

# medicaid and the uninsured

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## Emergency Departments Under Growing Pressures

Since the economic recession began over a year and a half ago, the impact of rising unemployment and uninsurance has rippled through families, communities, and the safety-net that supports them. To learn more about the recession's impact on hospital emergency departments – a crucial part of the health care safety-net and a setting where evidence of recessionary pressures might be expected to emerge – the Kaiser Family Foundation's Commission on Medicaid and the Uninsured recently conducted a set of interviews with emergency department heads and others practicing in emergency departments. The observations and perspectives of these clinicians offer a qualitative look at the impact of the recession on a diverse group of institutions and the patients they serve.

### Methodology

Interviews were conducted with the heads of emergency departments in selected hospitals across the country, as well as with officials of groups representing emergency physicians and nurses. All but one of those interviewed were practicing clinicians, and the emergency departments in which they practiced reflected a broad spectrum of settings, including academic, community, teaching, and non-teaching hospitals. Urban, suburban, and rural hospitals were included, and the four major regions of the U.S. were represented. The interviews, 12 in all, took place in July 2009.

### Key Findings

***ED capacity is strained and almost all EDs report rising volume.*** Nearly every ED represented in the study is operating at or over capacity and most have been experiencing rising volume over time; several were described as “overwhelmed” or “close to the breaking point.” One physician director likened his ED to a pitcher of water that is already full and constantly overflows as it gets filled more and more. Interviewees surmised that several pressures contribute to volume increases, including inadequate access to primary care among both the insured and the uninsured, rising numbers of uninsured, the growing inability of insured people to afford their out-of-pocket costs, demographic trends, and H1N1. The recession was widely viewed as a source of rising ED volume through its corrosive impact on health coverage and patients' ability to afford needed care. Only in a few small, rural communities where the recession had not yet hit hard were these effects on EDs less noticeable.

EDs are seeking to deal with volume increases by adding shifts for physicians, increasing physician staff, and increasing the number of patients emergency physicians see per hour. They pointed out that increased pressure on physicians and laboratory and imaging technicians to do more in less time inevitably increased the risk of errors, which worried them.

***Many observe a new “recession” population in their EDs.*** ED physicians and nurses report seeing more people who previously had health insurance but lost their jobs in the recession and became uninsured as a result. In addition, they perceive an increase in insured patients who seek primary care in the ED because they cannot afford to pay deductibles and cost-sharing at their doctor's office. One physician, citing the economic pressures families are under, said he had had ED patients leave in the middle of a work-up because they had to get to work or care for a young or elderly relative at home.

***Most uninsured people have nowhere to obtain primary care but the ED. Few private practices accept uninsured patients and sliding fee clinics are backed up.*** According to those interviewed, the increasing numbers of uninsured patients seeking primary care in the ED have no other options. Except in one ED that was part of a large area health care system that also included clinics for the poor and uninsured, ED doctors across the board cited sharp inadequacies in access to primary care in their communities, particularly (though not only) for the uninsured. They said that uninsured patients must come to the ED when they have the kinds of complaints – a sore throat, hives, a sprained ankle, etc. – for which insured patients go to their primary care doctors. Uninsured adults who have run out of their medicines also come to the ED to get a refill when they have no other access to physician care. Often, they have gone weeks without their medicine by the time they come. Since few ED physicians will prescribe more than a month’s worth of medicine for an ongoing condition, this situation is likely to be repeated a month later.

Interviewees reported that few private primary care doctors would accept uninsured patients and that current waits for appointments at community health centers and clinics are long – for new patients, 4 to 6 weeks, or as long as 4 or 6 months in some areas. Several ED physicians said that doctors’ offices in their communities had directed uninsured clients, clients with Medicaid, and insured clients whose benefits had run out to the ED for care.

***EDs see more insured patients who come because they cannot obtain timely or affordable primary care in the community.*** Insured patients sometimes seek primary care in the ED because they face unacceptably long waits for appointments with private physicians or primary care practices are full. The lack of after-hours appointment times is a problem for many who are working, especially in this economy. One interviewee observed that primary care practices are reducing their hours, but not the number of patients in their practices, leading to longer waits for appointments. For some insured patients, their deductible or the substantial copay required up-front in doctors’ offices stops them from seeking primary care there, and they come instead to the emergency department where they can receive needed care without having to pay immediately.

