Mission Versus Reality
In Emergency Care

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When an individual is in peril, federal law mandates that hospital emergency departments (EDs) screen; stabilize; and, if necessary, hospitalize that person without regard for his or her ability to pay. Unlike the early days after World War II, when emergency care was delivered in haphazardly staffed hospital rooms, today’s EDs are teeming centers of activity overseen by physician specialists, nurses, and allied workers who treat all comers. EDs are portals of entry for half of all hospital inpatient admissions; they perform complex diagnostic workups of patients with worrisome symptoms; they render after-hours and weekend care when most doctors and nurses are off duty; and they serve as community hubs in responding to disasters.

NEW ATTENTION TO EMERGENCY CARE

Despite these roles, emergency departments seem like orphans in the US health care system, with few strong allies among policy makers; as an afterthought in the Affordable Care Act; and, until recently, largely overlooked by agencies that fund research. For example, the Agency for Healthcare Research and Quality, which has supported the development of assessments by patients of their experiences in all manner of care settings, is only now developing a survey that applies to emergency care. Recognizing the growing importance of the field, the National Institutes of Health finally established an Office of Emergency Care Research in 2011, as Walter Koroshetz and Jeremy Brown—the office’s first permanent director—discuss in this issue.

This thematic issue of Health Affairs focuses on emergency care, long popularized by television dramas but less recognized for the array of activities in which its practitioners are engaged.

In an overview written with several colleagues, Arthur Kellermann—a leader in emergency medicine and the new dean of medicine at the Uniformed Services University of the Health Sciences—envisions a future for EDs based on four broad trends: Enabled by health information technology, they will become better integrated with traditional health systems in their communities (a concept more fully discussed in this issue by Ricardo Martinez and Brendan Carr); they will become regionalized to better serve victims of heart attack, stroke, and pediatric emergencies (as discussed by Brent Eastman and coauthors); they will become effective advocates for public health because ED providers see what occurs when prevention fails; and, if health care financing shifts from fee-for-service to value-based models, as is foreseen, EDs will be expected to do everything they can to avoid costly admissions.

A contrasting view is offered by Jesse Pines and coauthors, who hold that fee-for-service with new incentives based on currently lacking resource and quality measures (as Jeremiah Schuur and coauthors discuss) is the only feasible approach to paying for acute care.

MEETING MANY NEEDS

EDs are frequently mischaracterized as providing “the most expensive care there is.” However, this label dismisses the legal duty hospitals have to provide care to all patients who present for treatment, regardless of their ability to pay. In a thorough review, Sara Rosenbaum concludes that the Emergency Medical Treatment and Active Labor Act (EMTALA), for all of the controversies it generates, remains a “sweeping testament” affirming that in a wealthy nation, “no person should be denied emergency medical care.” This mandatory role prompts the question, Is heavy use of EDs being driven by a small number of patients—mentally ill substance abusers, as urban legend would have it—who visit EDs numerous times each year? John Billings and Maria Raven find a lack of evidence for such assertions in a study of Medicaid ED users in New York City.

Through predictive modeling, they write, EDs could determine who the repeat users will be and target interventions to reduce their unnecessary visits.

Steven Bernstein and Gail D’Onofrio offer another approach that they believe shows promise in treating patients with substance abuse and behavioral disorders. Medicare is another public program whose beneficiaries rely heavily on EDs. In 2009–10, 19.6 million ED visits (15 percent of the total) were made by patients age sixty-five and older. Abby Alpert and coauthors estimate that Medicare could safely save roughly $560 million per year if it allowed emergency medical services (ambulances) to manage nonemergent patients in alternative ways, instead of transporting them all to an ED.

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