

# Expanding the Emergency Room Model: 'Central Care System' Could Help Americans Gain Universal Health Care Access

01/28/2017 02:06 am ET | Updated 02/13/2017

[Dr. Sudip Bose](#) ★Emergency Physician ★Iraq War Veteran ★CNN Hero for treating Saddam Hussein after US capture ★Professor ★CEO ★Leadership Speaker



Dr. Sudip Bose, advocate of 'Critical Care Centers'

**By Dr. Sudip Bose, MD** — There are many reasons why emergency rooms are dangerously overcrowded. With millions of Americans lacking adequate access to primary care providers, emergency rooms have become the primary health care system and safety net for the uninsured, underinsured and those without access to other medical care.<sup>1</sup> Overcrowded and with overworked staffs, ERs are perilously close to collapse in many places. (See my other article on ERs here: [Our Nation's Emergency Rooms](#)). In fact, many already have closed their doors.<sup>2</sup> There is an increased demand for emergency department care, as hospital emergency rooms have experienced a 32 percent increase in patient volume over the past decade.<sup>3</sup>

There are many reasons why we are seeing an influx in the volume of people seeking care in the ER. For starters, the fastest-growing age group in the United States is those over age 65, according to the 2010 US Census,<sup>4</sup> and emergency room visits by the elderly are rising at an alarming rate. We also have a shortage of primary care physicians, and a growing percentage of health care practitioners that do not accept Medicare and Medicaid because of low reimbursement rates.<sup>5</sup> Confounding those issues is the EMTALA (Emergency Medical Treatment and Active Labor Act) of 1986, which requires emergency rooms to treat all comers, regardless of urgency or income. Two-thirds of emergency visits occur after business hours, when doctors' offices are closed.<sup>6</sup> For people who find themselves in distress without access to care for these various reasons, the emergency room is often the only place to turn, and the double doors will always be open for them.

Under the Affordable Care Act, or "Obamacare," with more people having coverage and wanting to see doctors, primary care physicians cannot keep up with the demand.<sup>7</sup> Since patients were not able to get timely appointments to see their own physicians, they resorted to seeking care in emergency rooms. Waiting times already have caused dangerous lag times for the most critical patients to be seen because exam rooms in the ER are occupied with others who also need medical care.<sup>8</sup> The narrow hallways of most perilously overcrowded emergency departments will struggle to create room between the man coughing up blood in the corner and the crying child with a broken arm.

Ambulances carrying patients with life-threatening conditions are currently diverted from the nearest ER on average once every minute in the US because there are no exam rooms available where they can be treated.<sup>9</sup> A critical patient may have to be rerouted several miles away to other "emptier" hospitals in order to be seen. Already we see patients losing consciousness from cardiac disease while in the ER waiting room, and some patients must suffer the humiliation of being evaluated in the hallway for conditions such as diarrhea. Simply put, space is limited and the system is stretched nearly beyond its limit. An incidence of a multi-car crash on the highway, a shooting at a mall or even the next flu epidemic can take an ER from being at maximum capacity to beyond the number of patients they are able to care for properly. The sad reality is that any of us could end up in an ambulance, only to learn the ambulance must continue on to another hospital because the nearest ER is already overflowing and cannot take on another major emergency. In critical situations every moment counts, so it is the patients - the people in need - who stand to lose most in this situation.

Despite increasing demand for emergency care, there is a decreasing supply of emergency rooms. Over the past decade, financial burdens have caused hundreds of our ERs to close their

sliding double doors for good, leaving people without options for emergency care.<sup>2</sup> Increased financial burden on emergency rooms largely results from low reimbursement rates. Remember that per EMTALA regulations, emergency departments must treat anyone who walks through the door in need of care, many of whom cannot afford to pay a hospital bill. Even for those with insurance coverage, often there is a portion of the bill that is owed by the patient, and sometimes they must choose between paying the hospital and buying food for their families. In addition, Medicare pays a fraction of the amount billed for care, thus further reducing the costs that a hospital can recoup for care.<sup>10</sup> The dollar amount billed by hospitals is largely facility fees,<sup>11</sup> not charges billed to see emergency room doctors.

