

GAPS IN COLORADO HEALTH AND HEALTH CARE DATA:

The need for a statewide Colorado Emergency Department Database

Emergency care is the only federally guaranteed right to health care for all U.S. and non-U.S. citizens, regardless of their ability to pay.¹ Across the country, visits to emergency departments (ED) are increasing. Nationally, 50 percent of all emergency departments are at or over capacity.² A large urban Denver hospital recently reported it cannot accommodate much more emergency department traffic.³ In Colorado, there are over 1.4 million emergency department visits each year⁴ (see Graph 1). With four Denver Metro Area hospitals moving to the suburbs in the next several years, a major gap in emergency department coverage may occur in the state's most populous metropolitan core.

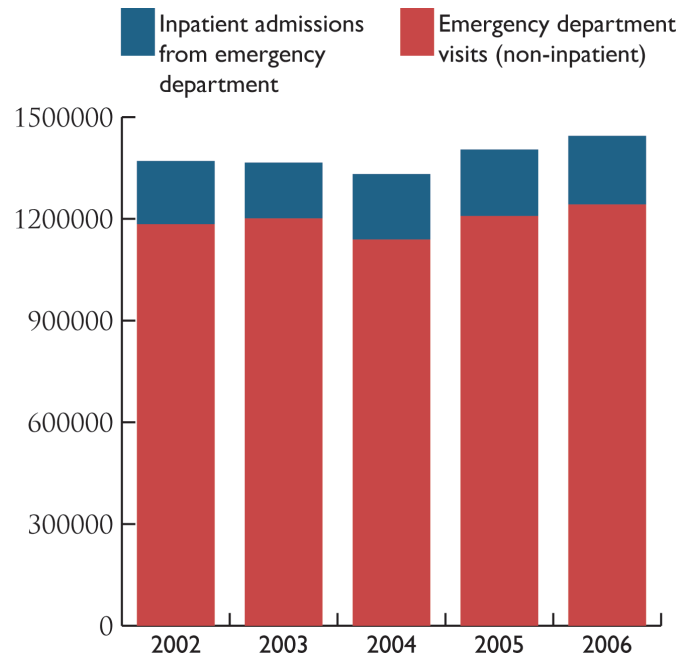
A recent study cited three reasons contributing to the rise in the number of emergency department visits: the aging of the baby boomers, a growing number of uninsured and underinsured individuals and the overall lack of access to primary care physicians.⁵ Studies in other states have shown 40 percent or more of ED visits are for primary care-related conditions that can be seen in a physician's office for less money.⁶ The average minimum charge for a hospital emergency department visit in the Denver Metro Area is \$519,⁷ a significantly greater amount than the \$100 charged for a physician's office visit.⁸

In spite of these trends, Colorado does not have a statewide, centralized emergency department database from which analyses can be conducted to inform health policy options at the state and local levels, particularly with regard to access to basic primary health care services.

Benefits

Significant benefits could be derived from establishing a statewide hospital ED database. For example, Colorado policymakers would have a more comprehensive understanding of health threats to the state's population through the enhancement of existing public health monitoring and surveillance systems. These systems include incidence registries such as intentional and unintentional injuries,

Graph 1. Colorado emergency department visits



Source: Colorado Hospital Association DATABANK Program

traumatic brain injury, oral health disease, diabetes, heart attack, stroke and sexual assault.

Hospital emergency departments are often the first to document disaster-related incidents or disease outbreaks. A statewide ED database would improve emergency preparedness by tracking incidents of bioterrorism or other public health threats such as influenza or SARS.

The statewide trauma system would benefit from an ED database by documenting the levels of care provided to injured individuals as they move from ambulance to emergency department to inpatient care or discharge.

Additionally, a statewide ED database would allow for the monitoring of individuals experiencing health care access vulnerability⁹ to better understand where they currently

receive or do not receive care and the symptoms they present to an ED for treatment. Because emergency departments are not designed to provide patient education, manage chronic health conditions or otherwise serve as a source of continuous care (components of quality primary care), the use of EDs as default primary care providers is inefficient and a potentially harmful solution to a lack of primary care resources in a community.¹⁰

Hospitals and physicians also would benefit from an ED database, particularly in light of current health care reform efforts at the state and national levels. Such a database would provide health care professionals with a better understanding of how emergency departments are functioning as default primary care providers. It also would document the extent to which EDs serve “frequent flyers” and the associated costs of providing care to these patients.¹¹

Finally, providers, payers and policymakers would have a more complete understanding of the aggregate costs of non-emergency ED visits compared to physician office visits. With this analysis, public and private policy options to reduce costs and improve quality of care will be better informed and evidence-based.

