

## The Hospital Emergency Department: An Anchor for the Community's Healthcare Safety Net

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North Carolina's community hospitals have a long respected tradition of undergirding the health and welfare of citizens and communities across the state, wealthy or poor, urban or rural, healthy or frail. One hundred thirteen (113) community hospitals provide needed healthcare services for North Carolina's 100 counties, ensuring local community access for both basic healthcare requirements and more complex interventions and therapies. North Carolina's community hospitals are also a prime anchor of the safety net that protects the state's most vulnerable citizens: the elderly, those with chronic disease, the poor, the disadvantaged, and the uninsured. Without a local hospital, many North Carolina communities would struggle to maintain even the most basic health services.

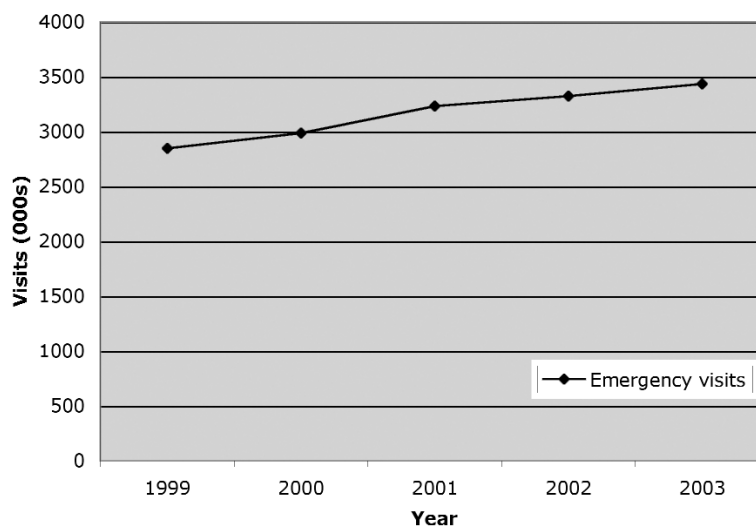
The North Carolina Healthcare Safety Net Task Force Report<sup>1</sup> by the North Carolina Institute of Medicine effectively describes the increasing burden of the uninsured and the poor, while documenting the "frayed edges" and the "worn patches" that shore up the state's healthcare safety net. While hospitals represent the virtual anchors of the safety net, hospital emergency departments are the ever-present backbone of the safety net's architecture. Emergency departments are often the first line of defense against community epidemics, like influenza and respiratory diseases, a provider of hope and life for citizens faced with debilitating disease or life-threatening injury, and a provider of last resort when no other avenues for healthcare seem available.

### North Carolina Emergency Departments Carry a Huge Burden

In 2003, North Carolina hospitals provided emergency services to 3,433,432 patients, an increase of 21% percent over

five years (see figure 1). North Carolina's rate of increase exceeds the national growth in emergency visits, which increased 11.6% over the same five-year period.<sup>2</sup> In a national

**Figure 1.**  
North Carolina Hospital Emergency Visits, 21% Increase in Visits Since 1999

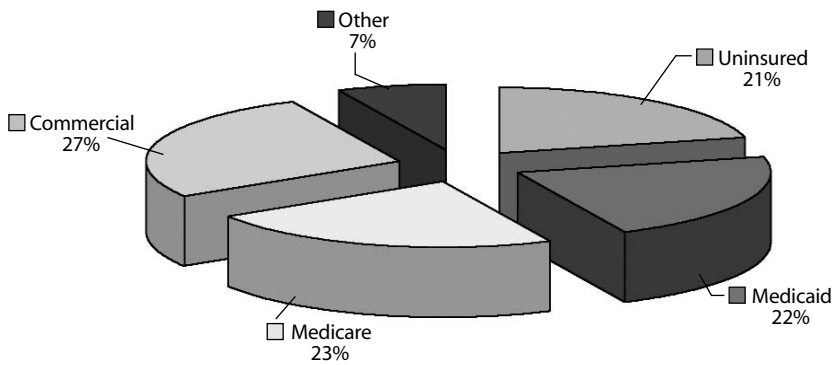


survey completed in 2002 by the Centers for Disease Control, abdominal pain, chest pain, and fever were the most commonly recorded principal reasons for an emergency visit, accounting for one-fifth of all emergency visits. The most frequently reported diagnoses were contusions, acute upper respiratory infections, open wounds, and abdominal pain. Diagnostic/screening services, procedures, and medications were provided at 86.8%, 43.2%, and 75.8% of emergency visits, respectively. Additionally, 12% of emergency visits result in hospital admission; and more than one-third of patients admitted to the hospital are first treated in the emergency department.<sup>3</sup>

