

Delivery of Acute Unscheduled Healthcare: Who Should Judge Whether a Visit Is Appropriate (or Not)?

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Emergency department (ED) utilization has become a hot-button health policy issue. Since the inception of the modern ED, people have debated “appropriate” reasons to seek ED care. More recently, they have wrestled to identify interventions to deter “unnecessary” visits.¹ Determining what might be considered appropriate emergency care is a challenging task and depends a great deal on the stakeholders.

To illustrate the various perspectives regarding appropriate use of the ED, consider these questions regarding a clinical example of a scalp laceration on a child:

1. Is acute care necessary? In this case, does the scalp laceration need to be assessed by a clinician?
2. If acute care is warranted, in what setting should it be delivered (eg, primary care provider office, urgent care, or ED)? Is there a consistent “appropriate” answer or does it depend on variables such as the time of day or day of the week?

The “prudent layperson” standard defined in the Affordable Care Act helps answer the first question (ie, is acute care indicated?) by defining an emergency medical condition.² The standard asserts that “if a person of average health and medical knowledge could reasonably expect that their health was in serious jeopardy or their symptoms could lead to serious impairment or dysfunction, then ED care is appropriate.” This broad definition is among the best available to determine ED appropriateness and is arguably better than a retrospective determination, given a level of diagnostic uncertainty prior to clinical assessment. Although this federal standard helps define an emergency, it unfortunately does not assist in directing patients to the appropriate venue of care (ie, the second question), nor do most health systems sufficiently guide patients to the best venue of care.

Enhancing access to primary care may decrease acute ED and urgent care visits. However, do most consumers prefer that their primary care physician treats a sore throat or a sprained ankle? Will the care be better or less costly? A recent study of an onsite medical clinic reported that lowering barriers to primary care visits

decreased urgent care visits but did not lower costs.³ Key variables, such as quality of care provided and patient satisfaction, are often not reported in studies comparing the relative costs of different care venues.

The prudent layperson standard and a federal policy that mandates that all patients receive emergency evaluation and treatment regardless of ability to pay are likely drivers of the consistent increase in the rate of ED visits.⁴ Although ED visits contribute to nearly half of the medical care delivered in the United States,^{3,5} “inappropriate” encounters may only represent 3% of the tens of millions of ED visits each year, depending on the definition used.⁶ Given the real, and perceived, financial burden of unneeded ED visits, multiple interventions aimed at reducing clinically inappropriate ED visits are being explored.

In this issue of *The American Journal of Managed Care*[®], Patel et al demonstrate that providing easily understood information regarding different care options *after* an ED visit effectively directed patients to alternative venues of care.⁷ Patient-centered educational interventions have great potential, and they are more likely to produce desired clinical and economic outcomes than programs designed to penalize patients, clinicians, or delivery systems for ED care deemed inappropriate. Moreover, actively including the ED in the solution, instead of raising barriers to ED care, may be more rational than programs that could alienate ED personnel.

As access to ED care is increasingly in the crosshairs of health policy makers, a thoughtful discourse among patients, clinicians, payers, and health systems regarding the provision of acute unscheduled care is warranted. Consumers must not be left on their own to decide whether acute care is necessary and where it should be provided. Patient-centered approaches to optimize the use of the ED must be integrated into more comprehensive population health initiatives. A key element of this strategic plan includes the development of user-friendly tools that help patients decide when to seek care and where best to receive it. In the era of expanding health information technology and near-universal internet access, a wide-ranging strategy includes virtual care

solutions, such as telehealth and e-health. In the absence of easily accessible information to change care-seeking behavior, it should come as no surprise that those with acute healthcare needs will continue to choose to visit the ED.

As alternative payment models and value-based insurance designs provide incentives for providers and consumers to move away from a quantity-driven system to a quality-based one, a coordinated approach to acute care delivery is vital. Future payment structures, which may no longer include high ED facility fees, could ultimately identify certain clinical scenarios in which the ED might be included in the acute care plan, even for conditions previously thought to be inappropriate.⁸ As our delivery system evolves through value-driven transformation, less attention should be paid to where acute care is delivered. More consideration should focus on the consumer's decision-making process as well as the quality and costs of the care provided. ■

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