CJEM *Debate Series*

CJEM Debate Series: #EDRedirection – Sending low-acuity patients away from the emergency department – An imperative for appropriateness and integration

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INTRODUCTION

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The redirection of low-acuity patients from the emergency department (ED) to alternative sources of primary care is a controversial and sensitive topic. Given that ED patients who are potentially amenable to care in other settings (e.g., urgent care clinics) deserve our compassion and respect, we believe that **redirection strategies provide better and more patient-centred care, while improving the healthcare system integration and efficiency**. However, those who oppose the notion of redirection will often cite three core arguments that we believe are fundamentally flawed.

Firstly, the overriding issue should not be whether or not ambulatory patients with non-urgent complaints contribute to delays in care and thus adverse outcomes for high-acuity patients.[1] In reality, most urban and semi-urban EDs in Canada manage high- and low-acuity patients in two separate sections of the emergency room, with different staffing models and unique care pathways. As a result, an increased burden of patients in one section will most often have little or no impact on care provided in the other.

Secondly, physicians who oppose redirection, many of whom are in leadership positions, often purport that this focus distracts from the real issue, which is access block and boarding. Boarded patients certainly embody the foremost issue for Canadian EDs, but ambulatory patients, who account for 40–60% of all ED visits in Canada, represent a significant strain on global ED operations and budgets.[1] In 2016–2017, six provinces/territories out of nine (excluding New Brunswick and Newfoundland/Labrador)[2,3] did not reach the Canadian Association of Emergency Physicians (CAEP) four-hour target for the ED length of stay for low-acuity patients (discharged Canadian Triage and Acuity Scale [CTAS] 4 and 5). In Québec, Manitoba, and Saskatchewan during the same year and for the same population, in the 90th percentile, ED lengths of stay were 9.7, 7.4, and 6.3 hours,[2,3] respectively. Moreover, all provinces experience seasonal peaks when demand exceeds capacity and the number of patients leaving prior to physician assessment significantly increases.

Thirdly, opponents will say that those eligible to be redirected and willing to do so are small in number and will not make a difference. This is a function of eligibility and should not be based exclusively on the CTAS or restricted to patients with CTAS 4 and 5. To be safe, useful, and efficient, redirection programs should instead target specific and frequent presenting complaints, highlight precise contraindications, and include selected CTAS 3 patients.

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ADVANCING PATIENT-CENTRED CARE

The most compelling arguments for implementing ED redirection strategies are not related to organizational or system-level issues, but rather to patient perspectives and preferences. Although some evidence suggests that patients prefer the ED for its convenience, a closer look at available data reveals a much more nuanced conclusion. As many as 50 to 88% of low-acuity ED patients initially seek but unsuccessfully access primary care[4] or would prefer a primary care appointment over an ED visit for their nonurgent needs.[5] Moreover, when redirected to alternative settings, ED patients report very high satisfaction rates (> 80%) with their care.[5]

Furthermore, an extensive redirection protocol implemented in Montréal in 2015 has been used to date on more than 52,000 patients from five different hospitals. Research on this protocol showed that eligible patients who accepted to be redirected away from the ED were four times more likely to be satisfied with their care than those choosing to stay in the ED after being offered but declining a 24- to 48-hour appointment at a walk-in clinic.[6] In addition to high levels of satisfaction reported for both patients and providers, other benefits included a remarkably low incidence of adverse events. Less than 6% of all redirected patients returned to the ED within 7 days. No patient was hospitalized or underwent urgent surgery within that time frame. No patient died within 3 months of being redirected.

If convenience is an essential part of an enhanced patient experience, it appears that convenient care can be delivered anywhere as long as it is safe, timely, accessible, and coordinated.[7] Where and when ED demand frequently exceeds capacity, patient-centred redirection strategies should be used, recognizing that prolonged wait times may significantly impact both patients' economic (e.g., lost income) and health status (e.g., anxiety).

