Decreasing Emergency Department Use Is a Complex Conundrum

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Emergency department (ED) demand often exceeds capacity, and many, including those who provide care in EDs, believe that some ED patients should be cared for in less costly non-ED settings. One common proposed explanation for nonemergent ED use is the lack of access to care, in part due to inadequate insurance coverage.1 Although some policy makers have suggested that expanding health care coverage will improve access, others contend that there could at least be a transient increase in ED use by those who have historically deferred care.2 There is also an assumption that having insurance equals access to primary care; however, that is not always the case. In adults, the effect of increased insurance coverage on ED use has varied, with some efforts resulting in decreases, whereas others result in increases.2 In their article “Trends in Pediatric Emergency Department Use After the Affordable Care Act,” Lee and Monuteaux3 used the Nationwide Emergency Department Sample and population estimates from the American Community Survey to perform a cross-sectional retrospective study of ED use rates in children. They compared trends before and after the Patient Protection and Affordable Care Act (ACA), noting that after 2014, when the ACA took full effect, an additional 900 000 children obtained health care coverage.3 Before 2014, ED visit rates were rising by 1.1%. In the post-ACA period, there was an increased rise noted (9.8%), and the findings did not vary significantly when analyses controlled for insurance.3 Although these findings are both informative and important, they are not particularly surprising, especially to anyone who practices pediatric emergency medicine. Reducing unwarranted, unnecessary, or inappropriate ED use is complex and multifactorial. There are many reasons1,4 families may choose to seek care from an ED rather than an alternative setting. From the patient perspective, ED care can be convenient, comprehensive, consumer centric, and sometimes less costly.

Let us look at these factors, starting with convenience, ease of access, and comprehensive service. The ED offers care 24 hours per day, 365 days per year. The ED does not close for lunch and does not require the parent or caregiver to miss work, which, for hourly paid employees, can result in lost wages. No appointment is necessary, but many EDs now offer them or some form of scheduling or preregistration. By law (Emergency Medical Treatment and Labor Act), anyone presenting for care will be, at a minimum, provided emergency medical treatment, even a 49-year-old with chronic back pain presenting to a pediatric ED. If laboratory testing or imaging is required, it is done without the added burden of preauthorization, making additional appointments, more time away from work, or traveling to various other facilities for care. If the

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ED physician feels the patient has an emergent condition requiring subspecialty care that day, the ED will make arrangements for it to happen. This model of care, from an individual patient perspective, is often far more efficient and consumer centric than most other ambulatory care delivery settings. Of course, ED visits come at a high cost for payers and sometimes for patients.

Although cost, in part, influences behaviors, the impact it has on families can be vastly different. Patients receiving the same care in the same ED almost always end up having to pay different amounts depending on copays, deductibles, and other factors. To make matters more complex, with Medicaid, the cost of care to the patient is usually lower in the ED (often free). Receiving care in the ED can therefore be convenient, comprehensive, consumer centric, and in some cases, from the patient perspective, even personally cost-effective.

ED use is complex. This Commentary highlights a few additional considerations beyond expanding insurance coverage. Alternative care delivery models that can successfully compete against the ED for patients need to develop and implement a more consumer-centric focus, including expanding hours, providing same-day appointments, facilitating care coordination, and incorporating virtual visits. Health systems looking to decrease ED visits may want to consider lower-cost care delivery options in close proximity to EDs with access to similar convenient resources (eg, laboratory and imaging). Finally, there needs to be payment models that incentivize both providers and patients and do not perpetuate the current model that indirectly incentivizes ED use for nonemergent conditions.

**ABBREVIATIONS**

ACA: Patient Protection and Affordable Care Act  
ED: emergency department

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