Hospitals Failing to Keep Pace with Rising Emergency Room Visits

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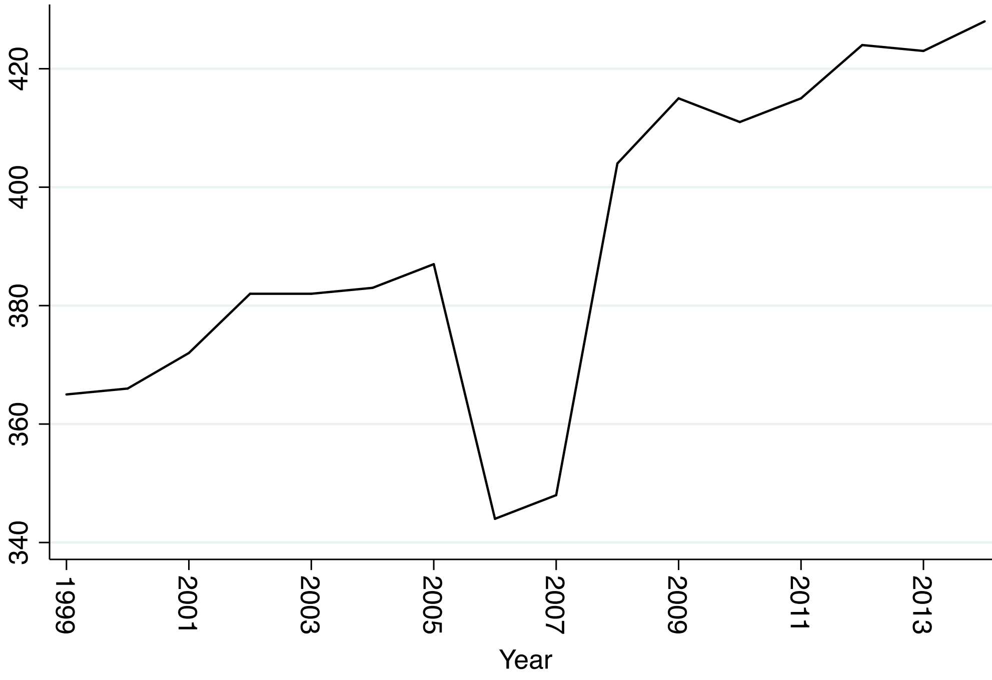
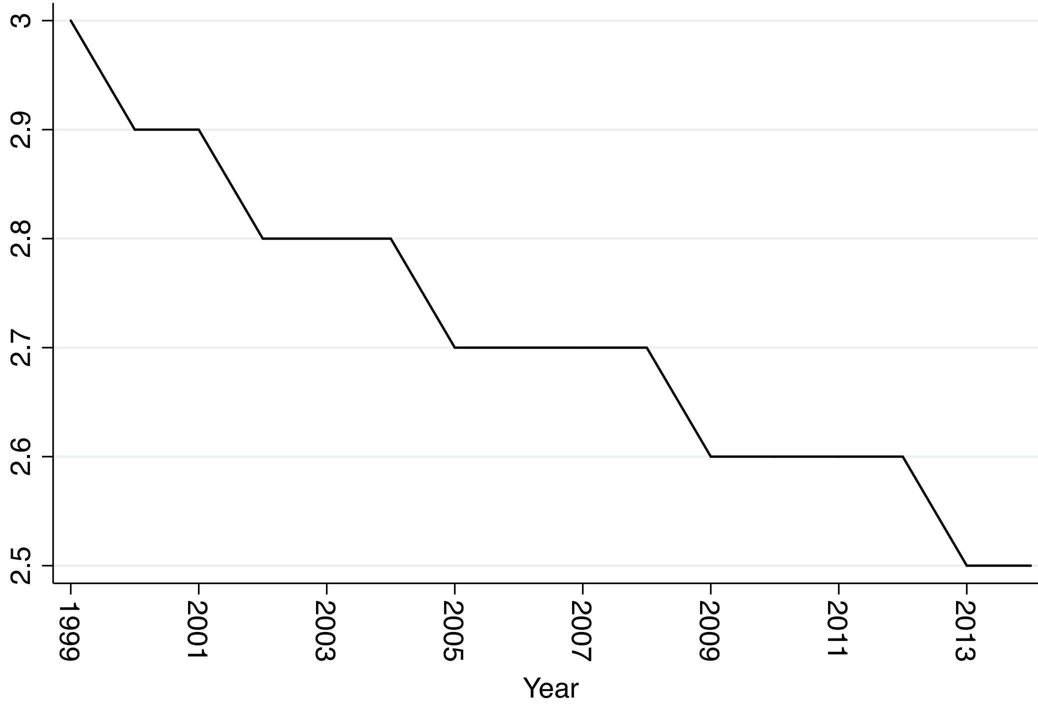
It has been observed that emergency room visits have increased in recent years in the aftermath of the implementation of the Affordable Care Act (ACA) as individuals are able to obtain coverage for care that they otherwise would not have sought. Between 1995 and 2010, annual ER visits grew by 34% while the number of hospitals that had emergency rooms actually *declined* 11%. Such trends are particularly prevalent among those states that opted for Medicaid expansion under the ACA, with Louisiana being the most recent state to adopt this policy.

