted as the answer to many of these problems. But it doesn't seem so far that most people have access to good alternatives to the ERs in their neighborhoods. I talked about that earlier. Is it financial problems, staffing difficulties, or other issues

that are preventing good alternatives like urgent acute care centers and local primary care clinics from being developed in every community nationwide, Barbara Ormond?

Barbara Ormond: Well, if you look at—if you take the privately insured population as a model, what they have available to them is a physician's office and someone who has their files and can take care of them whenever they need it. And usually if you're privately insured you don't change your source of insurance very often, so you can stay with that physician. If you have a managed care plan that is either provided by the government under Medicaid or Medicare, or if it's provided through your employer—these plans are often changed from year to year as the employer gets a new contract with their health insurance plan. Your doctor may not be on the panel of the next plan. There are issues where managed care promotes continuity of care, and there are areas where managed care actually gets in the way of continuity of care.

And sometimes if you have—or someone who has a multitude of problems, and have several physicians, some of your physicians will follow you on the next panel, your next managed care plan, and some of them won't.

Kojo Nnamdi: Dr. Akhter?

Dr. Mohammad Akhter: I think those plans are good, but we need to fund them for all the people. We just cannot have this fragmented system [where] some of [us] have and some of us don't have. This is not one nation under God; when it comes to health care it's divided in so many different pieces, and we have so many different kinds of insurance plans, and we have so many people with nothing at all, that we really need to develop a cohesive system for a nation such as ours on the top of the world, economically and otherwise. Really, it's time to take action and do something for all.

Kojo Nnamdi: Dr. Mohammad Akhter is the executive director of the American Public Health Association, he joins us in our Washington studio, along with Dr. Michelle Grant Ervin, chair of the department of emergency medicine at Howard University Hospital, and Barbara Ormond, research associate with the Health Policy Center of the Urban Institute. Joining us by phone from California, Dr. Charles Cutler, chief medical officer for the American Association of Health Plans.

We'll be right back.

(Commercial break.)

Kojo Nnamdi: Welcome back to our conversation on emergency care. Allow me to get back to the telephones, going to Robert in Washington, D.C. Robert, you are on the air, go ahead please.

Caller: Hi, my comment is very simple, but first let me say hello to Dr. Akhter, and my collegue Dr. Michelle Grant Ervin from the Mayor's EMS Advisory Committee, on which I serve here in the District of Columbia. To be very succinct, it's important to point out that we talk so much about how these issues should be addressed—there's the EMS agenda of the future, there's the Healthy People 2010 program—which all point out the fact that we need to ensure that health professionals are out in the community; we need to ensure that we train paramedics, EMTs, and firefighters who have that first response on those things, who are able to communicate with people and get them to understand that going to—well, to live healthy, and hopefully will reduce the number of visits to the emergency departments.

It's also important to point out that there is a perception in this nation that if you go by ambulance to the hospital, you will be seen a lot faster, and there is a prudent layman standard in the District of Columbia which we put in place a couple of years ago. So if we start training children now, as we used to have the Officer Friendly program, if we really begin to go back in and do the public health and the pre-hospital screenings that we used to do, we will be able to make a difference.

And finally, I'd like to point out that there is $80 million that Congress approved last July in EMS injury prevention and fire prevention that we need to ensure that our emergency management agencies and fire and EMS departments across the country have grant writers, and are able to go out there, get that money, and ensure that it works in our community.

Kojo Nnamdi: Okay. Robert, thank you very much for your call.

Moving onto Dr. Charles Cutler. Dr. Cutler, you watch a TV show like ER, and it appears that emergency room physicians are often the patient's best advocate. However, there are complaints that there is sometimes a disconnect between what the doctor wants to do and what the HMO is prepared to pay for. Dr. Cutler, is there such a disconnect?

Dr. Charles Cutler: Well, I think there are a number of things to say. The first thing to say is that as much as possible for the kinds of minor problems we were talking about previously, obviously we feel that it's better for patients to get continuous care from their primary care physician. If it is a true emergency, or if the physician isn't available, then obviously they should look for alternatives, like the emergency room.

The issues where coverage comes up has to do frequently with two aspects of coverage. One is whether the particular service requested is one which is covered by the health plan, and that's determined in a variety of ways, but usually in negotiations between employers and health plans, that determines what's covered. Whether a service is covered or not is sometimes the cause of disagreement or discussion between the emergency room or other physicians in the managed care plan.

And the second is whether the institution in which the patient is being treated is part of that managed care plan network. So on occasion patients will show up in the emergency room, and they'll be evaluated, as we

discussed previously, by the emergency room physician. The physician will suggest admission to the hospital, and if the hospital isn't one of the hospitals in the managed care plan's network, the plan may suggest transferring that patient to a hospital which is in their network.

