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HOSPITAL EMERGENCY DEPARTMENTS

Health Center Strategies That May Help Reduce Their Use

Statement of Debra A. Draper
Director, Health Care



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Chairman Sanders, Ranking Member Paul, and Members of the Subcommittee:

I am pleased to be here today to discuss strategies that health centers—facilities that provide primary care and other services to individuals in communities they serve regardless of ability to pay—employ that may help reduce hospital emergency department use. Hospital emergency departments are a major component of the nation’s health care safety net as they are open 24 hours a day, 7 days a week, and generally are required to medically screen all people regardless of ability to pay.¹ From 1997 through 2007, U.S. emergency department per capita use increased 11 percent.² In 2007, there were approximately 117 million visits to emergency departments; of these visits, approximately 8 percent were classified as nonurgent.³ The use of emergency departments, including use for nonurgent conditions, may increase as more people obtain health insurance coverage as the provisions of the Patient Protection and Affordable Care Act (PPACA) are implemented.⁴

¹In order to participate in Medicare, hospitals are required to provide a medical screening examination to any person who comes to the emergency department and requests an examination or treatment for a medical condition, regardless of the individual’s ability to pay. Social Security Act §§ 1866(a)(1)(I), 1867 (codified at 42 U.S.C. §§ 1395cc(a)(1)(I), 1395dd). Medicare is the federal health program that covers seniors aged 65 and older, certain disabled persons, and individuals with end-stage renal disease.

²In 1997, there were an estimated 35.6 emergency department visits per 100 people compared to 39.4 visits in 2007. See P. Nourjah, “National Hospital Ambulatory Medical Care Survey: 1997 Emergency Department Summary,” *Advance Data*, no. 304 (1999), and R. Niska, F. Bhuiya, and J. Xu, “National Hospital Ambulatory Medical Care Survey: 2007 Emergency Department Summary,” *National Health Statistics Reports*, no. 26 (2010).

³The National Center for Health Statistics developed time-based acuity levels based on a five-level emergency severity index recommended by the Emergency Nurses Association. The acuity levels describe the recommended time frame for being seen by a physician. The recommended time frames to be seen by a physician are less than 1 minute for immediate patients, between 1 and 14 minutes for emergent patients, between 15 minutes and 1 hour for urgent patients, greater than 1 hour to 2 hours for semiurgent patients, and greater than 2 hours to 24 hours for nonurgent patients.

⁴We refer to the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat 1029, as PPACA. According to estimates from the Congressional Budget Office (CBO), an additional 32 million individuals are projected to obtain health insurance coverage by 2019; CBO also estimates that gaining insurance increases an individual’s demand for health care services by about 40 percent. See D. Elmendorf, Director, CBO, “Economic Effects of the March Health Legislation” (presentation at the Leonard D. Schaeffer Center for Health Policy and Economics, University of Southern California, Los Angeles, Calif., Oct. 22, 2010).

Some nonurgent visits are for conditions that likely could be treated in other, more cost-effective settings, such as health centers. In 2008, the average amount paid for a nonemergency visit to the emergency department was seven times more than that for a health center visit, according to national survey data.⁵ While there are many reasons individuals may go to the emergency department for conditions that could also be treated elsewhere, one reason may be the lack of timely access to care in other settings, possibly due to the shortage of primary care providers in some areas of the country.

Like emergency departments, the nationwide network of health centers is an important component of the health care safety net for vulnerable populations, including those who may have difficulty obtaining access to health care because of financial limitations or other factors. Health centers, funded in part through grants from the Department of Health and Human Services' Health Resources and Services Administration (HRSA), provide comprehensive primary health care services—preventive, diagnostic, treatment, and emergency services, as well as referrals to specialty care—without regard to a patient's ability to pay. They also provide enabling services, such as case management and transportation, which help patients access care. In 2009, more than 1,100 health center grantees operated more than 7,900 delivery sites and served nearly 19 million people. With funding from PPACA—projected to be \$11 billion over 5 years for the operation, expansion, and construction of health centers⁶—health center capacity is expected to expand.

My statement will highlight key findings from a report we are publicly releasing today that describes strategies that health centers have implemented that may help reduce the use of hospital emergency

⁵According to estimates from 2008 Medical Expenditures Panel Survey (MEPS), the average amount paid for a nonemergency visit to an emergency department was \$792, while the average amount paid for a health center visit was \$108. Similarly, the average charge for a nonemergency visit to an emergency department was 10 times higher than the charge for a visit to a health center—\$2,101 compared to \$203. MEPS is a set of large-scale surveys of families and individuals, their medical providers, and their employers across the United States.

⁶Specifically, PPACA appropriated \$9.5 billion for fiscal years 2011 through 2015 to a new Community Health Centers Fund to enhance funding for HRSA's community health center program. It also provided \$1.5 billion over that same time period for the construction and renovation of community health centers. Pub. L. No. 111-148, § 10503, 124 Stat. 119, 1004 (2010); Pub. L. No. 111-152, § 2303, 124 Stat. 1029, 1083.

departments.⁷ For that report, we interviewed officials from 9 health centers, and conducted group interviews with officials from multiple health centers operating in three states, about strategies they have implemented that may help reduce emergency department use. We selected these health centers and states, based on our review of relevant literature and interviews with HRSA officials and experts, to provide geographic variation and to ensure that health centers serving rural and urban areas were represented. We also e-mailed all state and regional primary care associations—private, nonprofit membership organizations of health centers and other providers—to identify specific health centers in their jurisdictions that had implemented strategies that may have reduced emergency department use.⁸ In addition, we collected information about health centers’ strategies from the literature and our interviews with agency officials and experts. Our work was performed from November 2010 through April 2011 in accordance with generally accepted government auditing standards.

In brief, our work found that health centers have implemented three types of strategies that may help reduce emergency department use. These strategies focus on (1) emergency department diversion, (2) care coordination, and (3) accessibility of services. For example, some health centers have collaborated with hospitals to divert emergency department patients by educating them on the appropriate use of the emergency department and the services offered at the health center. Additionally, by improving care coordination for their patients, health centers may help reduce emergency department visits by encouraging patients to first seek care at the health center and by reducing, if not preventing, disease-related emergencies from occurring. Finally, health centers employed various strategies to increase the accessibility of their services, such as offering evening and weekend hours and providing same-day or walk-in appointments—which help position the health center as a convenient and viable alternative to the emergency department. Health center officials told us that they have limited data about the effectiveness of these strategies, but some officials provided anecdotal reports that the strategies have reduced emergency department use. These officials also described several challenges in implementing strategies that may help reduce

⁷GAO, *Hospital Emergency Departments: Health Center Strategies That May Help Reduce Their Use*, [GAO-11-414R](#) (Washington, D.C: Apr. 11, 2011).

⁸We received responses from 21 of 52 regional and state primary care associations we contacted.

emergency department use. For example, health center officials indicated that some services, such as those provided by case managers who may help coordinate care, are generally not reimbursed by third-party payers. Additionally, some officials noted that it is difficult to change the behaviors of patients who frequent the emergency department and some noted challenges with recruiting the necessary health providers to serve their patients.

Chairman Sanders, Ranking Member Paul, this concludes my prepared remarks. I would be pleased to respond to any questions you or other members of the subcommittee may have at this time.

For questions about this statement, please contact Debra A. Draper at (202) 512-7114 or draperd@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Individuals making key contributions to this testimony include Michelle B. Rosenberg, Assistant Director; Jennie F. Apter; Carolyn Feis Korman; and Katherine Mack.

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