I recently read a quote that resonated with me: “Here are the real silos: structural pushes and pulls by one group working towards its aims will, in effect, conflict with another group” (BMJ 2016;354:5199). The author was speaking of the conflict between generalists and specialists, but I was immediately reminded of the conflicts that can exist between acute care and chronic care when communication breaks down. Physicians work in a wide variety of clinical environments, having been exposed to most disciplines during our training. We eventually settle into an area of specialty upon completion of training, and after working in a specific, focused care environment we often forget about the challenges facing our colleagues in other areas. This is especially true in acute and chronic care departments.

Most, if not all physicians have been exposed to emergency departments (EDs) during training and are aware of the unique demands of this environment. The ED is a fast-paced, high-volume setting like a family medicine practice, urgent care center, or walk-in clinic. Presenting conditions are triaged according to their urgency. Diagnostic tests are performed or delayed by several days, X-rays can be delayed by several days, and patients often complain about the long wait times and lack of resources available at the ED. Many visits are not urgent and would be better suited to a more appropriate setting like a family medicine practice, urgent care center, or walk-in clinic. Long-term care poses very different challenges. It is a heavily monitored and regulated sector. The staff frequently feel overwhelmed by the limited staffing and heavy care because most residents have extensive care needs or are totally dependent on staff for all their basic activities of daily living (ADLs). “Emergency Department Visits in 2014–2015,” Oct. 2015, http://bit.ly/2piGCVg). The current media climate surrounding long-term care is often negative, uninformed, or at the very least unfriendly. Sensationalized stories in the media about post-acute and long-term care (PALTC) belie the reality of the excellent overall quality of care that these settings provide across Canada. This serves to bring into question the level of care that is provided and puts undue pressure on an already overworked staff. Families exposed to negative press, even when it is not validated by their own experience, become hypervigilant about the care their loved ones are receiving, which further increases stress for front-line care providers.

Over the past decade, the complexity and acuity of the medical conditions that residents present to PALTC have increased substantially (J Clin Nurs 2018;27:3653–3665). More people are choosing to age in place; by the time they move into a care environment, they are more frail, have multiple comorbidities, and/or may have advanced dementia, which results in increased care needs. If families are not adequately prepared for the decline in health that is expected at this stage, their efforts to advocate for loved ones are not sufficiently informed. When a resident becomes acutely ill, family caregivers often request that their loved ones be transferred to acute care for treatment of life-limiting illnesses to ensure they have done all they can. Often, even in the presence of do not resuscitate orders, families hold out hope that a definitive treatment will be provided to prolong life.

Acute illness at the end of life is, understandably, very stressful for families, and they will often turn to PALTC staff for guidance. Well-meaning staff may recommend transfer to acute care for fear of repercussions for not responding to a resident’s declining health, or to accede to a family’s wishes, or from a genuine belief that acute treatment will help the resident. Lack of immediate availability of the resident’s physician often leads to avoidable transfers to acute care. Many Canadian physicians who practice in long-term care have busy family practices and other professional commitments. Often a sudden change of condition in a resident occurs when the physician is unavailable to physically assess the resident in a timely fashion, leading to transfers to acute care when there is diagnostic uncertainty. As well, access to diagnostic tests including laboratory tests and X-rays can be delayed by several days, particularly in smaller centers or rural areas in Canada.

Generally, Canadian physicians who practice in long-term care would rather manage their residents on site, where a familiar environment best suits their needs. Physicians in long-term care have information about the resident that can potentially prevent unnecessary tests and procedures and save the emergency physician time and energy trying to obtain a history from a frail resident who is highly likely to have dementia. Understanding the patient’s baseline cognitive function, completed diagnostics, and the patient and family’s goals of care can help to streamline the process and save time and energy as well as substantially reduce costs to the Canadian health care system.

It is imperative that both acute and chronic sectors recognize the unique challenges their colleagues face and maintain a collaborative and respectful approach to our mutual patients. We are all working toward the same goal of excellent patient care and transitions. When we show respect for our colleagues, we instill confidence in our patients and their families, and can help one another provide the best possible care to a vulnerable population.

Dr. Collins is the chief medical officer of Revera. She is a family physician with an Associate Certificate of Competence in Care of the Elderly. She also is an associate clinical professor in the Department of Family Medicine at McMaster University and a member of the board of directors of the Ontario Long Term Care Clinicians. Dr. Collins is a Society member.

Correction
The upper left photograph and corresponding caption on p. 15 in the October 2019 issue incorrectly identified David Smith, MD, CMD, as Charles Crecelius, MD, PhD, CMD, receiving an award from Lames Lett, II, MD, CMDR. The correct photograph (below), picturing Dr. Lett and Dr. Crecelius, has since been published online. We sincerely apologize for this error.

Elizabeth Galik, PhD, CRNP, coeditor in chief of Caring for the Ages

Caring for the Ages welcomes an international perspective from our colleagues in PALTC and geriatrics. Although clinicians in Canada and the United States share many common challenges related to communication, collaboration, and care transitions between PALTC and the acute care setting, there are some differences that we would like to recognize. For example, in urban and suburban regions of the United States, there has been a decline in family medicine physicians who also maintain a PALTC practice in addition to their office practice. In the past several years, the United States has seen the emergence of specialty long-term care practices/services that consist of physicians, nurse practitioners, and physician assistants who provide increased access to advanced practice providers on site in PALTC settings. The United States also has regulations from the Centers for Medicare & Medicaid Services that target the prevention of 30-day acute care readmissions.

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