



## Treatment Instead of the Emergency Department: A Medically Appropriate, Cost-Effective Alternative

Today only 1 in 8 Rhode Islanders with an alcohol or drug addiction are getting the treatment and care they need to successfully fight their disease. The health care, prison, and governmental costs related to the tens of thousands of Rhode Islanders with untreated addiction are growing. Treatment works—expanding access to addiction treatment will produce significant societal and other savings.

Untreated substance use disorders (SUDs) contribute to poor health outcomes and increased use of health care resources, especially hospital emergency departments. When individuals with SUDs get the treatment they need, inpatient, emergency room and total healthcare costs decline by 39 percent, 35 percent and 26 percent, respectively.<sup>1</sup> One out of every 14 hospital stays – an estimated 2.3 million stays a year – is related to a substance use disorder.<sup>2</sup> In addition, more than 1.7 million emergency department (ED) visits a year are associated with drug use.<sup>3</sup>

In the words of Dr. Brian Zink, Chief of Emergency Medicine at Lifespan and The Alpert Medical School of Brown University: “ED providers have been a remarkably adaptable, efficient and a seemingly infinite source for care when patients with acute illness and injury cannot gain access to their ‘regular’ care.” In 2005, there were 382,243 ED visits not resulting in an inpatient stay to Rhode Island’s acute-care general and psychiatric hospitals.<sup>4</sup> However, for a significant percentage of patients with SUDs, the ED is not the most medically appropriate or cost effective placement. The CATG estimates that total SUD related ED costs in Rhode Island are roughly \$30.9 million annually.<sup>5</sup>

The Rhode Island Department of Human Services (DHS) administered Medicaid health insurance program and the Rhode Island Hospital have examined data to better understand who is using the ED and why. The Medicaid program spent \$52 million in FY 2008 on ED expenses alone; additionally, the spending is growing as a percentage of overall expenses for the program. In analyzing the ED data, DHS found that a relatively small percentage of patients were found to be high ED utilizers with at least three or more visits a year. This subset of patients, known as “frequent users”, represent a small proportion of ED users, but account for a high proportion of ED visits. It is important to note, however, that the definition of “frequent user” does not take into account whether an individual’s visits were medically appropriate. These individuals may indeed be sicker and require more medical care than the rest of the population—a frequent user does not necessarily indicate an inappropriate user.

DHS found that 6.8% of the Medicaid population visited an emergency department more than 3 times a year. These 3+ time

users frequent the ED 16 times more than other individuals in the Medicaid system. Furthermore, DHS found that utilization in the Medicaid Program is “notably higher” for Severely and Persistently Mentally Ill (SPMI) and Disabled Adults. In Medicaid, the SPMI population includes adults with severe and intensive psychological problems who often suffer from an SUD as well. DHS also completed an analysis of the 3+ ED users, examining the correlation between substance use and ED utilization. The



analysis revealed a strong correlation between substance use and number of ED visits. Within the SPMI population: among clients with 6-12 visits, **nearly two-thirds** were treated for substance use, and among clients with 13+ visits, **83 percent** filed a claim related to substance use within the past year. Within the adults with disabilities ages 21-64: among clients with 6-12 ED visits, **nearly 50 percent** had a substance use claim; among clients with 13+ visits, **67 percent** filed a substance use claim in the last year.<sup>6</sup> A subset of these disproportionately high utilizers could potentially receive more directed and improved care in an alternative setting to the ED.

Inappropriate visits to the ED are very costly to the provider institutions. The Rhode Island Hospital (RIH), which operates the largest ED in the state, incurred 47% of all ED expenses in the state. In a recent RIH analysis of their ED, 8,597 alcohol-related visits were identified for 2008. Overall, 2,994 visits, or 35% of the total,

## January 2008 Thru December 2008 – Alcohol and Drug Related High RIH ED Utilizers (>12 visits)

Financial Class	Patients	Visits
Medicaid	25	951
Self-Pay	13	527
Medicare	4	146
BS	2	31
Mass Health	2	57
<b>Grand Total</b>	<b>46</b>	<b>1712</b>

were from individuals with five or more visits for alcohol-related complaints. The total charges for these patients were \$3,462,438, or \$1,156 per visit. Of those RIH patients with an alcohol or SUD diagnosis in the past year, 2,290 individuals had no health insurance and gross charges were \$12,193,336. Further analysis of patients with 12 or more ED visits with an SUD revealed that a very small number - 46 patients - were responsible for 1,712 visits in 2008 alone. The costs for these patients with alcohol intoxication resulted in hospital charges of \$2,987,693.