Indeed, a 2015 survey of physicians revealed that three quarters observed that emergency room visits had increased, whether greatly (28%) or slightly (47%). This is in contradiction with the expectation that with more expansive health coverage, individuals would have access to physicians non an outpatient basis and manage medical conditions without the need for emergency care. (There is, of course, the reality that people are not always able to obtain medical care during business hours when they must be at work, while emergency rooms operate 24/7).

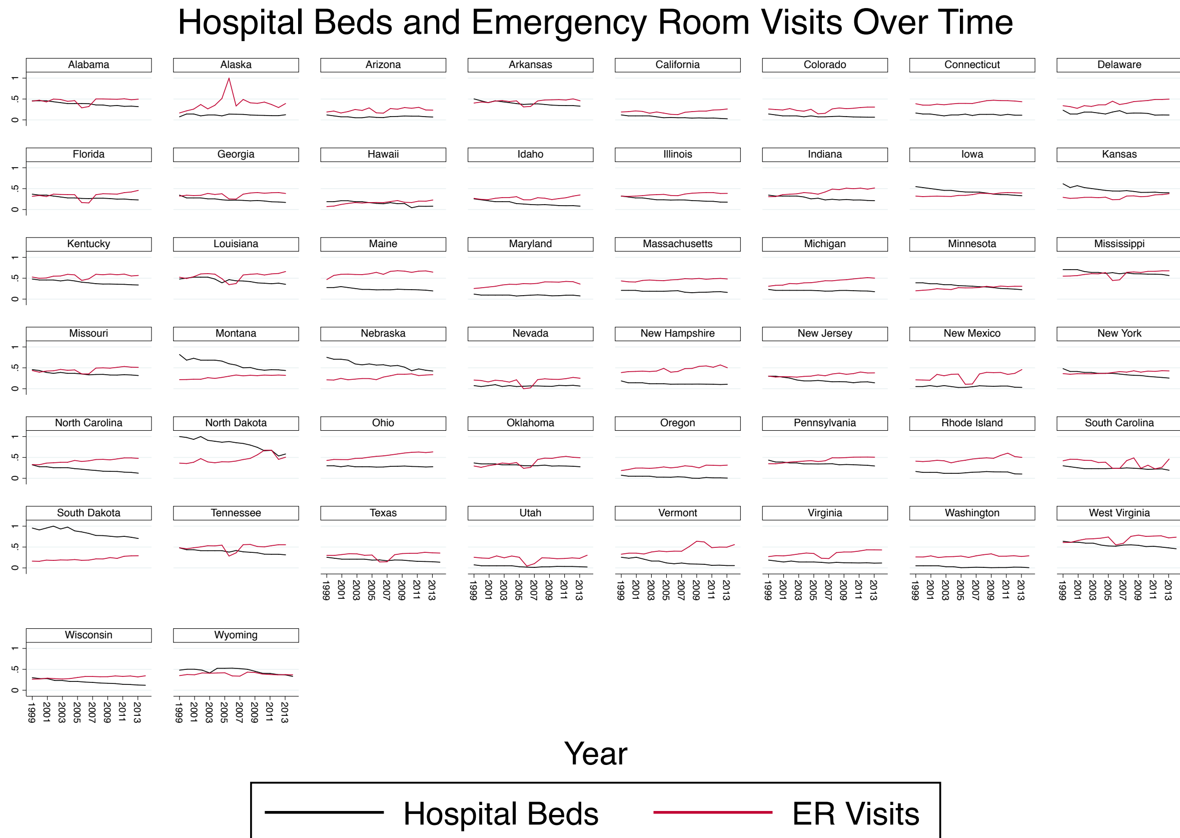
Approximately 12% of emergency room visits result in hospital admissions. With rising levels of emergency care, there is a question of whether hospitals are adequately prepared for larger numbers of patients potentially requiring not just emergency treatment, but hospitalization. It was reported by the Treatment Advocacy Center that the number of psychiatric beds has declined markedly over the years, with the United States having only 3.5% of the number of psychiatric beds that it had in 1955, nearly 20% fewer than the United States had in 2010. To what extent was that true of hospital beds more generally?

