

**Taking Action on the Issue of
Overcrowding in Canada's Emergency Departments**

The Canadian Association of Emergency Physicians

June 16, 2005

Situation Analysis

In 2004, Canada's First Ministers concluded *A Ten-Year Plan to Strengthen Health Care*, stating that improving access to care and reducing wait times are of national concern and a clear priority. Canada's physicians and provincial governments have taken some important first steps to reducing wait times starting with five priority areas including cardiac care, cancer care, diagnostic imaging, sight restoration and joint replacement.

The Wait Times Alliance, made up of six specialty groups, was formed to assist federal-provincial-territorial ministers of health in identifying evidence-based benchmarks for medically acceptable wait times for the five priority areas and to provide advice on the implementation of wait time reduction strategies.

Through the Canada Health Transfer, the federal government has committed \$4.5 billion over the next six years to a Wait Times Reduction Fund. Provinces and territories will determine where those dollars are allocated based on jurisdictional priorities within the framework of the Health Accord. In the 2005 budget, the federal government announced an additional \$15 million for wait time initiatives.

Work on the Wait Time Reduction Strategy is underway in each of the provinces. The Health Accord committed the federal and provincial governments to develop evidence-based benchmarks for medically acceptable wait times in five specific areas by December 2005. Multi-year plans to achieve these targets are to be in place by March 2007.

What's Missing from the Wait Time Strategy: The Need to Address the Crisis in Canada's Emergency Departments

Wait time in Canada's Emergency Departments is an issue of great importance to Canadians. Seventy-four percent (74%) of Canadians have indicated that they are concerned about prolonged Emergency Department (ED) waits and deteriorating service. Prolonged wait time is a national epidemic in Canada and a continuing issue in other countries around the world, including the United States. The principal cause of prolonged wait times is Emergency Department overcrowding.

ED overcrowding is the most serious issue facing Canada's Emergency Departments and is a very serious patient health issue. Overcrowding results in increased patient suffering, prolonged wait time, deteriorating levels of service, and on occasion, a worsened medical condition or even loss of life. Unless action is taken to effectively deal with this need, patient health will continue to be compromised and preventable patient deaths may continue.

In addition, Emergency Departments continue to be a major access point to the health care system and as such, have become a highly visible indicator of the state of Canadian health care generally.

With 10 million visits made to Canadian Emergency Departments every year, Canadians' opinions about wait times are determined very substantially by their Emergency Department experiences.

Emergency Department Overcrowding – Front Line Crisis

Overcrowding is defined as a situation in which the demand for emergency services exceeds the ability of an Emergency Department to provide quality care within medically acceptable time frames.

The principal cause of overcrowding is the lack of beds on hospital wards and in Intensive Care Units. With the shortage of hospital beds, overflow patients are often “warehoused” in Emergency Departments, creating a situation where the sickest patients are “blocked” from accessing timely care. Acute care bed capacity is also significantly affected by patients who require an “alternate level of care” (ALC), patients who could be served at home, shortages in home care resources as well as a lack of chronic and palliative care beds. These patients account for up to 20% of acute care hospital beds and act as “bed blockers”, thereby contributing to the problem of ED overcrowding by preventing the admission of emergency patients to hospital beds. On average, one patient “warehoused” in the Emergency Department denies access to four patients per hour to the Emergency Department, directly contributing to prolonged wait times and patient suffering.

Over the past decade, Canada has seen a forty percent (40%) decrease in overall hospital bed capacity due to government funding cuts. Hospital and bed closures, coupled with an aging and increasingly complex patient population have created an overcrowding crisis in Emergency Departments across the country.

British studies have shown that ED overcrowding rarely occurs when bed occupancy rates approach eighty-five percent (85%), but consistently occurs when occupancy is greater than ninety percent (90%). Most hospitals in Canada currently operate on ninety-five percent (95%) bed occupancy rates. The Canadian Association of Emergency Physicians (CAEP) believes that if bed capacity could be restored and there was a focus on matching the level of care to the level of patient need and on moving the ‘right patient’ to the ‘right bed.’, then the issue of long wait times and overcrowding could be largely resolved.

Medically Acceptable Wait Times in Canadian Emergency Departments

Medically acceptable wait times in Canadian Emergency Departments have already been identified and are defined by the Canadian Triage and Acuity Scale (CTAS).

The scale was developed by CAEP in 1998. The objectives of CTAS were to more accurately define patients’ needs for timely care and to allow Emergency Departments to evaluate their acuity level, resource needs and performance against certain operating objectives.

Patients are assigned a triage level on initial registration in the Emergency Department based on the perceived urgency of their presenting complaint. Patients are assigned to one of five categories according to level of urgency and, with each level, comes an expected fractile response time indicating maximum waiting time for the type of complaint.

CTAS is currently used in approximately eighty percent (80%) of Canadian Emergency Departments.

