Wait Times in Newfoundland and Labrador's Emergency Rooms:

Sensible Solutions

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INTRODUCTION

Your child wakes up crying in the middle of night; he seems to have a fever and begins to vomit. As a caring parent you bundle him up and head to nearest emergency room to have him checked out. If you live in Newfoundland and Labrador you could be waiting in excess of 8 hours to have your child seen by a physician. It has been proven that increasing wait times predict increasing mortality for emergency patients[1]. Therefore, people often wonder why the wait times are so lengthy and why we are not working harder to fix this growing epidemic. As newcomers to the medical profession, being first year medical students, we often wonder the same thing - why aren't we working harder to solve these problems?

There have been several instances across North America in which very successful initiatives have been put in place, with terrific reductions in ER wait times. Some of these approaches have been simple, while others have been more elaborate and expensive. Nonetheless, with the availability of multiple *relatively* quick-fix approaches at our fingertips, what possible harm could result from assessing the efficacy of these suggestions? Through the examination of various studies and reports across Canada and the United States, I have identified a myriad of plausible solutions that can be implemented universally to reduce ER wait times in our province.

CHANGING TRIAGE PRACTICES

There is a growing presence of literature supporting the use of triage staff to expedite the flow of patients into the emergency department. For instance, a report by

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[1] Plunkett, P., Byrne, D., Breslin, T., Bennett, K., and Silke, B. (2011). Increasing wait times predict increasing mortality for emergency medical admissions. *European Journal of Emergency Medicine.* E-pub ahead of print.

Ambulatory Care Quarterly (2010) discussed a strategy that resulted in a drastic reduction of wait times in their hospital – allowing triage nurses to order simple investigations (e.g. x-rays, blood work, urine analyses, etc) decreased the waiting time for patients in the ED[2]. Presumably this reduction is due to the fact that patients often have these investigations ordered after they are brought into the clinical area of the ED.

Moreover, a study by Chan et al. (2005)[3] examined, among other things, average wait times in a troubled New Jersey emergency department before and after implementation of a Rapid Entry and Accelerated Care at Triage (REACT) initiative. Their study included 37,000 individuals assessing the pre- and post-REACT (6-12 months after implementation) waiting times in the ED. Results of the study showed an astounding reduction of almost 74% in ER waiting times due to accelerated and expanded care at triage. Additionally, the study showed significant reductions in both total length of stay in the ED, as well as in the frequency of patients that leave the ED without being seen. The latter reduction is especially important due to the fact that the proportion of patients that leave without being seen in St. John's emergency departments is extremely high at 10-11%[4].

Putting the REACT initiative, or similar project, into practice would allow the examining physician to have ready access to lab data and study results, which could likely accelerate their diagnosis, treatment, and discharge of less-complex patients. This would, undoubtedly, involve modification of the nursing regulations and training to allow

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[2] No author. (2010). ED decreases 4-hour wait times to 9 minutes. *Ambulatory Care Quarterly (Hospital Case Management)*.
[3] Chan, T., Killeen, J., Kelly, D, and Guss, D. (2005). Impact of rapid entry and accelerated care at triage on reducing emergency department patient wait times, lengths of stay, and rate of left without being seen. *Annals of Emergency Medicine. 46*(6), 491-7.
[4] Accreditation Report – Accreditation Canada (2010).

them this privilege. However, the benefits from this relatively simple change could ameliorate some of the issues that our patients in the emergency departments of our province endure every day.

USE OF NURSE PRACTITIONERS

The hiring of nurse practitioners in the ED has become more commonplace in recent years, however I feel this practice is still under-utilized in our province. The increased usage of nurse practitioners in busy emergency departments has been an area of intense study in the past decade. One such review published by the Canadian Journal of Emergency Medicine in 2007[5] demonstrated that nurse practitioners utilized in low-acuity, fast-track areas of emergency rooms can significantly reduce wait times experienced by our patients. Considering the greatly shorter time frame required for the training of nurse practitioners, as compared to physicians, this could prove to be a worthwhile investment of our health care system.

One concern often expressed by those in the medical profession is the level of quality care provided by nurse practitioners. Are our patients receiving adequate emergency care if it is provided by nurse practitioners? The same study discussed above examined a multitude of research and concluded that nurse practitioners provide quality care, equivalent to a mid-grade resident. We entrust residents with caring for our patients on an extremely frequent basis, under the supervision of an attending physician. Why then are we so far behind on expanding something that has proven so beneficial in the past?

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[5] Carter, A., and Chochinov, A. (2007). A systematic review of the impact of nurse practitioners on cost, quality of care, satisfaction, and wait times in the emergency department. *Canadian Journal of Emergency Medicine.* 9*(4),* 286-95.

