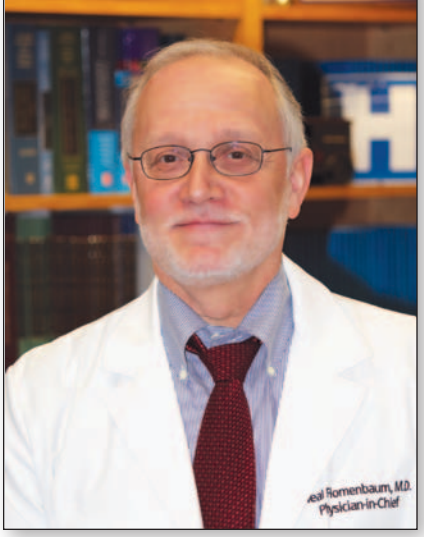
EDITORIAL

Neal Flomenbaum, MD
EDITOR-IN-CHIEF



The End Game

Among the problems that prevent emergency physicians from delivering the highest quality emergency care possible are the need to divert ambulances, ED overcrowding, boarding inpatients, difficulties obtaining timely consultations, lack of resources, and drug shortages—all driven to a greater or lesser extent by a lack of available inpatient beds. These problems have been the subject of many editorials in these pages during the past six years, but throughout this time, one thing that I've always taken for granted is that when "treat-and-release" patients are ready to be released, someone would be available to provide any necessary follow-up care.

In recent years, however, as increasing numbers of physicians have "opted out" of accepting any form of health insurance—including Medicare and Medicaid—and clinics have become overcrowded or have closed, the light at the end of the tunnel for many treat-and-release patients has turned out to be an oncoming train. Lack of adequate follow-up care is not a new problem for Medicaid patients and the EDs they go to. But more recently, lack of post-ED care has become a problem for non-Medicaid patients as well.

In a May 16, 2012, Perspective in the *New England Journal of Medicine*, entitled "Emergency department Medicaid costs and access to primary care—understanding the link," Kellerman and Weinick describe the recent attempts of many states to reduce their Medicaid expenditures by denying payments for ED care based on the application of retrospective diagnoses, rather than by providing Medicaid patients with adequate, lower-cost, non-ED alternatives. The authors also note the long-ignored difficulties Medicaid patients face in obtaining timely, needed follow-up care after ED visits. The authors cite a 2005 study by Asplin et al, published in *JAMA*, in which eight research assistants (RAs) posed as patients who had been seen in an ED and were in need of a follow-up appointment within a week for pneumonia, hypertension, or a possible ectopic pregnancy. The RAs twice telephoned 499 randomly selected primary care practices and clinics in nine US cities, using the same clinical vignette each time but offering different insurance coverage for the care. When the RAs claimed to have private insurance, 64.4% received appointments within a week, but when they claimed to be covered by Medicaid, only 34.2% were offered appointments.

Ironically, the problem in 2012 may be even more severe for non-Medicaid patients seen in the EDs of non–"safety-net" hospitals. Safety-net hospitals, predominantly municipal and county hospitals, frequently fill up to 90% or more of their inpatient beds with patients from their EDs. Similarly, almost all such hospitals have outpatient clinics and facilities available for the patients discharged from their inpatient services or EDs. Whether or not clinic care provided predominantly by residents and sometimes medical students, supervised by attending physicians, is considered to be as good as care provided by attending physicians in their own offices, isn't clinic care better than no care? In many instances, emergency physicians may now face the prospect of having to direct patients to one of two distinct types of follow-up care, based on their ability to pay out-of-pocket, as even private insurance may no longer be adequate to secure a timely follow-up appointment. When neither alternative is available, the third and only remaining alternative for the patient may be to return to the ED.

And who will be blamed if a patient does not receive appropriate and timely post-ED care, or returns to the ED for the most costly of all types of follow-up care? If you don't know the answer by now, you haven't been paying attention. **EM**