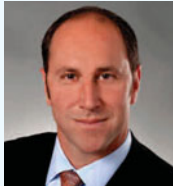




Show Me the Money: Alternative Access in Acute Care Delivery



In my last column I examined the recent study by the Center for Studying Health System Change which reviewed data from the 2008 National Hospital Ambulatory Medical Care Survey (NHAMCS). I identified critical flaws in the definitions used to distinguish “appropriate” emergency department (ED) visits from “non-urgent” or so-called “routine” visits. I concluded that the study missed a tremendous opportunity to identify alternatives for the vast majority of patients with conditions deemed “non-emergent” but that required care within 24 hours. All of those patients (75% of the study population) were deemed “appropriate,” yet no alternative places of care were considered. The media, and the special interest lobby machine feeding it, used the results to renounce theories of ED overutilization and declare the case closed on potential cost savings and resource utilization gains from re-directing “non-emergent” ED visits.

Where the study failed miserably, and what the media confounded, was the missed opportunity to ask the right questions. Consider this overlooked hypothesis: Alternative points of access exist for the 88% of patients with conditions deemed “non-emergent,” and re-directing these patients will produce significant cost-savings and system efficiencies.

Let’s examine the data more closely. Certainly some of the 88% “non-emergent” patients are better served in the ED. But are there ways to examine the data and more accurately categorize groups of patients who would be better off accessing care through alternative sources? Secondly, how can we define access points such that we can objectively determine their potential impact? And what other studies exist that might give us a clue about whether the alternative access points have a quantifiable impact on cost and efficiency?

To answer those questions we first need to identify the percentage of patients presenting to EDs who have conditions that can be handled in an alternative setting, such as an urgent care center. Then we need to understand how many of them present during typical urgent care center hours of operation.

A closer look at the NHAMCS data reveals that the vast majority of patients present with typical urgent care complaints such as headache and minor injury. A small number of complaints are more obvious emergencies. Then, there are complaints for which

urgency cannot be determined such as dizziness. It would be reasonable to assume that a percentage of “emergent-type” complaints are not real emergencies, and a percentage of “non-emergent-type” complaints require a higher level of care than anticipated. That division remains to be quantified, but experience tells us that it is pretty equal. A review of the raw data reveals that at least 75% of the complaints were of the “non-emergent-type” that require a level of care considered routine in the urgent care setting.

To answer the second question, time of presentation must be analyzed. Gross analysis of the NHAMCS data reveals that 75% of patients presented during typical urgent care hours of operation (8 am-10 pm).

During the study period (2008), there were 119 million ED visits. If 75% of those patients had typical urgent care complaints (89 million), 75% of which occurred during typical urgent care hours, the potential exists to re-direct 67 million ED visits to more appropriate and cost-effective places of care.

The average cost of care per patient visit in an urgent care setting is \$118, according to the UCAOA benchmarking study released in 2010. In contrast, \$500 to \$600 per patient visit is a conservative estimate, in most studies, for the average cost of care for “urgent care-type” conditions treated in the ED.

If all 89 million patient visits identified as potential candidates for urgent care diversion were re-directed accordingly, the health care system could realize \$34 to \$37 billion in cost savings. The potential impact is dramatic enough that it demands more thorough investigation. Using a more conservative algorithm, a 2010 Rand study identified 27% of ED visits that could be handled at either urgent care centers or retail health clinics.

Regardless of the ultimate figure, the potential for cost savings more than justifies a more thorough investigation and a more balanced dialogue about the impact of alternative access points for the delivery of acute care. ■

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