Kojo Nnamdi: Any response to that, Dr. Ervin, Dr. Akhter?

Dr. Michelle Grant Ervin: Well, first I would like to applaud Dr. Cutler, since his plan does incorporate the prudent layperson law, which is excellent. It needs to be adopted nationwide in all of the plans. Second, regarding the disconnect between what an HMO will pay for and what the emergency medicine physician is recommending or advocating, as far as the emergency medicine physician is concerned, they are going to do what is best for the patient. And yes, we do—after we have done our initial screening, stabilization of patients, we will make phone calls regarding admission. If we feel the patient is unstable for admission, we will relay that to the physician that we are having the discussion with on the phone, regardless of the ability to pay, and we will hear their recommendation. But if we feel the patient is unstable for transfer, we train our residents—as faculty we will state the patient is unstable for transfer for the various reasons.

Kojo Nnamdi: Dr. Akhter?

Dr. Mohammad Akhter: I think there is also another issue, which is basically that in the past we were used to provide the emergency treatment and then admit the patient. Now we are asked to do more and more in the emergency room: provide treatment, hold these patients while these arrangements are being made to transfer the patient. I mean, it is such a long, drawn-out process, negotiation and talking back and forth, that it sort of leads to the overcrowding; we are not able to pay attention to the people who really come in as an acute emergency. And that's the problem.

Kojo Nnamdi: Barbara Ormond.

Barbara Ormond: And in addition to that, adding to that problem is that, from the hospital's perspective, there's administrative work trying to decide which service is covered for which patient under which conditions, and is this one of those times, which adds extra time and extra work, which doesn't contribute at all to the health care of the population.

Kojo Nnamdi: Dr. Cutler, it sounds all very confusing to me.

Dr. Charles Cutler: Well, I think the goal of the health plan is the same as Dr. Ervin's, which is we would not want to have patients transferred who are unstable, so I absolutely agree with her. And that's a decision which we depend on the treating physician to make. I think Dr. Akhter's point about having patients staying longer in the emergency room is not just a characteristic of managed care. The services offered in the emergency room have expanded over time. Many emergency rooms now have separate holding areas designed to watch patients for a period of time, sometimes even up to a day in the emergency room intentionally; that is not keeping them from taking a bed, but it's a special area designed for that purpose.

In addition, some emergency rooms actually have been advertising to increase their volumes, which is interesting to me in light of the discussion we're having. But they actually want to bring in more volume, which is occasionally problematic for us as well, because we would prefer patients be treated by their primary care physician, but in the meantime they're hearing advertising on the radio to bring patients into the emergency room. So I think there are a variety of issues which vary from setting to setting, depending on the capabilities of the emergency room and how many beds they have available at any given time and the range of services that the hospital provides.

Kojo Nnamdi: I guess I have to ask for a follow-up on that question, Dr. Ervin, and that is emergency rooms that are marketing themselves to patients. Dr. Cutler seems to be making the argument that patients can become conflicted as a result of that.

Dr. Michelle Grant Ervin: I don't think patients can become conflicted; emergency departments that are "marketing themselves" are really identifying areas of the emergency department where they can move patients through the system quickly. For an example, I can use my own emergency department. We have something called a fast-track area, where patients who present—they all started either at the ambulance entrance or at our first front triage nurse, who present—who have minor illnesses, complaints, extremity injuries, we will send them to our fast-track area to be seen and not clog up patients seen on the main emergent side, where our more acute illnesses present.

We have another area in our facility called our chest pain observation area, and this is deliberately designed where there are lower costs, where patients who present with chest pain, they are not stable to just send home, because missed MIs [heart attacks, are] still one of the highest misdiagnoses in emergency medicine. We observe them over a certain period of time that we have worked out with cardiology, we do certain labs [and] EKGs on them, ensure that they are not having an acute MI, and we actually offer an evaluation test at the end of that, either a stress or a stress thallium at that point. And that's—you could consider that part of marketing, but in emergency medicine we really consider that doing an evaluation and stabilization of the patient instead of just sending them out, or sending them to their primary care physician to start a lot of the workup all over again.

Kojo Nnamdi: On to the telephone, on to Sandy in Jacksonville, Florida. Sandy, you're on the air, go ahead please.

Caller: Thank you. One of my questions, I heard them talking earlier about the need for acute care to work in tandem with emergency care. I have a 12-year-old daughter who broke her thumb yesterday. And because

her doctor's office closes at noon, and she's got a broken thumb, I have to take her down to the emergency room. We waited for four hours before we even got an X-ray. Now, if I had had the opportunity to take her to a place where it's low-level emergencies, I would have loved that. But there's nothing like that available for me under my insurance plan. Are there programs like this being worked up?

