No clear evidence that diverting patients from emergency departments curbs overcrowding

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There's no clear evidence that diverting patients, who are not seriously ill, away from emergency departments, in a bid to curb overcrowding, is

either safe or effective, reveals research published online in *Emergency Medicine Journal*.

Given the considerable costs of providing alternative sources of care, there is remarkably little good quality evidence to back this approach, conclude the researchers.

Redirecting low need patients from emergency care departments to alternative sources of care, has been proposed as a potential solution to tackling the overcrowding that often occurs in these facilities.

But it isn't clear whether this strategy actually works or is safe. The researchers therefore systematically reviewed and pooled the data from 15 relevant studies, evaluating the impact of redirecting patients to alternative sources of care before reaching, or once in, an emergency care department.

No strong evidence emerged to either back or refute the safety and effectiveness of this strategy, the data analysis showed.

What's more, the proportion of patients suitable for diversion was relatively low and a considerable proportion of those who were suitable didn't want to use alternative sources of care either.

Redirecting patients to alternative sources of care was twice as common among those who had already reached an emergency care department.

But compared with those who weren't redirected, doing this before the patient reached hospital didn't cut the proportion transferred to emergency care.

Nor did it stop them subsequently using emergency care services: their patterns of use didn't differ from those of patients who weren't

redirected.

While only three studies looked at the costs involved, none found any difference in total healthcare spend between patients who were diverted away from emergency care departments and those who weren't.

The overall quality of the published evidence was not particularly good. This included varying definitions of low need; limited information on the outcomes of patients given standard care; the numbers of patients willing and able to accept alternative sources of care; or the costs involved.

"Despite the clear resource implications for implementing [emergency department] diversion strategies, including training and hiring additional staff, costs of implementing the diversion strategies were infrequently reported," they write.

All this makes it difficult to draw definitive conclusions, they caution, concluding: "At this time there is insufficient evidence to recommend the implementation of diversion protocols as effective and safe strategies to address emergency department overcrowding."

And in a linked podcast in discussion with the journal's editor, Professor Ellen Weber, lead author, Dr. Brian Rowe, University of Alberta, isn't convinced 'the juice is worth the squeeze.'

"I am not sure the efforts involved in doing diversion are really worth all the costs, time, and surveillance," he says. And not all emergency department patients are the same, although the diversionary strategies to date tend to assume that they are, he says.

Surveys in Canada indicate that patients have often tried many other options before coming to an emergency department, or that they are

there because the health system has failed them, he suggests.

What's more, he adds, patients like the 'one-stop shop' service provided by hospitals, and younger patients often don't register with a family doctor, leaving them with few other options.

More information: *Emergency Medicine Journal* (2018). emj.bmj.com/lookup/doi/10.1136/emermed-2017-207045

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