In North Carolina in 2004, 21% of the emergency visits were attributed to patients without health insurance; 22% of

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**Figure 2.**  
**North Carolina Hospital Emergency Visits by Payment Type in 2004**



**Total Emergency Visits for North Carolina Hospitals in 2003 = 3,433,432**

emergency visits were by those with Medicaid; and 27% of the emergency visits in 2004 were covered by commercial insurance (see figure 2). The rate of uninsurance (21%) in North Carolina's emergency departments is greater than the national rate (16%). Furthermore, North Carolina's hospitals experience higher use of emergency services by the poor and elderly (Medicare and Medicaid) and lower rates of commercial coverage than the average emergency department nationally. Fifty-six percent (56%) of North Carolina's emergency visits occur in urban hospitals and 44% in rural hospitals. North Carolina's large hospitals, those with 200 licensed beds or more, accounted for 64% of emergency department admissions in 2004. North Carolina's largest hospitals, those hospitals with 400 or more licensed beds, serve the greatest proportions of uninsured and poor emergency care patients (23% uninsured and 26% Medicaid, respectively, 49% combined). For the average North Carolina hospital, the uninsured and poor account for 43% of the emergency admissions.<sup>4</sup>

### The Multiple Roles of Hospital Emergency Departments

In the National Hospital Ambulatory Medical Care Survey by the Centers for Disease Control (CDC), the authors state, "the primary role of the hospital emergency department is the treatment of seriously ill and injured patients. However, the emergency department provides a significant amount of unscheduled urgent care, often because there is inadequate capacity for this care in other parts of the healthcare system. The emergency department also serves as referral site for other providers to evaluate and stabilize patients."<sup>5</sup>

A May 2004 study published by the CDC examined the characteristics of emergency departments serving high proportions of safety net patients. Interestingly, the study defined a "high-burden safety net emergency department" as having greater than 40% combined services to Medicaid and uninsured emergency patients. Given that the average North Carolina hospital emergency department treats 43% uninsured and

Medicaid patients combined, many North Carolina emergency departments would readily meet the CDC definition as serving a high burden of safety net patients.

Furthermore, the CDC study found that emergency departments serving high proportions of poor and uninsured patients have a greater proportion of visits made by children and minority residents; have higher percentages of non-urgent and 'urgent, but primary care-treatable' cases; and higher percentages of cases that left the emergency department without being treated. Of note, the CDC study found that the percentages of 'emergent conditions that were avoid-

able with preventive care' were not significantly different between hospital emergency departments with varying (high versus low) proportions of the uninsured and poor. In addition, hospital emergency departments with higher proportions of uninsured patients had lower percentages of emergency cases that were 'avoidable with primary care' in comparison to hospitals with high proportions of Medicaid visits to the emergency department.<sup>6</sup>

Comparable data describing the use, characteristics, and demographics of emergency departments and patients in North Carolina are lacking. Therefore the appropriateness of emergency department admissions and the reasons for seeking emergency care by vulnerable populations, such as the poor and the chronically ill, are not well documented.

However, recent developments will improve the understanding of emergency care in North Carolina. A new partnership between the North Carolina Division of Public Health (NCDPH) and the North Carolina Hospital Association (NCHA), with support from two nationally prominent information technology companies, Solucient and MercuryMD, organized and developed the North Carolina Hospital Emergency Surveillance System (NCHES). The main purpose of the NCHES partnership is to capture near real-time emergency care data to quickly assess and manage public health or population health emergencies.

Biodisaster preparedness is the reason NCHES was developed. Because of this unique and successful partnership, North Carolina is the first state in the country to develop and implement this advanced biopreparedness warning system. An important and valuable by-product of the NCHES development will be the collection and analysis of emergency department diagnoses, trends, demographics, and outcomes. In the near future, NCHES will help the state's healthcare systems and providers understand the usage trends in emergency services and, in turn, be able to design interventions and healthcare access models to improve community health. NCHES will greatly contribute to the understanding of the adequacy of the healthcare safety net in North Carolina.

