

**NORTH YORK GENERAL HOSPITAL
EMERGENCY DEPARTMENT DIVERSION (EDD) PROJECT**

**AN INTEGRATED RESPONSE TO MENTAL HEALTH PATIENTS
PRESENTING IN HOSPITAL EMERGENCY DEPARTMENT**

**Winner Leading Practices Award – Access to Care
Ontario Hospital Association November 2008**

**Partners:
Saint Elizabeth Health Care
Toronto North Support Services
ACCESS 1
North York General Hospital**

Issues

- *Many clients seek assistance in Emergency Departments due to lack of alternative avenues for support or lack of knowledge of existing alternates.*
- *Many clients present in ED when their community support services are not accessible. Since they cannot be discharged quickly and safely they:*
 - *wait and are monitored in ED or*
 - *are admitted to an inpatient bed*
- *Many individuals have multiple visits to the ED in a short period of time or the pattern has accelerated.*

Partners in Project

- **North York General Hospital**
 - Lead agency
 - Liaise with SEHC team in identifying appropriate referrals
 - Leadership role in evaluation of initiative
- **Saint Elizabeth Health Care**
 - Provides a quick response to individuals presenting in the ED who are experiencing mental health related crises, and who can be supported in the community.
 - Crisis Management Stabilization Support for up to 10 days
- **Access 1**
 - Toronto North Support Services – Lead agency for Access 1 which coordinates case management services in NY.
 - Serves as the coordinator/navigator for short term case management services for clients needing additional support services after stabilization.

Overview of Project

- *Provides a quick response to individuals presenting in the Emergency Department at NYGH experiencing mental health related crises, and who can be supported safely in the community.*
- *Facilitates a seamless continuum of care for clients back to community.*
- *Provides an alternative to inpatient admissions by providing the right care, by the right provider, in the right setting at the right time.*
- *Improves access to and knowledge of community-based services for this population.*
- *Reduces readmissions in the Emergency Department.*

TARGET POPULATION:

- Individuals being held in the ED due to safety concerns and a lack of appropriate support resources in community, hospital staff are uncomfortable discharging the person and they may be admitted to a bed due to lack of support resources in the community.
- Individuals being held in the ED that need not be admitted and, although they have supports in the community, they are unable to access them.
- Individuals having multiple visits to the ED in a short period of time or the pattern has accelerated and staff have identified stressors that are contributing to the person's crisis.

EXCLUDED POPULATION

- Any person under the age of 16.
- Primary Axis 1 Diagnosis of eating disorder, developmental delay or substance abuse.
- Delirium, dementia (with aggression) or presence of acute medical illness
- Substance induced psychosis
- Current forensic charges and/or risk of violence (forensic involvement to be explored further)
- Anyone at high risk of suicide

The Initiative

- Increased coordination between the hospital and community agencies
 - Creation of Mobile Crisis Coordinator
- Establish and utilize protocols for patients who do not require admission to inpatient but require plan of care at discharge
 - NYGH crisis nurses and St. Elizabeth crisis workers work collaboratively in assessing and developing safety plan

Service Flow – ED Diversion

Step One:

- North York General Hospital crisis nurse will assess if client is appropriate for referral to the Emergency Department Diversion Program by following a predetermined set of criteria.

Step Two:

- North York General Hospital crisis nurse will inform EDDP Coordinator of referral when on site or will call the St. Elizabeth Mobile Crisis team if Coordinator is off-shift. EDDP Coordinator or designate will visit client at hospital within one hour.

Step Three:

- The EDDP coordinator or designate will meet with the client , conduct an assessment and develop a safety plan.

Service Flow – ED Diversion (2)

Step Four:

- EDDP coordinator or designate will ensure that safety concerns are addressed and will activate an immediate support plan.

Step Five:

- If the client needs further supports, the EDDP Coordinator can offer brief crisis management services and/or short-term case management services.

Service Flow – ED Diversion (3)

Step Six

- If the client could benefit from short-term case management, then the EDDP Coordinator will fill in the Common Application Form and send it to Access 1 for referral to case management community partners.

Step Seven:

- When the time period for case management is elapsing, the case management provider will work with the client on discharge plans. When the client has been discharged from short-term case management, the provider will inform Access 1 of the space that has been made available

Outcomes

- *Over 75% found the envelope of care they received through the EDDP very helpful*
- *Over half of patients referred to EDDP may have been admitted to inpatient beds had EDDP services not been available*
- *76% of patients had no return visits (compared to 44.4% with return visits pre-EDDP)*
- *63% of clients reported they were unaware of community crisis services prior to being referred to EDDP*
- *83% clients said they would seek alternate services than ED if another MH crisis occurred*
- *14% of patients seen by the EDDP utilized the community-based services again following discharge from the initial EDDP service*

Sustainability

- *Original funding was for the pilot project in FY2007-08*
 - *Enhanced the collaborative partnership between NYGH and its community crisis service providers*
 - *Created greater awareness of community support options for mental health patients seen in the ED*
 - *However, ongoing funding for the community crisis worker in the ED was not initially available after the pilot so the process for referring patients to the program and providing the seamless hand-off of care to the community partner was impacted*
- *The project has received one time funding in FY2009-10 and 2010-11 from our LHIN (CLHIN) to continue our work leading to some refinements of our model including:*
 - *Crisis worker is “housed” in our Emergency Department 5 days per week with weekend response available*
 - *The service is available for “early discharges” from our inpatient units*
 - *The service is available to outpatient programs as a means to avert admissions*
 - *We are testing Peer Support as a viable addition to services*

What We Learned

- Embedding community crisis worker in Emergency Department, as a member of the team, proved very successful as a means to increase referrals and broaden the reach of community support.
- This integrated approach to “patient flow” works well. Inpatient beds are freed up for more acute needs and readmission rates for this cohort of patient to emergency are reduced.
- Many patients attend emergency departments because they are unaware of more appropriate community resources or lack the strategies to manage crisis in the community.
- Short term crisis management and stabilization may reduce the need for longer term interventions for many of these patients.