The five CTAS triage levels are as follows:

CTAS Level	Level of Illness/Acuity	Nursing Response Time	Physician Response Time	Sentinel Diagnosis	Fractile Response	Admission Rate
Level 1	Resuscitation	Immediate	Immediate	Cardiac Arrest	98%	70-90%
Level 2	Emergent	Immediate	<15 minutes	Chest Pain	95%	40-70%
Level 3	Urgent	<30 minutes	<30 minutes	Moderate Asthma	90%	20-40%
Level 4	Less Urgent	<60 minutes	<60 minutes	Minor Trauma	85%	10-20%
Level 5	Non Urgent	<120 minutes	<120 minutes	Common Cold	80%	0-10%

Notes:

- In recognition of wide variations in demand for care and that ideals cannot always be achieved without unlimited resources, each triage level is given a fractile response objective. A fractile response is the proportion of patient visits for a given triage level where the patients were seen within the CTAS time frame defined for that level. Fractile response does not deal with whether the absolute delay for an individual is reasonable or acceptable.
- This would mean that even though a Level 2 patient should be seen within 15 minutes, it might only occur 95% of the time. Although Level 5 patients have been given a time response objective of 2 hours, the fractile of 80% means that patients may have to wait over 6 hours on occasion. Patient assessment errors may occur when waiting times are beyond the recommended response times.
- The physician response time for CTAS Levels 1 and 2 are based on scientific evidence. The physician response times for all other levels are based on physician expert opinion and consensus and assumes ideal operational conditions.
- The CTAS defined response times are, at present, guidelines only. There remain no articulated, enforced, minimum guidelines for operational performance for Canadian Emergency Departments.

Not Addressing the Issue of ED Wait Times and Overcrowding – What’s at Stake?

Until the issue of wait times and overcrowding on the front line within Canadian Emergency Departments is addressed, CAEP believes that Canadians will continue to doubt the safety and accessibility of their health care system.

No matter what progress is being made in other areas with respect to wait time, if we can't improve the front line experience of patients, then we run the risk of looking as though wait times are not being addressed. The prevalence of media reports about diverted ambulances, long waits and regrettably, a worsened medical condition or even loss of life will continue to erode confidence in our health care system.

CAEP believes that success in relieving ED overcrowding will help build positive momentum for other key health care reforms and demonstrate meaningful reform to improve patient care.

Diversion of Patients is Not the Main Issue

One of the most common myths about overcrowding is the notion that it is caused by people who opt for a visit to the emergency ward when they could be cared for elsewhere. This is simply not the case. The reality is that Emergency Departments can handle these cases efficiently and at little, if any, incremental cost. Given the relatively fixed costs of the ED operation (facility, staffing, 24-hour access), non-urgent patients do not cost the system more money.

The reason that “non-urgent” patients are not relevant to the overcrowding problem is because they do not occupy acute care stretchers, they require little or no nursing care, and they typically have brief treatment times. In its report on primary care renewal, the Canadian Medical Association stated unequivocally that public health initiatives aimed at diverting non-urgent patients from the ED would not have an impact on the overcrowding issue. Similarly, the American College of Emergency Physicians’ study on overcrowding found that while there were more people in the waiting room area, non-urgent use of the ED had no effect on the treatment areas.

Emergency Departments also provide those in need with important access to care. By moving these patients to other primary care facilities, extra costs will be incurred.

Solutions and Critical Success Factors

CAEP believes that the CTAS scale already serves as THE standard for medically acceptable wait times in Canadian Emergency Departments. CAEP strongly recommends that the scale be adopted by federal and provincial governments and incorporated into the National Wait Time Strategy.

Not all hospitals have incorporated CTAS into emergency care management. As a first step to implementation, each jurisdiction must ensure that the CTAS scale is used in every hospital. In many hospitals, there is no common computerized system for recording Emergency Department operations. CAEP recommends that each jurisdiction ensure that systems are put in place to record wait time against the CTAS scale.

CAEP also recommends that each jurisdiction establish working groups to investigate and address challenges in meeting the CTAS standard for all Emergency Department visits. This will include determining the number of additional acute care beds required in each hospital and outside the hospital in the community, human resource issues, minimum operational standards for Emergency Departments and other factors.

Benchmarks and Indicators

In the majority of Emergency Departments in Canada, there are already indicators and benchmarks in place to monitor Emergency Department activity. The data base has been developed by the National CTAS Working Group and the Canadian Emergency Department Working Group (CEDIS). The standards have been set and the collection of the data can be undertaken. Time to triage, time to nurse, time to physician, time to admission and time to transfer to floor are all indicators of overcrowding. This data is easily retrievable and can be used as benchmarks when implementing changes needed to relieve Emergency Department overcrowding.

About CAEP

The Canadian Association of Emergency Physicians (CAEP) is a national advocacy and professional development organization representing 1,800 of Canada's emergency physicians. CAEP's mission is to provide leadership in emergency health care with a goal to enhance the health and safety of all Canadians.

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