HEALTHCARE SYSTEM INTEGRATION

Many patients also present to the ED simply because they are struggling to navigate an optimal path within a bureaucratic system where care providers from different institutions are rarely encouraged to collaborate on a patient's care.[7] **Today's reality is that Canadian urgent care resources (e.g., walk-in clinics, urgent care centres, EDs) are fragmented and disconnected**. For decades, the lack of healthcare integration across Canada has been a difficult issue to tackle, impeding efficient care, despite multiple attempts at reform. In a system based on universal coverage, and with constrained resources, no reasonable arguments could justify such redundancy in service. At a time when care options for low-acuity patients are increasing, well-structured **ED redirection protocols can foster health system integration** and help patients consult in the setting where they will receive the most appropriate care. Urgent care resources must be better integrated and seen as part of a whole coordinated system instead of a collection of independent facilities where stakeholders protect their own corporate interests. As such, system capacity will be more responsive to population needs and peaks of demand.

HEALTHCARE SYSTEM EFFICIENCY

A growing body of literature confirms that **ED care for low-acuity patients is more expensive than the care provided to the same population in walk-in clinics or primary care practices**. Although controversies persist on the magnitude of potential savings, variable costs related to human (e.g., physicians) resources and use of diagnostic tests are systematically higher in the ED.[8] From that vantage point, one can hardly justify an ED-focused strategy for the assessment of benign conditions (e.g., urinary tract infections), while redirection strategies would potentially decrease costs from a public payer perspective and increase efficiency across the whole system.

INGREDIENTS FOR SAFE AND EFFECTIVE REDIRECTION

A recent systematic review revealed that data supporting or refuting ED redirection were scarce or missing.[9] Indeed, only four eligible controlled trials studying the impact of ED-based redirection strategies were found, and, among them, two were from the same research team. However, from these trials and through other observational studies not included in the review, it appears that redirection of patients from the ED to outpatient clinics is safe: the risk of death and hospital admission after deferring medical care is not higher in an appropriately selected population. Based on our own experience with ED redirection and informed by available evidence, we propose some essential ingredients to ensure that ED-based redirection strategies are patient-centred, safe, and successful, including:

1. Standardized and extensive criteria targeting specific presenting complaints must be clearly defined so that triage nurses can readily identify eligible patients.
2. An appointment in an outpatient clinic at a specific time during the following 24 to 48 hours must be easily and promptly provided in the ED for all redirected patients in order to ensure patient safety and avoid waiting in the other care setting.
3. Explicit arrangements, close coordination, and constant communication must be established between the ED and surrounding participating clinics.
4. Proportions of clinic no-shows, ED returns, subsequent hospital admissions, and deaths must be monitored to ensure that a redirection protocol is effective, safe, and appropriately applied.

Despite all of these, **redirection strategies must be integrated into a multidimensional intervention to enhance unscheduled urgent care for ambulatory patients**, including, among other elements, patient education, improved access, and attachment to primary care as well as the creation of care pathways. Patients and providers should be open to new care alternatives involving professionals with augmented responsibilities,[10] such as nurse practitioners, pharmacists,[11] or physiotherapists.[12] The paradigm of the ED (and as a result, the ED physician) being the primary portal of entry to the health system or society's safety net must be reconsidered. Overemphasizing the role of the ED makes the health system ever more medicalized and hospital centric. **We believe that the high performing health systems of the 21st century will preserve ED care for medical and surgical emergencies and provide much more integrated and multidisciplinary health services to all patients with urgent care needs**. ED redirection strategies are just one of the potential interventions that will achieve that goal.

Readers can follow the debate on Twitter and vote for this or the opposing perspective[13] *by going to @CJEMonline or by searching #CJEMDebate or #EDRedirection.*

Competing interests: SB and ESL have no competing interests to declare. AM is the inventor of a redirection solution via a web application and works as a medical consultant for Logibec, the company responsible for its marketing and distribution.

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