Chapter 14
Utilization of the Emergency Department

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ABSTRACT

The primary role of the Emergency Department (ED) is to treat the seriously injured and seriously sick patients. However, because of federal regulations requiring the ED to treat all who enter, EDs have become the providers of a large number of unscheduled, non-urgent care patients. The role of the ED has changed considerably in recent years to treat those without insurance, and without primary care physicians. The main purpose of this study is to investigate the use of the hospital ED for non-urgent care in relationship to socio-economic status and payer type. This study will identify the Socio-economic factors related to the utilization of the emergency department for health care. The study will identify for the purpose of shifting patients that use the ED as primary care to a nearby clinic. The clinic is within a mile of the ED. It is a Nurse-managed health center that provides free care.

BACKGROUND

The primary role of the Emergency Department (ED) is to treat the seriously injured and seriously sick patients. However, because of federal regulations requiring the ED to treat all who enter, the EDs have become the providers for a large number of unscheduled, non-urgent care patients. The role of the ED has changed considerably in recent years to treat those without insurance, and without primary care physicians.

Many patients choose to go into the ED instead of using a primary healthcare provider. The National Center for Health Statistics states that most patients who go to the ED do not need urgent care. In 1996, a record fifty percent of the 90 million visits to the ED were deemed unnecessary. These unnecessary visits translated, in terms of dollars and cents, to a mean of 40.5 million people paying up to three times as much for routine care as they would have paid at a physician’s office or clinic. Many of the patients who visit the ED are uninsured and without the means to pay, creating a financial burden. 
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on EDs across the United States (US). Also, if a patient goes to the ED with a skin rash or a sprain or other non-urgent problem, insurance may not cover it. These non-urgent visits create economic and financial burdens on both the patient and the ED. The number of EDs in the US has been cut by 14%, but the number of visits has increased to about 114 million, according to the Centers for Disease Control (CDC). (CDC, 1996)

Health care policymakers need to investigate some, if not all of the characteristics of the most frequent users of the ED. It was reported that in 2003, 20.9 percent of all children made one or more visits to the ER (ED). The Urban Institutes' 1997 and 1999 data showed that the most frequent users of the ER are more likely to be publicly insured and to have worse health conditions compared to others. (Urban, 1999)

Previous studies have shown the inappropriateness of the use of the ED by non-urgent patients. However, these studies have different estimates of non-urgent care that ranges from 5 percent to 82 percent (CDC, 2003). In general, many insurance payers consider a primary care setting to be more cost-effective, and there are many suggestions presented in an attempt to decrease the burden on the ED. There is also a general concern that non-urgent patients delay care to the seriously injured or ill by crowding the ED. The Centers for Disease Control and Prevention have reported that in 2003, visits to the ED reached a record high of nearly 114 million, but the number of EDs decreased by 12% from 1993 to 2003. The number of visits increased 26% during this time period when the United States population increased by 12.3%. The report indicated that Medicare patients were 4 times as likely (81 visits per 100 people) to seek treatment from the ED than those with private insurance (22 visits per 100 people). This information is based on data from the 2003 National Hospital Ambulatory Medical Care Survey (NHAMCS) Emergency Department Summary, which is a national probability-based sample survey of visits to US ER. (CDC, 2003)

EDs in the US are more crowded than ever. EDs do not operate on a first come, first served basis. The ED uses a triage method to classify patients; providers assign patients into categories based upon the severity of the medical need. The most severe are seen first regardless of the time of arrival. The last thing a patient wants to do is to sit for long hours in the waiting room. Overall, patients spend an average of 3.2 hours in the ED. The average wait time is 46.5 minutes. A recent government report indicated that overcrowding is occurring in most EDs, along with an increase in the number of people who leave the ED before seeing a doctor because they get tired of waiting (called elopement). One of the reasons for overcrowding is that many patients choose the ED because of a lack of a primary provider. Those without primary providers tend to use the ED for the treatment of everything from a fractured toe to a cough. Use of the ED for such minor problems helps create the overcrowding. An urgent condition is defined as one that does not pose an immediate threat but does require prompt medical attention; non-urgent are those who do not require prompt attention.

Reports have questioned the ability of the ED to handle the widespread overcrowding. (Gao, 2002). Reports have indicated that more than 90% of large hospitals are operating at or over their capacity. Overcrowding not only causes delays in both diagnosis and treatment, but is a risk to the critically ill. When the ED is overcrowded, the average wait time is 5.8 hours. With overcrowding, there is not enough staff to give the severely ill the undivided attention they require, so there is an increased risk of medical errors. Errors have been linked to overcrowding as the quality of patient care is compromised, since the medical staff is constantly under pressure by the needs of all the patients (Jcrinc, 2004).

When EDs are overcrowded, ambulances carrying the severely injured or ill are sometimes diverted to more distant sites. In many urban areas, there is as much as a 20% to 50% diversion rate of