Kojo Nnamdi: Dr. Cutler?

Dr. Charles Cutler: Yes, there are in two ways, but unfortunately I don't think they're as widespread as any of us would like. The first example is the example that I cited earlier, especially in group practices, where group practices—by that, I mean groups of physicians practicing together; they're usually in one site. So examples could be Kaiser Permanente, or the Mayo Clinic, or other clinics that practice together and frequently have acute care centers that are open expanded hours, and open on the weekends, and available for these kinds of emergencies. So that's one example.

The second example is free-standing urgent care centers, which have been started by a number of companies around the United States, and they're available at least in limited geographic areas. And a number of managed care plans do have contracts with these urgent care centers to provide those kinds of services. And the third example, I think, is the example that Dr. Ervin was talking about, which is a separate part of the emergency department that does not take care of heart attacks or car accidents or gunshot wounds but does take care of minor trauma and minor respiratory illnesses and things like that.

Now, having given all those three examples, I think all of us would likely say that there aren't enough of those options available across the country right now.

Kojo Nnamdi: This is Public Interest. I am Kojo Nnamdi.

Talk a little bit about the use of emergency rooms by patients with chronic illnesses, or by elderly people. How widespread is that, Dr. Ervin?

Dr. Michelle Grant Ervin: That's very widespread in my setting. About 44 percent of the patients that present to my setting are Medicare, if you look at their reimbursement. These are elderly with chronic illnesses; these may be individuals who have identified end-of-life issues, cancer diagnoses, AIDS diagnoses, but they're having acute signs and symptoms along with their chronic illnesses that need to be addressed immediately. Just because someone is at the end of their life that doesn't mean that they cannot have an emergency that could be stabilized, and extend not only the quantity, but the quality of their life a little bit longer. So we see that in emergency medicine.

Kojo Nnamdi: And that is not likely to change?

Dr. Michelle Grant Ervin: No, not as America continues to age.

Kojo Nnamdi: Dr. Akhter, Barbara Ormond, we've been talking about all of these problems. Are there any solutions on the horizon?

Dr. Mohammad Akhter: Certainly the best solution would be that we have universal coverage, where the Congress takes leadership and says, wait a minute, enough is enough, we just need to develop a system where the preventive care is available, where the urgent care is available, where the people have the access to care, so that we could actually provide service to the people, and do it in a very professional way, and not have people wait for two, three, sometimes five or six hours in the emergency room for care. But in the meantime, there are some things that we could do. And that's where some of my colleagues here, the emergency room physicians, have really done wonderful work to try to manage with the shoestring budgets that they have. But, literally, the additional resources are needed to expand the capacity; without expanding the capacity we are overwhelmed no matter what else we do. We will not be able to take care of these people.

Kojo Nnamdi: Barbara Ormond?

Barbara Ormond: I think we have to recognize the emergency room as what an economist would call a public good. It's something that we all want to be there when we need it, but we don't want to have to pay for it unless we need it. And so who is it that's going to pay for the standing capacity of the emergency room? And until we recognize that we are paying both for the services and for the fact that it is there when we need it, we won't be able to adequately fund our emergency rooms.

Kojo Nnamdi: Dr. Cutler?

Dr. Charles Cutler: I would add one more aspect, and that is planning. We don't really have effective planning on the local or national level for health care resources. So the lack of hospital beds, and the lack of emergency rooms at peak times or in certain geographic areas could be avoided with better planning and forethought.

Kojo Nnamdi: Dr. Ervin, you get the final word.

Dr. Michelle Grant Ervin: I would like to thank my colleagues for saying two things that I can only underscore, regarding the emergency department being seen as a public good that is definitely needed and that is not funded adequately. And to emphasize that as an emergency medicine specialist, despite all of the challenges in my specialty, the majority of us are glad that we are in our specialty and that we are available to provide for patients.

Kojo Nnamdi: In that case, I have another question: Do you think that universal health care coverage would solve the financial problems that cause the emergency rooms to be in the condition in which many of them

find themselves, overcrowded?

Dr. Michelle Grant Ervin: Universal health coverage would help one aspect—it still would not help regarding the planning, regarding the education issues, because you still would need to look at the access. Yes, everyone would have access, but there are abuses on both sides of emergency departments, both those who don't come by ambulance, who don't present when they should, and those who do overutilize emergency departments. So it would help one component, but not the other components.

Kojo Nnamdi: Dr. Michelle Grant Ervin, Dr. Charles Cutler, Dr. Mohammad Akhter, and Barbara Ormond, thank you all for joining us. If you missed part of today's program and want to listen to it again, or find useful background information and related links, visit the health care section of www.kaisernetwork.org, a free health policy Webcasting and news summary service of the Kaiser Family Foundation.

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