A Quarter of Acute Care Delivered in the ED

Patients with severe symptoms, including pain and fever, are more likely to seek emergency care.

BY ALICIA AULT
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WASHINGTON – More than a quarter (28%) of all acute care visits in the United States are made to the emergency department, while slightly less than half (42%) take place in primary care physician offices, according to a study released Sept. 7.

Another 20% of acute care visits are made to subspecialist offices, lead study author Dr. Stephen R. Pitts said at the briefing.

It appears that the more severe a complaint, the more likely a patient will seek care in the ED, said Dr. Pitts of the department of medicine at Emory University, Atlanta. However, the ED is frequently the only option for care, he said, noting that, “too often, patients can’t get the care they need, when they need it, from their family doctor.”

Two-thirds of acute care ED occurred on weekends or on weekdays after office hours, Dr. Pitts and his colleagues found.

Uninsured patients received more than half their acute care in EDs, according to the study, which appears in the journal’s September issue.

The authors based their study on data from the three federal surveys of ambulatory medical care in the outpatient, ED, and physician office setting.

Presenting complaints such as stomach and abdominal pain, chest pain, and fever, dominated the list of what brought patients to the ED. Conversely, patients who presented to the primary care physician’s office for acute care most frequently complained of cough, throat symptoms, rash, and earache.

Seventy-five percent of patients with acute respiratory problems received care in a primary care practice or hospital outpatient department, the authors found.

Overall, emergency physicians took care of 11% of all ambulatory care visits, yet make up only 4% of the physician workforce, the authors said.

Previous studies have shown that emergency care accounts for only 3% of all health spending, Dr. Arthur L. Kellermann, a study coauthor, said at the briefing.

“The fact that 3% of our dollars and 4% of our doctors are delivering that percentage of care is not such a bad deal,” said Dr. Kellermann, an emergency physician and the Paul O’Neill Alcoa Chair in Policy Analysis at the Rand Corp. But, he said, it might not be the best possible care for patients or the optimum use of dollars for the health system.

In a separate study, Dr. Ateev Mehrotra and his colleagues reported that 14%-27% of ED visits could have been handled at either a retail clinic or an urgent care center. Switching to these alternative sites could save the system $4.4 billion a year.

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IMPLEMENTING HEALTH REFORM
Accountable Care Organizations

One new concept to come out of the health reform debate is the Accountable Care Organization (ACO). The concept builds off the idea of the patient-centered medical home and calls for primary care physicians, specialists, and hospitals to band together to provide high-quality care for patients.

Under the ACO concept, payments would be linked to quality, and ACOs have the advantages of a medical home. So, while we’re likely to see improved efficiencies of scale, other physicians’ practices fit into a larger health care community to provide comprehensive, integrated care.

The ACO builds on the foundation of a medical home based in primary care. Both have the same goals for the patient: coordinated care that ensures the patient and the patient’s medical home in the center.

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The ACO concept requires that medical-home practices commit to performance improvement and publicly reported performance results. ACOs are a new form of the medical home neighborhood, which is essential for an integrated medical home to realize its full potential. Thus, an ACO may be the next logical step for physicians whose practices offer a mix of services; however, isolated rural practices will have more barriers to overcome to become members of an ACO.

The movement will likely begin in large and well-organized independent practice associations (IPAs), multispecialty groups, and integrated delivery systems. For efficiencies of scale, other physicians will first need to organize into groups that can assume performance risk (for quality and efficiency, not insurance risk) and contract with specialists, hospitals, and other providers to build out the ACO model that will be attractive to employers and insurers.

Disclosures: Dr. Mehrotra and his coauthors received funding from the California HealthCare Foundation for their study. One of Dr. Pitts’ coauthors disclosed that she received a training grant from the Centers for Disease Control and Prevention; others reported no conflicts.

CN: What do physicians need to do now if they want to experiment with the ACO idea?

Dr. Heim: The first step is to become a high-performing practice by implementing medical procedures, protocols, and services, as well as quality improvement systems. The second step is to think about how physicians’ practices fit into a larger health care community to provide comprehensive, integrated care.

Physicians need to know their options for organizing into groups to create or become a part of an ACO. They need to understand their options for, and the implications of, contracting with or being employed by hospitals.

Hospitals are strategically buying primary care and subspecialty practices in markets where ACOs are mostly likely to form in order to maintain a flexible posture for the future.

It is important for us to examine future contracts in light of potential shared savings for ACO and other payment models, whether we remain in private practice and negotiate contracts, or consider becoming salaried physicians.

Dr. Heim is also a hospitalist at Scotland Memorial Hospital in Laurinburg, N.C.