In addition to the direct facility and physician costs, there are other indirect costs of ED utilization. The RIH ED has approximately 100,000 patient visits per year. Despite being a large facility with 76 patient care slots, it can reach maximal capacity in the late afternoon and evening hours, the time when many SUD patients present for care. Patients with acute problems may be required to wait, while patients with SUDs occupy beds. The average length of stay for patients with SUD-related presentations is at least double that of other non-admitted patients, meaning that an SUD patient often occupies a patient care space for most of a day. It is estimated that the time spent caring for patients who present with only alcohol-related complaints reduces the ability of the RIH ED to see an additional 200 to 300 patients per month. Collectively, these data represent a significant cost burden to the hospital in terms of inefficient and/or less than optimal care and unreimbursed expenditures.

The RIH established a “Chronic Inebriate” Taskforce to identify solutions for inappropriate use of the ED and specifically to deal with this relatively small group of largely homeless individuals

who repeatedly cycle through the ED. To the frustration of the ED doctors, few of these individuals, get access to treatment for their SUD. Part of the problem is that Emergency Medical Service (EMS) personnel from the fire department are required by law to bring these individuals to the ED. Even if there was flexibility in the state EMS protocol, there are currently few options for safe placement of these individuals in a facility other than an ED. Without intervention, this insidious and costly cycle will continue without end.

## Policy Recommendations

- 1 Pilot an ED triage approach that will quickly move SUD-only patients to an alternative facility** and produce dramatic savings by shortening time spent in the ED, reducing admissions and improving overall efficiency. Patients who are brought to the ED by EMS, or walk in will be quickly evaluated according to preset guidelines and evaluated for suitability in an alternative setting.
- 2 Establish an alternative facility for review, care and connection to treatment for individuals with chronic SUDs.** Incentivize providers to create alternative units. The newly created Rhode Island Medicaid Behavioral Health Adult Stabilization Unit (ASU) funds, CNOM funding for the uninsured and private insurance could be used to resource these units.
- 3 Initiate a Medicaid review team and address specific medical care, substance use, mental health and housing needs of the highest ED users with an SUD to stop the costly cycling of these individuals.** A comprehensive intervention for this population would yield significant benefits. The Communities of Care model used in the State of Washington may offer solutions, but many of the SPMI Medicaid population are dually eligible for Medicare and cannot be placed in a managed care setting without a Medicare waiver. Moreover, any proposed model adopted by Medicaid will have to be sufficiently financed to support the more comprehensive case management needed to effectively address the needs of the patient.



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<sup>1</sup> Parthasarathy, S. et al. “Association of Outpatient Alcohol and Drug Treatment with Health Care Utilization and Cost: Revisiting the Offset Hypothesis,” Division of Research, Kaiser Permanente Medical Program, 2001.

<sup>2</sup> Agency for Healthcare Research and Quality (AHRQ), Healthcare Cost & Utilization Project (HCUP), Care of Adults With Mental Health and Substance Abuse Disorders in U.S. Community Hospitals, 2004. <http://www.ahrq.gov/data/hcup/factbk10/>

<sup>3</sup> SAMHSA Drug Abuse Warning Network (DAWN) report – 2006. <http://dawninfo.samhsa.gov/files/ED2006/DAWN2k6ED.htm>

<sup>4</sup> Buechner, Jay and Williams, Karen “Classification of Emergency Department Visits:

How Many are Necessary”. Medicine and Health Rhode Island, December 2006.

<sup>5</sup> \$30.9 million derived by 382,243 RI hospital ED visits that do not result in an admission x the national average of SUD ED visits (.07 x\$1,156) This is a conservative estimate of minimum costs of a non-admitted emergency room visit. Many ED visits cost much more than this.

<sup>6</sup> ED Diversion Project. RI Department of Human Services. Stakeholder Advisory Group. November 5, 2009. Page 16.