Out of the ER: Finding the 'right' setting for elderly patients

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Emergency departments are health care's "canary in the coal mine." Today, the canary is telling us that the health care system is already reeling from the growing needs of older Canadians with chronic diseases like congestive heart disease, asthma and diabetes.

In Ontario, emergency visits by people under the age of 55 have not changed much over the past decade, averaging about three million a year. But people 55 and over are another story. Their visits have increased to 1.4 million per year in 2004-05 from 800,000 in the mid-90s.

The needs of older patients are more complex, so they require more staff time. They are also more likely to require a hospital bed. When beds are not available, they occupy space in emergency and still need staff attention. The crowding therefore affects waiting times for all patients.

For years now, the provinces have made health care their spending priority with negative repercussions for the quality of infrastructure and public services such as education. At the same time, demographers and health planners have been warning that the health care system has to get ready for an influx of elderly patients. Now the pressure on emergency departments has provided the wakeup call - greatly intensifying the need to strengthen community management of chronic disease.

"Emergency department overcrowding is a product of system-wide problems regarding patient access to "the right care at the right time in the right setting," according to the 2006 report on "Improving Access to Emergency Care: Addressing System Issues." It was prepared by a committee chaired by Dr. Robert Bell, president and CEO of the University Health Network in Toronto. The prescription is now being implemented in ways that could transform health service in Ontario.

First, getting the right care at the right time in the right setting requires better information. Ontario is building a standardized information system for emergency departments that should go public later this year. For the first time, health planners will be able to hone in on the bottlenecks in the system and identify best practices.

But the Bell report's main prescription is co-ordination and integration of care between hospital and alternative care settings. That requires root and branch change in the way care is organized. Such deep-rooted change can only happen when there is a commitment from governments, health administrators and the professionals who deliver the care.

Experience in the U.S. shows that integrated care for patients with chronic diseases like congestive heart disease or diabetes can make a huge difference - their emergency visits can drop by 50 to 70 per cent.

Dr. Richard Lewanczuk has seen these effects up close. He heads the Regional Diabetes Centre at Edmonton's Capital Health Authority, which co-ordinates services for all diabetics in the region. Emergency visits by diabetics in Capital Health Region are the lowest in the province. "If we do our job in co-ordinating care, there will be fewer visits to emergency."

And, he explains, "if there is an emergency visit, we can also speed up the outflow from emergency because our care team will provide the follow-up care." That means fewer hours in the emergency department, freeing up staff to care for other patients.

Integrated care teams have already proven their worth in Canada because they have contributed to the success in reducing wait times for the five priority areas established by governments in 2003 -

cataract surgery, hip and knee replacement, cancer care and diagnostic imaging. The goal is to co-ordinate care for each patient through the full continuum of treatment from diagnosis to recovery, or, for some, the end of life.

The challenge is to get doctors from different specializations to work collaboratively with each other and with other health providers - pharmacists, nurses, dieticians, psychologists, social workers, home care co-ordinators and so on.

The problem is that every health region has to build its own system for co-ordinating care for each disease. While progress is hard to assess because it is so fragmented, there are success stories in every province. In most cases, both the patient quality of care and the quality of working life for health professionals have improved.

The success of the Regional Diabetes Centre in Edmonton demonstrates the potential payoffs, but does nothing to alter diabetes care in other regions because health institutions are not set up to learn about or replicate good practices from other places. The result is that health providers in each region or community have to build their own in response to local needs and resources.

In times past, overcrowding in emergency departments because of a shortage of hospital and long-term care beds could have led to a building spree to construct hospital and long-term care facilities, creating yet another claim for scarce public funds. To its credit, the Bell committee put its focus on preventing emergency visits by building a system designed to meet the needs of the elderly.

If patients receive the right care at the right time in the right setting, you can bet that, in most cases, the right setting will not be the emergency department.

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