Moments of Clarity

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There's an ongoing uncertainty about how many of the visits in our nation's emergency rooms are actually emergencies. That uncertainty arises from several different aspects of the problem:

1. How do we, or patients, define an "emergency?" Everyone agrees, I think, that given the choice, we'd prefer that patients err on the side of caution. There is a long-established "standard" in measuring emergency room visits: that it should not be measured by what the discharging diagnosis was, but the "prudent layperson" standard. If a prudent layperson would think it could be an emergency, let's start the pursuit of care in the emergency room.

   Given this long-held standard, the definition of an emergency could be that it is a condition that a prudent patient *thinks* is an emergency.

2. How then, do we measure that? Is it a matter of asking patients if they believe they are having an emergency?

   Currently at the federal level (Health and Human Services), it is measured by the "time needed to be seen," though it is somewhat unclear as to what the measures of those measures are (how is it decided how quickly someone needs to be seen?). In addition, the ranges that are measured are quite broad after a certain point; currently, the CDC measures are "immediately," "under 15 minutes," "15-60 minutes," "1-2 hours," then "2-24 hours." It is unclear what visits fall into what triage measure, and who decides that. It is also unclear what the consequences are to a patient in a certain category if they are not seen within that time frame.

   I acknowledge that this is a very challenging part of the problem. The prudent layperson might also ask, if someone can wait one to two hours to be seen, is that really an emergency? If I'm picking an ED by its posted wait time, should I really be there? The unfortunate answer is that it's probably tough to for a layperson to know, and we are back to erring on the side of caution.

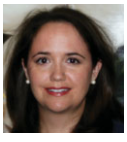
3. Lastly, there is an unfair struggle over patients going on here that no one likes to talk about. Our healthcare delivery system is such that having a patient visit is a good thing, and losing one to another provider is a bad thing (unless it is a non-paying patient). There are very large dollars at stake here, or no one would really care much about this issue. The burden this places on our emergency rooms is quite unfair; the patients that won't later clog up the ED waiting for a bed, but that can be treated and sent home and/or back into the primary care system, are the very patients that the majority of us outside the ED are trying to take away.

I, certainly, am on the side of urgent care and cost savings and wanting to get patients into the best location for the illness or injury that they seem to have, at the right time; I think everyone is—in the abstract. However, we don't live in the abstract. I also understand why measuring where those patients should be is a large challenge, and why there are enormous implications of doing so that could cripple our emergency departments in the current system. No one wants that.

In late March, UCAOA's president, Dr. Don Dillahunty and I sent a letter to the directors in charge of the national ED study we all watch so carefully at the Centers for Disease Control, asking them to reconsider their models of measurement to help us all gain some clarity. Until we better understand what these visits look like, I believe it will be hard to design a system that will help our ED colleagues do what they are all so well-trained and well-equipped to do, which is handle emergencies, and provide both their facilities and their professionals with adequate compensation for the immeasurable benefit they provide.

It's a tough problem that affects us all, but that doesn't mean we don't need to look directly at it and see where the truth lies and what really needs to be done about it. Odds are, if we don't, it's only going to get worse.

(Notes: UCAOA members can read our letter in the UConnect Resource Library. The CDC study referred to can be found at *http://www.cdc.gov/nchs/data/nhsr/nhsr026.pdf*). ■



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