

E-BOOK



REDIRECTION IN THE EMERGENCY DEPARTMENT IN FRANCE

A hope for better patient care

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The background

The problems related to the overcrowding of emergency rooms are not new in Quebec nor are they new everywhere else in the world. One of the avenues health organizations are pursuing to address this is to collaborate with the frontline to treat patients who do not have an urgent medical condition. In 2018, LGI Healthcare Solutions¹ looked at this harsh reality in Quebec. It was also at this time that the research centre of the Montreal Sacred Heart Hospital licensed its redirection software to LGI Healthcare Solutions. Since then, the various LGI Healthcare Solutions teams assigned to the development and management of the solution have been working to improve and distribute LGI Emergency Redirection throughout Quebec and Europe. To date, more than 200,00 patients have been redirected with LGI Emergency Redirection in Quebec and France. The work with the Montreal Sacred Heart Hospital research centre continues in the areas of emergency room overcrowding and access to care. This is in addition to collaborative approaches between LGI Healthcare Solutions and key institutions in France.

Redirection in the emergency department in France

In France, emergency departments (ED) receive more than 20 million visits per year. According to the Cour des Comptes and its 2019 Annual Public Report, this number is increasing by about 4% per year. This increase would be mainly due to visits that do not require hospitalization and that can, in large part, be managed in another context, such as unscheduled care in a medical clinic.² The quality of care offered in emergency departments is currently benefiting from increased political, administrative and public awareness. In addition, multiple initiatives are underway to provide better access to alternatives.^{3,4,5}

1. Formerly known as Logibec

2. France – Rapport public annuel 2019 – Cour des comptes – chapitre 6. Les urgences hospitalières : des services toujours trop sollicités <https://www.ccomptes.fr/fr/publications/le-rapport-public-annuel-2019>

3. Ma Santé 2022 – <https://solidarites-sante.gouv.fr/systeme-de-sante-et-medico-social/masante2022/article/mieux-orienter-les-patients-selon-leurs-besoins>

4. Pacte de refondation des urgences – Septembre 2019 – <https://solidarites-sante.gouv.fr/actualites/presse/communiques-de-presse/article/pacte-de-refondation-des-urgences-20-decembre-2019>

5. INSTRUCTION N° DGOS/R2/2020/129 du 24 juillet 2020 relative aux attendus pour la désignation de projets pilotes expérimentateurs du service d'accès aux soins (SAS) – https://www.samu-urgences-de-france.fr/medias/files/Instruction_projets_pilotes_expe%CC%81rimentateurs_SAS.pdf

In 2016, 80% of emergency departments had a reception and triage function for patients upon entry.⁶ This function is typically performed by an intake and referral nurse (IRN) who may be involved in a redirection of some patients. Redirecting non-urgent visits to medical clinics will not, on its own, solve all the issues of ED overcrowding, but it could certainly be part of the solution. It is important to remember that overcrowding has direct effects on the quality of care, resulting in longer wait times, delays in treatment, and patient dissatisfaction. In addition, several studies have shown

that beyond a certain threshold, emergency department congestion has direct effects on patient health, even increasing the mortality rate for some hospitalized patients.⁷

Although there is a need to improve access to outpatient medicine (see Table 1), it is impossible to predict whether this will address emergency department overcrowding issues. In 2018, a study in Ontario, Canada's most populous province, analyzed a reform increasing office hours at unfavourable times. Surprisingly, the results showed an increase in the

annual rate of emergency department visits after the changes were implemented.⁸ Across the board, two main reasons for the presence of mild cases were observed: the convenience of EDs (walk-in; 24/7 hours; access to a large technical platform; and the presence of specialists on site), and the psychological aspect characterized by anxiety about the patient's health status.⁹

Table 1

Canadian Institute for Health Information 2016: Access to Care Indicator Values

Indicators	France	Average OECD
Percentage of individuals who needed care outside of regular work hours and reported difficulty receiving care in the evening, on weekends, or on days off without going to a hospital emergency department	64,1%	54,1%
Percentage of individuals who were able to get an appointment to see a doctor or nurse again the same day	56,2%	59,2%

Faced with these observations, redirection has been recommended for the last ten years by many health organizations, both in Europe and in North America. (NHS, ACEP, CAEP, etc.).

