Defining Frequent Use: The Numbers No Longer Count

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Just about every other business but ours welcomes frequent patrons. Rack up more airline miles and you get a better seat; buy 10 lattes, the next one is free. But in the emergency department (ED), frequent translates to “too frequent.” Frequent users of EDs—in the opinion of the public and many in the health care profession—are responsible for the increase in ED visits and abuse of health care dollars; they are likely homeless, mentally ill, substance users, and (in the United States) uninsured; they are too impatient or too lazy to make an appointment with their primary physicians (if they have them); and their problems don’t require an ED. These myths persist despite several previous large population-based studies showing that the factors prompting frequent use exist along a continuum, and either a mathematical or descriptive definition of a frequent user is an oversimplification. Patients with higher numbers of visits are more likely to have certain characteristics, but it would be inaccurate and unfair to say that after a certain number of visits, the aforementioned stereotypes of the frequent user necessarily apply. We must also be careful not to place value judgments on these different tiers of use because of their statistical association with less “desirable” characteristics. It would be ludicrous to say that 6 visits a year to an ED are acceptable but 7 are not.

Frequent use is only “too frequent” if the patient could have been better served in another setting or with another approach. Instead of trying to figure out how many visits are too many, we should be examining the reasons for the visits and whether patients are receiving what they need. Doupe et al have also done a great service in clarifying this point. Setting aside the exact cutoffs of frequent and highly frequent use, Doupe et al have demonstrated that policies need to be aimed at the causes. Interventions for patients whose frequent use is due to their chronic illness will likely involve improved access to primary care and more intense monitoring of chronic conditions, whereas those whose visits are more likely related to poverty, substance abuse, and mental illness will need intense social interventions. However, because only a small percentage of patients with frequent use continue that pattern after a few years, identifying those who will benefit most from these interventions is essential.

Most important, what the study illustrates is how integral the ED has become to routine health care delivery. Four visits is not really “frequent” anymore; it’s to be expected if you have a chronic illness. On my last 2 shifts, I cared for a lupus patient receiving warfarin presenting with a subarachnoid hemorrhage, a patient 1 week after from his kidney transplant, 2 unfortunate young men with cancer undergoing chemotherapy and radiation, and several elderly patients with pneumonia. All had physicians; all had insurance. Why were they there? It was after hours, it was a holiday, the on-call physicians had referred them, it was too complicated to handle in a primary care setting. Any or all of these reasons applied. Although we have expanded the technical abilities of medical care, how we deliver that care and how we handle the predictable complications have not kept pace. In the current system, an ED visit makes perfect sense for these patients: we are already there, we are capable, and we are
equipped. There is nothing wrong with using the ED for these kinds of problems; we need to stop thinking that there is. As Doupe et al⁵ have illustrated, we should be paying attention to the individuals with frequent use not because they are wasting health care resources but because they need the help.

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