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 physicians' 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.

Up to 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.

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 alternate sites could save the system $4.4 billion a year, said Dr. Mehrotra of the University of Pittsburgh and a policy analyst at Rand.

The authors determined that most visits for nine common conditions treated at EDs could be switched easily to those alternate sites. Those conditions include upper-respiratory infections; musculoskeletal conditions such as strains, fractures, and back pain; dermatologic conditions; abdominal pain, headache, and other symptoms without a specific diagnosis; urinary tract infections, some chronic illnesses, and psychiatric conditions; lower-respiratory conditions; such minor problems as insect bites and conjunctivitis; and preventive care. ■

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.*

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 ACO providers would have the opportunity to share in any savings realized through better, more cost-effective care. Under the Affordable Care Act, Medicare will launch a shared savings program in 2012 to test the concept.

Dr. Lori Heim, president of the American Academy of Family Physicians, explains how these ACOs might work and what might drive their popularity.

CARDIOLOGY NEWS: The AAFP has spent a lot of time promoting the concept of the patient-centered medical home and the medical home neighborhood. Is an ACO the next logical step?

Dr. Heim: 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 a seamless transition from one service to another and one level of care to another.

The core of an ACO is effective primary care with a focus on prevention, early diagnosis, chronic disease management, and other services delivered through primary care practices.

We believe that in order to be successful, ACOs will require a robust network of practices founded in primary care. They may involve other primary care practices, subspecialists, and in some cases hospitals.

Envision the ACO as an expanding circle of health professionals with the patient and the patient's medical home in the center.

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DR. HEIM

The ACO concept requires that medical-home practices commit to performance improvement and publicly reported performance results. ACOs are a formalization of the medical home neighborhood, which is essential for a 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.

CN: What are the advantages and disadvantages of an ACO?

Dr. Heim: ACOs will improve information flow and communication. They will offer payment incentives designed to produce high-quality, patient-centered, efficient care. The problem areas are in aligning the financial incentives in a way that provides the best value to the patient.

Cost savings to support an ACO will come largely from reductions in three areas: inappropriate hospital admissions and readmissions, diagnostic testing and imaging, and subspecialist expenses.

One of the greatest challenges to implementing an ACO is managing the conflicts associated with the internal distribution of funds.

So, while we're likely to see improved referral patterns and communication that will provide seamless, high-quality health care, we also are likely to see tension as health communities move away from competition and toward cooperation and collaboration.

CN: In the future, will all physicians be part of an ACO?

Dr. Heim: Because this concept is so new, it's hard to say. Decisions on organizing the delivery system will be local. We're going to see considerable experimentation with different structural models, different financing models, and different approaches to sharing payment or system savings among all providers.

The medical home is important because its performance can be quantified and compensated relative to the value it brings to the entire system.

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.

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. ■

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