***ED patients, whether insured or uninsured, face long waits for care.*** Between high volume and high occupancy in both ED and inpatient hospital beds, overcrowding in EDs emerged as a major problem. Long waits to be seen in the ED were cited frequently; the current average wait in one large, urban hospital was 18 to 24 hours. Sometimes patients who have waited for hours give up and leave without care; physicians expect they will come back later in worse shape. One ED physician said, “It is only a matter of time before people are dying in the waiting room.” Several ED physicians were interviewed mentioned the “boarder” problem, which occurs when no beds are available for patients being admitted, so they must board in the ED. When this happens, patients on gurneys occupy the hallways. As patients continue to stream in the ED door, but there is no inpatient capacity for those who need admission, everybody waits for care.

***Lack of insurance and access to primary care leads to repeated ED visits and sicker patients.*** When patients with health problems cannot get timely and regular primary care, they tend to come to the ED again and again as their problems flare or they get sicker. Both patients and EDs are burdened as a result. More than one physician gave as an illustration of this problem an uninsured patient with gall bladder disease who only gets surgery after his fifth or sixth visit to the ED, when there is infection. An earlier admission would have prevented substantial pain and suffering, several costly ED visits, and the more difficult surgery now involved since infection is present.

***Uninsured and even insured patients are declining medically recommended care for cost reasons.*** ED physicians noticed patients now weighing which medical services they will agree to because they are worried about the costs. Interviewees gave numerous accounts of patients – both insured and uninsured – choosing not to follow their medical advice because of the cost, including the cost of missing work. Patients had turned down recommended care ranging from lab tests to a hospital

admission for chest pain. A patient diagnosed with acute appendicitis at an urgent care center had refused to take an ambulance to the ED because of the cost, saying that he would call his mother for a ride. Doctors raised concern that these decisions were risky and jeopardized patients' health.

***ED physicians see anxiety and depression among patients who lost their jobs.*** Many of those interviewed observed increases in complaints of anxiety, depression, and stress among their patients, linked to joblessness and financial worries. Also, some noted that they done comprehensive work-ups of patients who came in with stomach pain, chest pain, and other somatic complaints, but found no physical cause. Based on their knowledge of the patient's circumstances, they thought it likely that the symptoms were stress-related.

***The inability to arrange for follow-up care for uninsured patients is a huge problem, with impacts on how ED physicians practice and on how patients fare.*** ED physicians described follow-up care for uninsured patients as an enormous problem. Teaching hospitals often have ambulatory clinics to which ED patients can be referred, but it can take months to get an appointment. Some also charge fees that many uninsured patients cannot pay. For community hospitals, finding follow-up care for ED patients can be even more difficult. Private practices are often full and most require a substantial fee up-front. Community health centers and clinics are swamped and have long waits for appointments. The lack of primary care access outside the ED means that their patients will be back.

When ED physicians know their patients are unlikely to get follow-up care, they practice differently. Whereas they might do more limited tests and screens for a patient who could see his or her primary care doctor for further evaluation in a day or two, they feel compelled to do more extensive and costly work-ups for those without insurance, or to admit them in some cases, to ensure the safety of these patients. At intake, ED physicians also see the effect of no follow-up on patients' health. For example, uninsured people who have gone for weeks or months without needed medication because they cannot afford it come to the ED because their chronic disease has worsened and they are now symptomatic. When that happens, one physician said, "you are back to square one."

***EDs do not have the financial cushion to absorb new pressures.*** Already under difficult strains, EDs do not have adequate resources to meet rising pressures. To handle increasing volume, they need additional clinical staff and ancillary services capacity. Inpatient capacity will also need to grow in many hospitals where beds are already full; otherwise, EDs will grow even more crowded and the waits for care even longer. If the H1N1 pandemic hits hard in the fall, EDs will be under extraordinary pressure. Some physicians said they might have to go into "disaster mode." Yet, with these mounting pressures, EDs report that more patients are uninsured, primary care access in the community continues to worsen, hospitals reimbursements are declining, endowments are down in teaching institutions, and collections of deductibles and copays from insured patients are reduced as families cannot afford to pay. Support for expanded health insurance is broad, but some voiced concern that public financing for EDs might be reduced in the same legislative stroke – a prospect that would leave EDs financially unequipped to meet the needs of many of the nation's sickest patients.

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