- **Emergency rooms are dangerously overcrowded**
- **Counter-intuitively the problem may be the solution**
- **Expanding the emergency room model and sending more patients to ERs may control costs and improve access**
- **To do this we must allocate more of our health care dollars to the ER**
- **Utilize the “central care system” to redirect patients appropriately to a primary physician, urgent care, or ER**

Knowing that information, why do doctors choose to specialize in emergency medicine? The average emergency physician statistically provide nearly \$140,000 of uncompensated charity care annually.<sup>12</sup> Based on those statistics, it is fair to say that doctors choose emergency medicine not for money, but to make a difference for people in need. These physicians are dedicated to caring for all people, regardless of income, and find their work very rewarding on a personal level.

In comparison, if a gas station were mandated to provide gasoline for every car that drove through and a large portion of that gasoline was uncompensated, eventually the gas station would be forced to close. Emergency care is efficient, managing to treat more than 130 million of the sickest patients each year using less than two percent of the trillions of dollars spent on health care annually in the United States.<sup>13, 14</sup> It is unfortunate that less than two cents of every health care dollar goes to emergency care when the ER provides care for every person, at any time of day or night, and any one of us may be the next patient as we are all one heartbeat away from an emergency.

Another reason for the decreased supply of available emergency care is that very good doctors leave clinical practice because of high liability in malpractice lawsuits. This has resulted in a shortage of critical “on call” specialists who curtail their services due to high liability and low reimbursements in emergency situations.<sup>15</sup> So what is a tearful parent to do when her child urgently needs a neurosurgeon, orthopedic surgeon or other specialist, but those specialists are no longer available on call? Furthermore, the physicians who continue to treat patients in hospital emergency situations may try to defend themselves against malpractice lawsuits by ordering unnecessary tests or procedures — x-rays and CT scans, for example — but in doing so exposes the patient to potentially hazardous radiation. Medical liability reform should reduce this type of defensive medicine by doctors who fear lawsuits, thus decreasing cost and improving efficiency to both patients and providers. Many people have the misconception that doctors order additional tests because they receive more compensation, but in reality these practitioners fear

malpractice lawsuits if the studies are not performed. Such reform is necessary to sustain any healthcare system in our country, not only to keep physicians in practice but to reduce costs of medical care.

### **What is the anatomy of the solution?**

It may sound counter-intuitive, but sending more people to the emergency room is what I would propose. Instead of offering only emergency services, however, the ER needs to evolve to encompass mental health and primary care clinics to create a “**central care system**,” allowing more people to be seen. Emergency rooms already provide 24-hour care to people who need urgent medical attention, but also to those whose work schedules or other issues make it impossible to be seen during regular clinic hours. In the ER, the infrastructure already exists to see anyone with a common cold to mental health issues to heart attacks and strokes 24 hours a day, 7 days a week; obtain labs, x-rays and the aforementioned CT scans (computed tomography scans — CT or “CAT” scans). It is logical to use what already works.

It is a dangerous fantasy to think that urgent care centers or mini-clinics can eliminate ER overcrowding. While urgent care facilities are staffed with competent medical providers and use the best technology for many injuries and illnesses, they lack the overall expertise and resources to handle true emergencies. The wrong patient visiting an urgent care center in order to save money or time could well cost a life. Urgent care centers are very much needed and should continue to be available, but are no substitute for emergency care.

With today’s 24-hour lifestyle we can buy groceries, fly across the world, Tweet a message to thousands of people, and even work out at the gym at any time, day or night. Medical care has to adapt to the fast-paced world in which we live. When a patient comes into the hospital central care system, they will initially present to a main check-in area where staff will determine how urgently he or she needs to be seen. A person experiencing a heart attack will be sent immediately to the emergency department, but a child with bronchitis will be directed to see another qualified practitioner quickly in the adjacent clinic or urgent care. By the same token, patients presenting with problems that do not need urgent treatment will be asked to schedule an appointment with a doctor at a local clinic within a couple of days.

