Seniors and Hospitals: crisis or prophecy fulfilled?

The CEO of Horizon Health Authority correctly recently called attention to the problem created for hospitals by the pressure on emergency departments and acute hospital beds from patients who really require a different level of care. In health care parlance, such patients are called ALC's or Alternate Level of Care Patients.

This is not a new phenomenon! ALCs were identified largely from the first days of the national hospital insurance system and the problem was documented in the late 1960's in academic reports and studies by the provincial Ministers of Health. That we have watched the situation grow without properly re-organizing the care processes simply is a reflection on a Health and Long Term Care system that changes like an ocean liner…..lots of sea, space and time!

But what is worse is that the care afforded to seniors in acute care hospitals and emergency departments is often not appropriate to their needs, yet they often remain in that environment for weeks and months waiting for that correct level of care to be made available. The care requirements of frail seniors is so vastly different than that of younger patients that we now see, in other jurisdictions, Acute Care for the Elderly units being operated successfully. That is not to say that care is not good; it is just different.

Seniors arrive in crisis for many reasons such as fractures and other injuries resulting from falls, complications of multiple clinical problems, stroke, Dementia-related behavior challenges, caregiver burnout, and much more. Can these crisis experiences be prevented? And can admission as "an ALC patient" be prevented? No, so as the population ages there simply will be more seniors presenting in some form of crisis in need of professional help.

But the numbers and proportions can, in fact, be significantly reduced as witnessed in some other jurisdictions where care at the Primary level is changed. Once it is determined that a patient has Dementia-related problems, their care needs to be carefully managed by a professional case manager who ensures that medications are routinely reviewed for effectiveness, there is adequate and essential support service to enable the person to live safely at home, the home has modern safety equipment, be it hand rails, bed, seating, bathing, alarm systems and more.

This type of case management must include oversight of all the care and services required to keep a person safe at home. The province introduced Care Link, First Link and Home First strategies several years ago; these are programs that, when fully expanded in the province, can serve as serious aids in Aging in Place (at home). But to date these programs are not fully understood by many family doctors offices and the public, therefore, is often denied access to good coordinated care at home.

For many years there have been strong public cries for reform of the home care system; often the cries take the form of improving compensation of home care workers. Appropriate compensation is critical as a means of assisting in attracting and retaining superb care givers. But equally important is the training, professional standards monitoring, and governance of the home care system. Government

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would be ill advised to simply react to the pressure to improve the salaries without dealing with the other issues at the same time.

As seniors age and their chronic conditions develop, there comes a time when a more aggressive form of Case Management becomes necessary. In Winnipeg, the Health Science Complex developed the PRIME program which is a seniors day program were people can be admitted for 1-3 days per week. While they are at the day program, they may see their doctor, a nurse practitioner, a foot care specialist, a physiotherapist, a dentist or hygienist, and, certainly, the case manager. The PRIME program serves to manage the health and social service requirements for each client up to and including home visits and emergency intervention…..whatever it takes to keep the client out of the emergency department and the hospital! In Ontario, Dr. Linda Lee, Professor of Family Medicine at McMaster University, developed a specific clinic for persons with dementia and their caregivers. At the clinic the patient may see Dr. Lee but surely sees persons representing support from the Alzheimer Society, Social Service, mobility aids, and much more. So successful has this been that in just over two years over 200 “Linda Lee Clinics” have been developed to support patients and families at home.

So the message for New Brunswick simply is to take the good ideas that already have been proposed (some 10 years ago) and link them with organizations capable of developing great pilot projects, doing all this with a sense of urgency. New Brunswick tends to wait for “one size fits all” solutions in health and senior care and we must move forward with innovation and great pilot projects. That is exactly how the recent New Brunswick Association of Nursing Homes Project of Reduction of Anti-Psychotic Use got started. We need much more of that innovation.

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