6. France – Rapport public annuel 2019 – Cour des comptes - chapitre 6. Les urgences hospitalières : des services toujours trop sollicités <https://www.ccomptes.fr/fr/publications/le-rapport-public-annuel-2019>

7. Sprivulis PC, Da Silva JA, Jacobs IG, Frazer AR, Jelinek GA. The association between hospital overcrowding and mortality among patients admitted via Western Australia emergency departments. *Med J Aust* 2006;184:208-12.

Guttman A, Schull MJ, Vermeulen MJ, Stukel TA. Association between waiting times and short term mortality and hospital admission after departure from emergency department: population based cohort study from Ontario, Canada. *BMJ* 2011; 342:d2983.

8. Kiran et al. *Annals of Family Medicine*. Oct 2018. Emergency Department Use and Enrollment in a Medical Home Providing After-Hours Care. <https://www.annfammed.org/content/16/5/419.full>

9. Patient Motives Behind Low-Acuity Visits to the Emergency Department in Germany: A Qualitative Study Comparing Urban and Rural Sites. 2016. *BMJ Open* Thibon E, Bobbia X, Blanchard B et al. Association between Mortality and Waiting Time in Emergency Room among Adults Hospitalized for Medical Etiologies. *Annales Fr Med Urg.*2019;9:229-34.

Is it possible to easily identify patients who are eligible for redirection?

Estimating the number of avoidable emergency room visits is not easy and can even be controversial. In France, the Emergency Severity Index (ESI) is used to determine the severity of a patient's case after he or she has been admitted to the emergency department. Although it is performed post hoc and its reproducibility varies from one place to another, this tool can give an idea of the proportion of non-urgent visits. Thus, 10 to 20% of visits are classified as ESI-1 (patients requiring no additional imaging or medical biology procedures), so it is possible to imagine that a significant number of these are avoidable visits. Similarly, the Canadian Institute for Health Information (CIHI) estimates that 17% of emergency room visits could be handled by general practitioners in their offices.¹⁰ In summary, 81% of healthcare professionals believe that too many patients with mild cases are presenting to the emergency department.¹¹

However, determining what is non-urgent is not easy and several definitions exist in the literature. One approach that has been used to identify such visits is to include patients. Patients who are assigned a "low" priority based on assessment with a triage scale (e.g., Canadian Triage Scale-CTAS, priorities 4 and 5). However, these tools are only designed to determine how long patients can wait before seeing a physician in the emergency department.

They do not determine whether the patient's clinical condition allows for safe redirection. A patient categorized as P4 can wait, in theory, a maximum of 60 minutes before being seen by a physician.¹²

Triage of patients in the emergency department is done in a stressful and difficult context. Subjectivity is often observed during assessments. According to a 2015 study in Canada, for the same patient with the same medical condition, just over one third of emergency professionals (37%) triaged the patient as P3 on the CTAS, implying that 63% of emergency professionals classified it as something else (P2 or P4)¹³. Also, just because a patient's case is classified as non-urgent does not mean that the condition could not be a serious pathology or that it would not require resources available only in hospitals. All these arguments illustrate why the medical community no longer wants to use triage scales for patient redirections, as dangerous results have been observed in local experiments.



10. L'ICIS: Sources of Potentially Avoidable Emergency Department Visits. 2014. - https://secure.cihi.ca/free_products/ED_Report_ForWeb_EN_Final.pdf

11, 12. Apprendre des meilleurs : Étude comparative des urgences du Québec. 2016. Commissaire à la santé et au bien-être.