Every day we have lists of things to do for our families, jobs, recreation and other obligations. We prioritize our to-do lists constantly, taking care of the most urgent and important needs first.

### **It may sound counter-intuitive, but sending more people to the emergency room is my proposed solution.**

In a medical setting the term for determining priority is “triage”. The triage system is why you may wait in the ER waiting room for hours, as patients in need of emergency treatment must be seen first. With the central care system, there will be physician assistants and nurse practitioners who are available to treat less urgent issues and thereby reduce waiting times. In this way more people can be seen appropriately, without sacrificing quality or timeliness of care. Digital platforms like [liveClinic.com](http://liveClinic.com) can also be used to connect virtually to someone’s own primary care doctor.

Of course patients needing to see providers for less critical situations will still spend some time in the central care waiting room, just as they currently do in doctors' offices and urgent care clinics. Using that time to educate people will improve understanding about disease prevention, healthy living, vaccinations, home treatments for common illnesses like flu and colds, and other issues related to health. Introducing basic health education while people wait to see providers in the central care system may help them to avoid or more effectively manage chronic diseases and other common health issues. If we "use the wait to educate," the information can be spread by word of mouth and it has the potential to benefit the entire community.

Traditional primary care at outpatient clinics should continue to exist outside the hospital. A patient can schedule appointments with a primary care physician for regular check-ups or to manage any chronic health issues. But for acute illnesses or injuries, the central care system is available 24 hours a day to accommodate those needs. The central care system will also be able to schedule future appointments for patients to be seen by their regular doctors during normal clinic hours.

In any business, tasks are usually delegated based upon experience and skill. The owner of a grocery store has a lot of responsibilities, but of course he has many employees who have various jobs in the store. If the owner were to spend part of his time stocking shelves or bagging groceries, work reserved for the owner would be neglected and fall behind. In the same manner, the central care system will be more efficient. Escaping the entrenched mentality of professional roles will be important for streamlining medical jobs, leading to better separation of cognitive and technical aspects of care. That means nurses should not do jobs that can be automated or delegated to technicians, and physicians should ask nurses to perform certain tasks so they are free to attend to other patients. Efficient use of all resources, both human and automated, is critical to maintaining productivity, suppressing costs and providing appropriate care.

That means digital information as well. Efficient universal electronic medical record system that still incorporates patient confidentiality is critical. If someone is on a trip hundreds of miles away from home and is injured or becomes ill suddenly, and is unresponsive, when that person arrives at an emergency department, ER doctors would not have access to his medical history, medicines or other factors that may affect the way his emergency is treated.

Without an adequate understanding of a patient's medical history, the wrong type of treatment or misdiagnosis could result. For example, the hospital staff does not know what medicines this person is on, and may prescribe another medicine in the ER that could cause dangerous interactions with the patient's current medications. Having a full and clear picture of someone's history is critical to ensuring appropriate treatment. That could be done digitally.

Skyrocketing health care costs must also be addressed in the development of the central care concept. In order to tackle the issue of cost we must first recognize that the "cost" of care is not necessarily equal to the amount "billed." For example, although the cost of pressing the "on" button may be similar, patients and insurance companies are billed anywhere from under \$500 to upwards of \$10,000 for a CT scan.<sup>16</sup> Although the effort of doing the scan is similar, the amount billed often varies wildly depending on the type of facility where the scan is performed (such as a hospital emergency room, a freestanding clinic, or an outpatient clinic).

The amount billed also varies by whether or not the patient has insurance, the area or areas of the body being scanned, and whether or not contrast is used for the scan. Remember, too, that half of all ER bills are never paid, meaning they have to bill higher amounts to make up some of that money lost in order to keep the facility in operation. This discrepancy in the amount billed and the actual cost of performing that CT scan could be narrowed after the above changes make the entire system more efficient. No matter where or when the scan is performed, we must consider the fixed cost of purchasing and maintaining equipment, paying the technician performing the scan as well as the radiologist who evaluates the results, and cost of maintaining the facility. Still, the wide gap in the price of CT scans and other types of testing needs to be evaluated to achieve better balance in the cost of care across all boards.