PAYMENT METHOD FOR ER PHYSICIANS

An area of less-dedicated study has been the payment methods for physicians employed in the ED. Traditionally, many physicians in the ER were paid on a fee-for-service (FFP) basis. However, a shift during the past two decades have resulted in emergency room physicians (ERPs) being paid based on an alternate funding arrangement (AFA) whereby physicians are paid an hourly wage for their work[6]. While this payment arrangement equalizes pay between physicians performing the same work, it does not encourage ERPs to function efficiently in order to decrease wait times. The current system functions on the presumption that all ERPs will work in an effective and efficient manner in the treatment of patients in the ED. However, an article published by the American College of Emergency Physicians (ACEP)[7] suggests the possibility that productivity incentives such as ERPs being paid for volume and complexity of care may improve flow and decrease wait times in our emergency departments. Encouraging productivity by usage of financial incentives for ERPs working in high-volume, bottlenecked ERs may prove to be a worthwhile area for further investigation and possible implementation.

AVAILABILITY OF PRIMARY CARE PHYSICIANS

It is a well-known fact that our province is experiencing widespread shortage of family practitioners in both urban and rural areas. Thus, many of the low-acuity patients present in the ED because they either do not have a family physician or the physician's

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[6] Drummond, A., and Drummond, R. (2000). The Alternative Funding Agreement for emergency services in Ontario: a new compensation method for rural emergency departments. *Canadian Journal of Emergency Medicine.* 2*(4)*, 232-6.

[7] Proctor, J. (2011). Gauging emergency physician productivity: Are RVUs the answer? *American College of Emergency Physicians.*

office is closed during evening hours[8]. A sensible solution, therefore, would seem to be the encouragement of family physicians to open and staff 24-hour walk-in clinics. As mentioned previously many of the cases presented to the ED are generally non-emergent. Thus, the establishment of an alternate place to obtain medical care in the evening and on the weekend would almost certainly alleviate many of the burdens placed on the EDs, especially in the more urban regions of the province. Although this sounds like a simple change, there has to be an incentive for general practitioners to set up such clinics. Providing financial subsidies such as covering office administrative costs and other benefits such as hourly/per volume bonuses could possibly attract GPs to fill this role. Alternatively, these clinics could be set up under the regulation and funding of the Regional Health Authorities (RHAs) and operated much like a health care centre, staffed by GPs and nurses.

A related issue regarding the availability of family physicians is the awareness of current vacancies within existing family practices in all regions of the province. Although the College of Physicians and Surgeons of Newfoundland and Labrador (CPSNL) has posted a list of family physicians accepting new patients[9], a step in the right direction, the presence of this list is not actively publicized and many average citizens would not think to visit their website or call the CPSNL for this information. Thus, I feel that actively advertizing these vacancies in popular and frequently visited venues could alleviate some strain placed on our EDs for non-emergent visits. Placement of these lists in frequently visited locations such as the grocery store or bank may result in an increased awareness

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[8] The Commonwealth Fund 2010 Commonwealth Fund international health policy survey. New York, NY: The Commonwealth Fund; 2010.
[9] The College of Physicians and Surgeons of Newfoundland and Labrador: http://www.cpsnl.ca/default.asp?com=DoctorSearch&adv=2

of this excellent resource. This is a very simple and cost-effective method of ensuring as many of our citizens have consistent medical care, thereby reducing the number of ER visits.

EXPANDING EMERGENCY DEPARTMENT SIZE AND STAFF

Overcrowding and lack of space is a common problem affecting the EDs Canada, and our province is no exception. Recently, EDs in St. John's have adopted the use of an over capacity protocol (OCP), which reflects our inability to keep up with the medical demands of our population. It is important to note that our inability to meet these needs is not at all reflective of the competency of our ED staff – rather, it is an indication of a lack of space and personnel to accommodate our sick.

One seemingly simple solution to many of the issues discussed in this paper is the expansion of the size of our ED clinical assessment areas and increasing the number of physicians and nurses that work there. While the logic of this solution is crystal clear the finances of such a solution are muddled by politics and bureaucracy.

CONCLUSION

Access to emergency care in a timely manner is one of many issues that plague our health care system. While many of the options discussed above are simple in nature, implementation into 'real world' practice may prove to be excessively difficult. However, the problem of wait times for emergency care in our province is not an issue that can be ignored – it needs to be dealt with effectively and urgently as to avoid any further deterioration in the care we provide to our population. Also, it must be recognized that these solutions have the potential to be costly. Nevertheless, investment in the primary care of our citizens will inevitably have benefits and result in reduced costs of chronic

care in later life. In short, some hard decisions need to be made and decisive action needs to occur in the *very* near term to avert a crisis. It is up to us, the guardians of our citizens' health, to do whatever is necessary to protect one of our nation's most fundamental beliefs – the provision of *accessible* care.