13. The Reliability of the Canadian Triage and Acuity Scale: Meta-Analysis. 2015. Mirhaghi, A., et associés.

The LGI Healthcare Solutions Emergency Redirection Solution

To address all these issues, the research centre of the Montreal Sacred Heart Hospital and LGI Healthcare Solutions are proposing a redirection tool for triage teams. In addition to assisting in clinical decision-making, this solution reduces the variability or subjectivity that may exist between users. The collaboration of emergency physicians and healthcare professionals has resulted in a unique medical algorithm that includes more than 50 common reasons for consultation. In order to minimize the risk of returning to the emergency room, these specific reasons are associated with appropriate contraindications. In addition, for the first time, a key element has been included in a medical algorithm: technology and its essential support in the redirection system.

The ED is known as a place where medical decisions must be made quickly and appropriately. Regardless of the format, an algorithm alone – on paper, in a poster, in a binder, or in Excel – would not be viable and effective. Using this tool would require an unreasonable amount of assessment time for triage staff. Then they would have to make an appointment for each patient eligible for in-office referral by phone or fax; another time-consuming and process-intensive step.

LGI Emergency Redirection remedies these obstacles since it allows triage teams to evaluate the patient with the algorithm in only 30 seconds and to have access to appointment slots reserved specifically for redirected patients.

This way, the patient leaves the emergency room with an appointment at a specific time, the same day, or the next day, with a healthcare professional in the facility of their choice.

If the patient has a regular doctor, the solution promotes appointments in the facility where the doctor works.

This solution was created at the Montreal Sacred Heart Hospital, where the emergency room receives nearly 60,000 visits per year. In the first year of use, this solution reduced the number of pre-admission departures by 35%.

Since then, the solution has been successfully deployed in an additional 130 healthcare facilities. In Quebec alone, 400,000 patients per year can be safely redirected to outpatient care, which represents about 15% of ambulatory visits.

In a prospective research study in Quebec, 1,112 patients were surveyed. A total of 95% of respondents said they would like to see this project rolled out across the province.¹⁴ In this research, it was demonstrated that the redirection algorithm is safe, that the project has excellent acceptability to triage staff, and that it improves the patient experience in the emergency department.



Conclusion

Our deployment experience demonstrates not only is there a reduction in overcrowded emergency departments, but it shows that the LGI Emergency Redirection solution could be beneficial in other environments. For example, hospitals with a higher rate of pediatric visits than the Montreal Sacred Heart Hospital, where the research was conducted, could improve access to patient care by reducing their number of non-urgent visits through redirection.

14. Morris, J., Daoust, R., Cournoyer, A., Marquis, M., Chauny, J., & Messier, A. (2018). LO65: Safety and satisfaction of a new program redirecting low-acuity emergency department patients to medical clinic: A prospective cohort study. *CJEM*, 20(S1), S29–S30. doi:10.1017/cem.2018.127

ABOUT LGI HEALTHCARE SOLUTIONS

A trusted healthcare technology partner

LGI Healthcare Solutions offers healthcare management solutions that help make healthcare organizations more efficient and improve the experience of healthcare teams.

With 40 years of experience and dedication creating innovative, best-in-class technology projects, LGI Healthcare Solutions is in a unique position to help healthcare organizations integrate innovation in a sustainable and measurable approach.

40

years of experience
in healthcare IT

450

dedicated
employees

320K

healthcare professionals
and staff users

6M

of patients
supported



“It is always a pleasure to work with LGI Healthcare Solutions’s team. Their staff always answers questions quickly and follows up to ensure the products work according to our needs.”

ESTHER BRIAND
Medical Archives and
Appointments Control Centre
Coordinator, Cissss of Laval

“The platform LGI Education (MedSIS 3C) enabled our medical school to deliver on many accreditation items and achieve an outstanding and successful accreditation, receiving an unprecedented accreditation with compliance in all 132 standards.”

ASSOCIATE DEAN
Doctor of Medicine (MD) Program
University of Alberta

“Proper recording of the staff’s time in and out will give us accountability in addition to reducing the time wasted by nursing staff trying to find replacement.”

GILLES VERRIER
Interim Executive Director
for the Lions Housing Centres