## Emergency Department Care: Often Inappropriate and Expensive When No Alternatives Exist

While specific North Carolina data are unavailable, national studies routinely conclude that providing care for non-emergent or primary care-treatable conditions in emergency settings is expensive, sometimes inappropriate, and often inefficient. The federal Agency for Healthcare Research and Quality (AHRQ) recently published a study examining the health and economic costs of the lack of preventable primary care for diabetes patients. The study estimates nearly \$2.5 billion in savings annually if patients received more appropriate primary care for diabetes complications.<sup>7</sup> Community Care of North Carolina networks across the state have documented reductions in emergency department usage by patients with chronic diseases, namely asthma and diabetes, when the local and regional primary care systems collaborate to improve and support chronic disease management in the community setting.

A national study by the Center for Health System Change concludes that uninsured citizens rely on emergency departments for one-fourth (25%) of their ambulatory care visits, compared to 8% for the privately insured population.<sup>8</sup> The authors posit that the greater reliance by the uninsured on emergency departments for primary care is likely due to a decline in access to office-based providers. The same study indicates, however, that contrary to popular wisdom, uninsured patients are not driving the increased use of hospital emergency departments. Instead, privately insured patients and Medicare beneficiaries accounted for two-thirds of the overall increase in emergency department visits, nationally, between 1996 and 2001.<sup>8</sup>

The Center for Health System Change suggests that capacity constraints experienced by office-based providers, combined with a loosening of managed care restrictions, may contribute to the increase in non-urgent emergency visits, a trend apparent in all payer segments. The Center's 2003 Issue Brief states, "other research shows that more patients are having difficulty making appointments with their doctors, and more people have long waits for appointments. For their part, more physicians report having inadequate time to spend with their patients and are increasingly closing their practices to some new patients, despite spending more time in direct patient care activities. With extended hours and no appointment necessary, emergency departments increasingly may be viewed by many patients as more convenient sources of primary care than their regular physicians. For uninsured patients, emergency departments are one of the few remaining primary care options."<sup>8</sup>

A 2005 report by the National Association of Community Health Centers tracks the federal government's plan to place federally-funded community health centers serving the poor and uninsured into every poor county in the United States. The report identifies 47 poor counties in North Carolina, divided

into 20 counties with a community health center (CHC) and 27 North Carolina counties without a CHC.<sup>9</sup> With the rising numbers of uninsured and poor in North Carolina, the ability of the public system of care (health departments, CHCs, indigent care clinics, rural health clinics and centers, free clinics, etc.) to accommodate the increasing indigent care burden is certainly being stretched.

Hospital emergency departments are increasingly the last remaining reliable and routinely available source of primary healthcare in many North Carolina communities. If the uninsured visit rate of 21% is applied to the emergency visits tabulated for North Carolina in 2003 (3.43 million emergency visits), then North Carolina hospitals experienced more than

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721,000 uninsured emergency visits in 2003. Adding in Medicaid, hospital emergency departments provided care for nearly 1.5 million uninsured or poor North Carolina residents in 2003.

The Emergency Medical Treatment and Active Labor Act (EMTALA) of 1986 has had a profound effect on hospital emergency departments. EMTALA requires emergency departments to screen and stabilize all patients that present to the emergency department regardless of ability to pay. The federal government does not guarantee such expansive access to any other segment of the healthcare system. Thus, emergency departments are often viewed as the ultimate safety net providers, ensuring a minimum level of care and services regardless of the patient's disease category, background, ethnicity, immigration status, or insurance class. While EMTALA is viewed as an unfunded federal mandate and presents enormous compliance issues for the hospitals, the concept of the hospital emergency department as a guaranteed source of immediate healthcare is important and vital to sustaining and improving community health.

## Challenges Faced by North Carolina Hospitals' Emergency Departments

It is comforting to know that North Carolina's hospitals and emergency departments are a solid anchor and backbone for the state's healthcare safety net. However, regardless of the strength and commitment of community hospitals to emergency care, hospitals face many difficulties in maintaining this important aspect of the safety net anchor. Among the issues that impact hospital emergency departments are reasonable and adequate financing, increasing volumes of uninsured patients, access to capital for expansion and technology enhancements, adequate physician coverage for unassigned and uninsured patients, the unstable nature of mental health reform in the state, the rapid influx of immigrants and foreign-born citizens requiring care, and the rising cost of malpractice insurance premiums. Several of these issues are worthy of further examination.

