

Efforts to Reduce Emergency Room Costs: A New PublicHealth Q&A: David Ring, M.D. From: Robert Wood Johnson Foundation

In a recent study, researchers at Massachusetts General Hospital reviewed data on lower-leg injuries from the National Electronic Injury Surveillance System, which monitors injuries in emergency rooms in about 100 hospitals.

Study authors found that most patients with the injuries who had been evaluated in the ER had relatively minor problems that didn't require an ER visit. The researchers suggest in their study that these types of injuries account for a substantial number of emergency department visits, and that the use of telephone triage to schedule appointments, and other alternatives to a traditional ER visit, could result in better use of emergency healthcare resources.

NewPublicHealth spoke with the David Ring, M.D., one of the study authors, about the findings and other efforts to reduce emergency room costs.

NewPublicHealth: Tell us about the idea the study prompted.

Dr. Ring: If a patient sprains their ankle, they have no way of knowing if it's an emergency—it certainly feels like an emergency—and they may have trouble walking on it and probably imagine it's broken and wonder if they need surgery. So they're probably going to want to go to an emergency room. I know I would if I hurt my ankle.

But given that the vast majority of these cases end up being sprains, the alternative is that you can call a nurse or somebody else and talk to someone who knows how to triage these injuries. There are some basic questions a health care professional can ask to help prompt information from the patient. And if there aren't any red flags that come up that would suggest immediate attention, then a timely appointment with either a primary care doctor or a specialist, probably within a day or two, would be arranged, which could put people at ease, knowing they're getting good care. Usually in emergency rooms you wait for hours and hours just to hear that you didn't even need to go to the emergency room in the first place. So I think there's much room for improvement.

NPH: Did your study specifically look at whether money could be saved with such a triage system?

Dr. Ring: No. It's speculative. But we know that since the patient is going to an emergency room, they're definitely going to have an x-ray. Whereas, if you see a specialist, he or she might say—given the factors—that you might not need an x-ray. So there are ways to foresee that it could be much less expensive but this data does not address whether it's actually the case. A specialist would order those tests less frequently and would rely on those less for diagnosis and decision-making. So, the specialist may cost more money to see or maybe will require an extra physician visit—but in the end—that may be substantially less than paying for an MRI. It is something worth studying.

NPH: Have you thought of continuing your study to see if this is really practical in at least a few emergency rooms?

Dr. Ring: Yes. I'm aware of some colleagues in Scotland doing some pilot work on things like common fractures of the arm. So what they're looking at is a pilot program where they make the diagnosis, without the tests if they don't think they're warranted, and they give the patient information with a telephone number. If the patients feel they're not recovering the way they think they should—or they think something needs to be checked again—they can call and make an appointment. But otherwise, if all goes well they don't come in. They're just starting to do this work and so far only 2 out of 30 people have made appointments and they haven't seen any decrement in health outcomes. So I'm sure there are very innovative and creative ways to provide optimal care with fewer burdens to patients and equal peace of mind and lower costs.

NPH: What do you think you will do next as a follow-up to this study?

Dr. Ring: We're going to follow that line of thinking that I just mentioned, with probably more of a focus on the upper extremities, which is my area of expertise. There are a couple of other common fractures that probably don't need routine follow-up. We could look at setting up phone triage for upper extremities—although some of those can be a little more tricky. The idea of having different modes of treatment that are equally safe and effective but use fewer resources is definitely a way that our research will move forward.

NPH: How would you address problem such as language barriers and health literacy from some callers?

Dr. Ring: I think the language barrier could address by translation services. The health literacy problems would require that whoever is on that phone triaging has to not only understood the medical facts—they also have to have excellent communication skills for a variety of people accessing the system.

NPH: Do you think some of the technology that consumers have today, such as an iPhone or a webcam, might be helpful?

Dr. Ring: I think that the technology available today helps a lot. I've had patients call me and say, 'I'm not sure I like the way my incision looks after surgery' and I'll have them take a photo of it and send it to me.

For more information, see <http://bit.ly/nBy7AO>