Establishing a Colorado Emergency Department Database

Expanding on the current voluntary Colorado Hospital Association administrative claims database processing structure, preliminary estimates for implementing an Emergency Department Database during the initial 12- to 15-month development and implementation period have been estimated at \$500,000.¹²

The steps involved in developing a Colorado ED Database include:

1. Establishing a statewide ED Database Task Force
2. Developing a statewide vision and ED database development plan
3. Identifying funding source(s) for start-up costs
4. Reviewing national content and data reporting standards
5. Assessing how other states have implemented statewide ED databases
6. Communicating and establishing trust among all Colorado stakeholders

7. Defining standards for completeness and timeliness of ED data reporting
8. Developing a communication plan for stakeholders reporting ED data
9. Pilot testing a statewide ED data reporting system
10. Implementing a statewide ED data reporting system to include all Colorado hospitals.

Emergency departments are both the mirrors that reflect the adequacy of Colorado’s health care system and a window into the adequacy of individual communities’ health care resources. A statewide ED database will provide much needed information to inform policymakers and planners and have the potential to positively affect the health of vulnerable Coloradans that lack access to basic primary health, mental health and dental care services.

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Endnotes

¹ The Emergency Medical Treatment and Active Labor Act (EMTALA). <http://www.cms.hhs.gov/EMTALA/> Accessed from the Web, April 25, 2007.

² American Hospital Association. Reported in *Modern Healthcare* “By the Numbers,” December 18, 2006.

³ “City hospitals trying to avoid emergency rush,” *Denver Post*, February 23, 2007. http://www.uccs.edu/~ur/2006/view_article_mediawatch.php?y=mediawatch_articles&article_id=19150

⁴ Colorado Hospital Association. DATABANK Program for 2002-06.

⁵ Institute of Medicine. “Hospital-Based Emergency Care: At the Breaking Point,” June 2006.

⁶ *Primary Care Sensitive Emergency Department Visits in Utah, 2001*. http://health.utah.gov/hda/Reports/Primary_Care_ERvisits_Utah2001.pdf;

Non-Emergent and Preventable ED Visits, Analysis in Brief, Massachusetts Division of Health Care Finance and Policy, Number 11, February 2007. http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/analysisbrief/aib_11.doc

⁷ Amount based on Level 3 HCPCS code 99283, 2004 MEDPAR Outpatient Charge Data, compiled by PricewaterhouseCoopers Health Research Institute, *Modern Healthcare* supplement, 2006. <http://www.pwc.com/us/eng/about/ind/healthcare/pubbrotherskeeper.html>. A 99283 code is defined as an emergency department visit for the evaluation and management of a patient, which requires these three key components: an expanded problem-focused history, an expanded problem-focused examination and medical decisionmaking of moderate complexity.

⁸ Amount based on an average expense nationally for an office visit with a primary provider. From *Expenses for Office-Based Physician Visits by Specialty, 2004*, March 2007 AHRQ Statistical Brief 166. http://www.meps.ahrq.gov/mepsweb/data_files/publications/st166/stat166.pdf

⁹ CHI has defined “health care access vulnerability” as individuals with incomes below 300 percent of the federal poverty level (FPL)—nearly \$62,000 for a family of four in 2007—who lack access to primary health, dental and mental health care by virtue of their low-income status coupled with other risk factors. These factors include lack of insurance, enrolled in a publicly financed health insurance program or high-deductible health plan, geographic isolation, no regular source of primary care and cultural, language or other social barriers. *Colorado’s Health Care Safety Net*, May 2007. http://www.coloradohealthinstitute.org/documents/sn/safetynet_primer.pdf

¹⁰ *Non-Emergent and Preventable ED Visits*.

¹¹ “Frequent flyers” are repeat users of hospital emergency departments for non-urgent care.

¹² Colorado Hospital Association (CHA) start-up planning and implementation budget estimate, March 27, 2007. CHA would accept responsibility for the ongoing maintenance of the ED data reporting system.

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The Colorado Health Institute (CHI) is an independent, nonprofit health policy and research organization based in Denver. It was established in 2002 by Caring for Colorado Foundation, The Colorado Trust and Rose Community Foundation. CHI's mission is to advance the overall health of the people of Colorado by serving as an independent and impartial source of reliable and relevant data for informed decisionmaking.