**Financing the Care of the Uninsured.** Operating and maintaining a modern, fully equipped, adequately staffed and appropriately sized emergency department is an expensive proposition. Yet, emergency care is such a basic and essential aspect of community health networks that almost every community hospital in North Carolina offers emergency care. The primary financing mechanism for emergency departments is insurance coverage for health services. For the average North Carolina hospital, one in five patients (21%) is uninsured, with very little or no resources to pay for their care. Another 45% of emergency care is provided to Medicare and Medicaid patients. Obviously, maintaining adequate levels of reimbursement, especially from the government payers, Medicare and Medicaid, is essential if hospital emergency departments are to remain viable and accessible. Cutting hospital payments in Medicare and Medicaid, especially at a time when the numbers of uninsured residents are rising, will definitely impact the quality and availability of essential, yet expensive hospital services such as emergency departments. In the federal 2006 fiscal budget, Medicaid expenditures are under attack, threatening the ability of the state of North Carolina to adequately fund its Medicaid program. The retraction or reduction of Medicaid funding by the federal government cannot be allowed. This one factor alone, inadequate Medicaid funding, is a major threat to North Carolina's healthcare safety net.

**Malpractice Insurance Costs.** The rapid rise of malpractice insurance premiums also hampers the emergency department safety net. Some North Carolina hospitals and physicians have experienced malpractice premiums increases of 300% or more

over the past few years. The malpractice cost increases are so dramatic and expensive that some physicians can no longer afford to cover certain services, such as labor and delivery, or even general surgery. Also emergency department back-up coverage is often considered a high-risk, high-liability service, which can influence the cost and/or availability of malpractice insurance, driving physicians to curtail or drop emergency department coverage from their privileges. Losing community physicians from the coverage panel for the hospital emergency department is a serious problem. Having fewer physicians available for emergency patients, especially those patients who present at the hospital without a regular physician, means that hospital emergency departments may be unable to provide care for some very basic, yet essential, healthcare services. Solving or at least abating the malpractice crisis in North Carolina will give some respite to hospitals and health providers that struggle daily to maintain adequate emergency care coverage.

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**Growth of the Numbers of Uninsured.** The expanding ranks of the uninsured in North Carolina cannot be ignored either. The loss of manufacturing, tobacco, and textile jobs in North Carolina will continue to push the number of uninsured residents into record territory (almost 20% of residents under age 65 in 2004). Uninsured

residents frequently do not have a regular source of primary healthcare. Thus, uninsured residents may seek primary care in hospital emergency departments, often too late, after a treatable condition has progressed into a true emergency. If the rate of increase of the uninsured continues at the current pace, then hospital emergency departments may be one of the few remaining care settings available for uninsured patients. A hospital emergency department with 30% or more of its care provided to uninsured patients and 20% or more emergency care being provided to Medicaid patients is at serious risk for financial failure.

**Mental Health Reform.** Mental health reform is a vastly important issue for hospital emergency departments. The state of North Carolina is currently undergoing major reforms to the mental health system. As a result, the mental health system in North Carolina is very fragile; not enough providers, too few community-based services, inadequate reimbursement, uneven insurance coverage, and an increasing demand for service. The rate of uninsurance is 70% higher for mental health visits to the emergency department than the average emergency visit. If mental health reforms, such as the development of community service alternatives and mental health reimbursements, are not adequate or incomplete, then hospital emergency departments will be overwhelmed with patients requiring care for mental health conditions. In fact, many hospital emergency departments

across the state already report significant increases in patients requiring mental health service with few options for community referral.

*The Need for Expanded Primary Care Options.* Besides preserving and protecting Medicaid funding, one major solution is recommended to help maintain the hospital emergency department's strength and viability as a safety net anchor: the commitment to create and maintain multiple and additional community access points for primary care service for the uninsured, the poor, and the vulnerable. Community health


centers, rural health clinics and centers, public health departments, free clinics, mental health centers, and community physician practices must be developed and supported in close collaboration with the local care networks, especially in the neediest communities and counties. If additional primary care access points for the uninsured are not developed and funded, then hospital emergency departments will become increasingly crowded, suffer from inadequate staffing and less advanced equipment and technology, and require more financial subsidies. **NCMJ**

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