Consistent with some observations regarding hospital closures in order to emphasize outpatient care, I evaluated the Kaiser Family Foundation data from 1999 to 2014 on the number of hospital beds per 1,000 people per state, as well as the number of emergency room visits per 1,000 people per state, and find declines in the number of hospital beds alongside increases in the amount of emergency room care. This increase in ER visits does not appear to be a substitution of outpatient care for emergency care, as the number of outpatient visits also has increased over time. Rather, with a greater number of people having at least some degree of health coverage, they are newly seeking care for things otherwise being left untreated.


Emergency Room Visits Per 1,000 People, Nationally
420
400
380
360
340
1999
2001
2003
2005
2007
2009
2011
2013
Year


Hospital Beds Per 1,000 People, Nationally
3
2.9
2.8
2.7
2.6
2.5
1999
2001
2003
2005
2007
2009
2011
2013
Year

I then evaluated the Kaiser Family Foundation data within states, normalizing the numbers of hospital beds and emergency room visits to fall within the range of 0 to 1 so as to facilitate easy comparison on the same scale. In almost every state (South Carolina being the lone exception), we see the trend of hospital beds versus emergency room visits parallel to the trend nationally, with increasing ER visits and stable or declining hospital beds.



This can result in increased emergency room overcrowding, which can adversely impact patient care. For example, between 2003 and 2009, the average wait time in emergency rooms increased 25%, with longer wait times in urban regions. As a consequence of overcrowding, 50% of ERs are operating at or above capacity, with 90% of emergency rooms reporting patient boarding while waiting for hospital beds to open up for those patients being admitted. Moreover, 500,000 ambulances are diverted annually from the closest hospital as a consequence of such overcrowding.

There clearly is much need for improvement. The Healthcare Triage medical videos highlighted the advantages of retail clinics, which can help to offset the burden that emergency rooms face in addressing acute medical problems during off-hours, particularly those not requiring extensive medical training (e.g., ear infections, urinary tract infections, sports injuries, strep throat). Urgent care centers, while not unlimited in their scope and certainly not addressing severe issues (e.g., heart problems, severe bleeding, etc.), can address a wider range of health conditions not on a 24/7 basis, typically have longer hours than do primary care practices and operate on a walk-in basis

for those unable to get appointments with a primary care physician. While emergency rooms will not turn away patients, they will not necessarily alert patients to the existence of local urgent care clinics that may be both more affordable and more convenient, relieving both the ER and the patient of the burden of longer wait times. (Of course, if there is a likelihood of admission, the ER would be the proper venue in which to seek care).

Enhancing psychiatric treatment options is also going to be an imperative aspect of the policy solution, though it is far from simple. After all, 1 in 8 emergency room visits are related to mental health and substance abuse (with 2 in 5 such individuals rating their emergency room experience as "bad" or "very bad"), though there are only 11.7 psychiatric beds per 100,000 people in the United States (whereas a minimum of 40 to 60 is recommended). This increasing boarding in emergency rooms while waiting for hospital beds can put greater burden on ER resources, leaving doctors and nurses stretched thin with respect to both psychiatric and medical care. And somewhat relatedly, improving services to low-income populations is essential to relieving both emergency room and hospital admission burdens. Anyone who has spent extensive time in emergency rooms is familiar with each hospital having a number of "frequent flyers," whether due to homelessness, mental illness, or drug or alcohol abuse (or some combination among the three) in search of shelter and food. Further, absent clean and safe living conditions, one is more likely to be exposed to pollutants or extreme temperatures that can contribute to respiratory problems, to have malnutrition, to be subjected to crime and related traumas requiring intensive treatment, and to find it more difficult to keep a wound clean and free from infection. Improving interventions in low-income communities and among those in need of affordable mental health care will be essential to delivering essential care while not further contributing to the burdens that American hospitals increasingly are facing.