America's innovation has defined who we are as a nation; it has propelled us to the world's wealthiest population, and today it must be tapped to resolve the health care crisis that threatens Americans' personal and financial well being. As Obamacare is repealed and replaced and/or amended in some way, I would hope that the crafters of the legislation take into account the efficiencies listed above, added to the economies of scale that would be gained through consolidation. This will create a strong foundation that would be complemented by future universal health coverage for Americans. As we see health care reform evolve in America, the issues presented will need to be taken into account. Our nation must change to meet the demands of our health, and our demands must change to meet the needs of our health.

*For more about Dr. Sudip Bose, MD, please go to [SudipBose.com](http://SudipBose.com) and visit his nonprofit [TheBattleContinues.org](http://TheBattleContinues.org) where 100% of donations go directly to injured veterans*

---

## SOURCES

1 - "[The Uninsured: Access to Medical Care](#)" American College of Emergency Physicians. Web. 23 Jan. 2017

2 - Adamson, David M. "[Why Are Many Emergency Departments in the United States Closing?](#)" Web. 23 Jan. 2017

3 - "[Access to Emergency Medical Services Act of 2009](#)" American College of Emergency Physicians. Web. 23 Jan. 2017

4 - "[2010 Census Shows 65 and Older Population Growing Faster Than Total U.S. Population](#)" U.S. Census Bureau. 30 Nov. 2011. Web. 23 Jan. 2017

5 - Matthews, Merrill. "[Doctors Face a Huge Medicare and Medicaid Pay Cut in 2015](#)" Forbes. 05 Jan. 2015. Web. 23 Jan. 2017

6 - "[Costs of Emergency Care Fact Sheet](#)" American College of Emergency Physicians. Web. 23 Jan. 2017

- 7 - Bodenheimer, Thomas, M.D., and Bauer, Laurie, R.N., M.S.P.H. "[Rethinking the Primary Care Work Force - An Expanded Role for Nurses](#)" 15 Sept. 2016. Web. 23 Jan. 2017
- 8 - "[Emergency Department Wait Times, Crowding and Access Fact Sheet](#)" American College of Emergency Physicians. Web. 23 Jan. 2017
- 9 - Tuller, D. "[Ambulance Diversion](#)" Robert Wood Johnson Foundation. 02 June 2016. Web. 23 Jan. 2017
- 10 - Cromwell, Jerry and Burstein, Philip. "[Physician Losses From Medicare and Medicaid Discounts: How Real Are They?](#)" US National Library of Medicine, National Institutes of Health. Web. 23 Jan 2017
- 11 - Worth, Tammy. Modern Medicine Network. "[Hospital Facility Fees: Why Cost May Give Independent Physicians an Edge](#)" 06 Aug. 2014. Web. 23 Jan. 2017
- 12 - "[The Impact of Unreimbursed Care on the Emergency Physician](#)" American College of Emergency Physicians. Web. 23 Jan. 2017
- 13 - Roseneau, Alex M. [Letter](#). American College of Emergency Physicians. 07 Nov. 2013. Web. 23 Jan. 2017
- 14 - "[Costs of Emergency Care Fact Sheet](#)" American College of Emergency Physicians. Web. 23 Jan. 2017
- 15 - "[The Impact of Unreimbursed Care on the Emergency Physician](#)" American College of Emergency Physicians. Web. 23 Jan. 2017
- 16 - "[That CT Scan Costs How Much?](#)" Consumer Reports. July 2012. Web. 23 Jan. 2017

Follow Dr. Sudip Bose on Twitter: [www.twitter.com/docbose](http://www.twitter.com/docbose)

[http://www.huffingtonpost.com/dr-sudip-bose/expanding-the-emergency-r\\_b\\_14444940.html](http://www.huffingtonpost.com/dr-sudip-bose/expanding-the-emergency-r_b_14444940.html)