Counter-Point: Frequent Users of the Emergency Department: Meeting Society's Needs

Rick A. McPheeters, DO Kern Medical Center, Department of Emergency Medicine, Bakersfield, CA

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Internal medicine physicians were once known as the "physician's physician." These clinicians were consultants or specialists to the general practitioners of society. As medicine matured, their practices changed significantly. Now internists are one of the leading primary care specialties, while remaining specialists in their own right. When the specialty of emergency medicine (EM) was born, its intent was to care for patients with emergency medical conditions. However, as societal needs changed, so did the house of medicine, blurring the line between primary and episodic care. For better or worse, EM has changed to become the safety net for all of American healthcare.

"It has long been acknowledged that ED visits are frequently the result of a failure of prevention."[1] Others frequent the emergency department (ED) due to the lack of timely primary care. Yet, a significant portion of ED patients, primarily low-income and underserved, have no other place to go. The underinsured are having increasing difficulty finding healthcare providers willing to accept Medicaid reimbursement.[2,3] To compound the problem, the fully insured are turning to the ED for a variety of reasons. Open 24 hours a day/7 days a week, EDs give access to those who can't make time during regular business hours. And in this era of instant gratification, some seek ED services for the sole reason of expediency.[4] Many patients see the ED as a one-stop shop, where a physician and diagnostic and therapeutic options are available in the same facility. Very few primary care office practices can offer the same convenience. Finally, even insured patients have significant barriers to their primary medical doctor (PMD) for urgent medical needs and can only get appointments weeks or even months later. In essence, the ED has become the preferred provider of choice for some.

The EM community, although far from unanimous in proposing solutions, has at least recognized the problems associated with access to care in our current healthcare system. The Society of Academic Emergency Medicine (SAEM) developed a Public Health and Education Task Force (PHETF) to investigate the appropriateness of including primary and secondary preventive interventions in routine emergency care. Assuming sufficient resources, the PHETF found enough evidence to support alcohol screening and intervention, HIV screening and referral, hypertension screening and referral, adult pneumococcal immunizations, smoking cessation counseling, and referral of children without primary care physicians to a continuing source of care.[5] This, coupled with the belief that EM provides access to all, meets the critical needs of our most vulnerable patients and is uniquely positioned to conduct public health surveillance, makes the ED an effective site for preventive care.[1]

Impetus to broaden the scope of EM to include prevention found support in the Institute of Medicine (IOM) reports requesting that all persons coming for care to medical settings be screened for alcohol problems and in the creation of "Safe America" by the National Center for Injury Prevention and Control and the Centers for Disease Control to limit injuries.[6] Because studies have shown that up to 22% of injured patients return to the ED one or more times in the following year, many believe that identifying them initially and offering preventive services could potentially diminish patient suffering significantly.[7] To better solidify this argument, Hungerford et. al.[6] provides encouraging preliminary evidence that alcohol screening and preventive services in the ED can decrease alcohol intake, related harm, and dependence symptoms at least four months post-baseline.

Although EM training focuses on acute care, recent graduates have had significant exposure to patients with recurrent and chronic conditions, as none of the EM training programs have remained immune to ED "frequent users." The training of EM specialists is dependent on the environment. Recall that the specialty developed from a societal need for hospital-based acute care generalists in the 1960s through 1980s. In fact, EM is the first and still one of the few specialties not focused on an organ or organ system. As the

evolution of EM practice continues, by definition it embraces chronic and recurrent disease. In a sense we are what we eat! I believe that, for purists who cling to acute care of life-threatening illness or injury as the sine qua non of EM, the treatment of chronic or recurrent disease is more a dislike rather than a lack of capability. Change is generally resisted to some extent. EM's ability to deliver a full range of medical services, coupled with accessibility 24/7, truly make it the ultimate safety net for those turned away by other providers.[8]

Where is EM headed? We will always need to care for those with life or limb threats. As the needs of society change, we will have to adapt. Are we destined to be primary care physicians? For a segment of the American population, I would offer that we already are. However, ED-based public health surveillance will likely be the critical link in the future of ED-based preventive services.[9] Knowing the inevitable change, we may now have to redesign the ED so that it has the staff and systems in place to ensure some level of continuity of care and serve as the primary provider of care for many who now seem dependent upon it.[10] Lastly, we will need to push our legislators regarding distribution of resources from federal payers to enable us to fill this role. Once adequate reimbursement is available, ED physicians will be less reluctant to provide preventive services, as evidenced in the recent growth of alcohol and tobacco screening with the institution of Centers for Medicaid and Medicare Services CPT codes.

Preventive and primary care services continue to creep into the ED and have been met with a wide range of emotion, from open arms to complete disregard. With a steady increase of uninsured, the Medicaid office visit reimbursement of $27 and an overall diminished access to primary care, the frequent users of the ED are likely to increase. We have many challenges ahead: acceptance by ED staff, hindrance of clinical operations and changing the mindsets of ED physicians.[6] Fortunately, recent legislation has added reimbursement for some of these efforts to Medicaid patients in 10 states so far.[11] Grumbach et al.[12] opined some 15 years ago: "Many patients presenting to public hospital EDs may not require emergency services, but almost all have health care needs that deserve medical attention. Policies that deny patients emergency department care either explicitly, through criteria for refusing care, or implicitly, though long waiting times, without assuring patients of access to an alternative source of care are ethically and clinically unacceptable." Like internal medicine, we must adapt to the needs of our patient, who must always come first.

Address for Correspondence: Rick A. McPheeters, DO, Department of Emergency Medicine, Kern Medical Center, 1830 Flower Street, Bakersfield, California 93305. Email: mcpheetr@kernmedctr.com

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