



Alternatives to the transfer of long-term care patients to emergency departments: a new kind of house call?

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Published online: 8 November 2023

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Keywords Emergency department avoidance · Long-term care residents · Community integrated care

Long-term care (LTC) residents have unique care needs such that ageing, medical complexity, frailty, polypharmacy and increasing care requirements have all been associated with a higher likelihood of emergency department (ED) transfer for illness or injury [1]. Similarly, advance care planning and advanced directives have been shown to decrease the rate of ED transfers for long-term care residents [1]. Previous research has demonstrated that nursing home residents may not even want transport to the ED, and patients and families, and nursing home staff desired shared decision-making in these cases [2]. However, there are often resource constraints of timely in-house medical assessments, risk intolerance of LTC staff and lack of advanced directives specifically regarding ED transfer. These factors fuel the decisions to activate EMS and transfer LTC residents to the ED when unplanned acute care needs arise [3].

With the impending “silver tsunami” of ageing Canadians, it is anticipated that increasing ED transfers from LTC will significantly impact ED and acute care utilisation. Further, the ever-more chaotic and lengthy ED experience for seniors from LTC has been associated with increasing rates of delirium, decline in mobility, nosocomial infections, and even mortality. This begs the question of whether ED assessment and care outweighs the risks for many LTC residents. Choosing Wisely Canada has emphasised the LTC recommendation “Don’t send the frail resident of a nursing home to the hospital, unless their urgent comfort and medical needs cannot be met in their care home” [4].

Novel models of community outreach care represent an opportunity to address unplanned acute care needs for such patients. The advent of community paramedicine—a community-based integrated healthcare service that provides preventative and responsive care has presented an opportunity to support vulnerable populations such as LTC residents. Community paramedics can assess and initiate diagnostics and therapies, refer to appropriate resources and provide follow-up in models of shared care, potentially avoiding costly ambulance transports to acute care [5].

In this issue of CJEM, Leduc et al. aimed to quantify avoidable ambulance transports to the emergency department (ED) for long-term care (LTC) residents. Their findings suggest that 11.1% of patients transported to the ED by emergency medical services (EMS) from LTC could potentially have been assessed and treated in their long-term care facility using existing local paramedic protocols [6]. This represents potentially avoidable ED visits for an already vulnerable population. Grant et al. have previously reported on avoidable LTC to ED transfers, and found that extended community-based paramedic programmes, amongst other interventions, may reduce ED transfer for LTC residents [7]. There are tangible downstream impacts on ED flow as well as ambulance availability when these visits are viewed with the lens of a potentially avoidable ED visit.

In a recent article exploring the landscape of community paramedic programmes treating LTC patients on-site, Leduc et al. found that ED diversion programmes were highly desired by providers, but lacked consistency in the types, availability and legislation supporting such paramedic-based programmes across Canada [8]. Integrated outreach teams have been explored and implemented in an effort to address this care gap, and ultimately reduce avoidable ED transfers. Further, the COVID pandemic has highlighted the role for telemedicine in assessing and treating community patients,

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a service that has been explored in other studies exploring ED avoidance for LTC patients [9].

Whilst not all ED visits may be avoided, for example in orthopaedic trauma requiring surgical intervention (e.g. hip fractures), or those requiring timely diagnostic and treatment resources, it is possible that bolstered support for community paramedicine programmes may nonetheless contribute to decreasing acute care resources. Hullick et al. detail the impact of community integrated health care in LTC, demonstrating that a collaborative approach to supporting care facility patients and staff facing emergency care needs may decrease ED length of stay, admission rate and hospital length of stay [10]. Each incremental reduction in emergency and acute care length of stay ultimately impacts ED crowding. The precise economic impact of such programmes remains to be demonstrated but would be valuable to ensure cost-effectiveness in local contexts.

What is left to address is how Canadian emergency care providers, including emergency physicians and EMS policymakers can best collaborate with community care facilities in local contexts to provide multifaceted approaches to unplanned care needs. This collaboration will require novel approaches across specialties of family medicine, emergency medicine, geriatric medicine and nursing and EMS organisations to deliver alternate models of episodic care.

Author contributions KC and EL participated in all aspects of editorial.

Declaration

Conflicts of interest The authors declare that they have no conflicts of interest.

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