Facilitating Community Support Linkages for Frequent Emergency Department Users: The ENCOMPASS-ED Project

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ABSTRACT

The ENCOMPASS-ED project implemented embedded health system navigation and mental health peer support to proactively engage frequent emergency department (ED) users, facilitate linkages to community services, and reduce ED overuse. This model of care is generalizable to other communities across Canada to support reductions in unnecessary and costly ED visits.

Keywords: patient navigation, emergency service hospital, mental health, case management, psychosocial support systems

RÉSUMÉ

Le projet ENCOMPASS-ED a mis en place un processus de gestion intégrée dans le système de santé et un soutien par les pairs en santé mentale afin d'impliquer de manière proactive les utilisateurs

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fréquents des services d'urgence (SU), de faciliter les liens avec les services communautaires et de réduire la surutilisation des services d'urgence.

Mots clés : gestion des patients, services d'urgence hospitaliers, santé mentale, gestion de cas, systèmes de soutien psychosocial

BACKGROUND

Frequent emergency department (ED) users comprise an estimated 3.5–6.7% of ED patients yet represent upwards of 25% of total visits to EDs (Arfken et al., 2002; Boudreaux et al., 2011; Urbanoski et al., 2018). Individuals presenting frequently to the ED often have numerous co-occurring medical and psychiatric challenges. In Ontario, it has been noted that frequent users presenting with mental health and addiction (MHA) needs visit the ED more than twice as often as all other frequent ED users (Urbanoski et al., 2018). Frequent ED users often experience difficulties with basic physiological and safety needs, social isolation, and treatment adherence (Arken et al., 2002). When attending the ED, they do so for non-urgent concerns that do not require emergency care and are more likely to return to the ED within one month. As such, those frequently presenting to the ED may be doing so due to service gaps and barriers to community care, or because existing health and social services are not meeting their complex needs. Thus, developing interventions that facilitate access to alternative, less costly community-based supports may support reduced ED usage.

In recognizing these needs, we piloted a MHA Navigation and Peer Support practice innovation within the Sunnybrook Health Sciences Centre (SHSC) ED, in partnership with Hope + Me – Mood Disorders Association of Ontario and Toronto North Local Health Integrated Network in 2018–19. The goal of this innovative hospital-community pilot partnership project was to reduce recurrent emergency department visits and increase connectedness to community supports.

The ENCOMPASSED Project (Enhancing Navigation – Connecting Overusers of Medical, Psychiatric, and Addictions Support Services in the Emergency Department)

This pilot intervention was implemented in the Sunnybrook Health Sciences Centre for six months. SHSC is a large academic health sciences centre in Toronto, Ontario with over 61,000 ED visits annually. At SHSC, frequent ED users can average more than 50 visits in a 6-month period. SHSC's psychiatry program helps patients and families identify, understand, and treat mental illness and addiction while facilitating access to acute-care hospital resources and community supports.

Patients with complex medical and comorbid mental health challenges were identified through an automated information system (Better Care System), used to flag frequent emergency service users at SHSC. Those with four or more visits in a 6-month period or those with perceived rapid escalation in ED use with the potential to become a frequent ED user (e.g., multiple visits in the same week) were offered navigation supports upon next presentation in the SHSC ED.

The intervention team included three embedded community-based social workers (MHA navigators), two peer support workers from the same community mental health organization, two consulting psychiatrists, and two local health system administrators. Navigators provided care coordination and linkage to internal and external MHA resources and peer support workers provided emotional support to patients awaiting assessment in the ED, facilitated linkages to community supports, and followed up with patients in the community. Navigators provided rotating coverage to the ED seven days per week, during peak hours (from 4 pm to 12 am). The navigators functioned as consultants to ED staff by providing resource identification, matching, and disposition planning. Patients were encouraged to contact the navigator through an established crisis line for phone coaching when they felt an urge to return to the ED. Phone coaching allowed for emotional support and validation, and discussion of behavioural, cognitive, and distress tolerance strategies to divert ED visits. Navigators met with patients in the community, as well as family members when permitted, to set goals, offer family interventions and support, and put care plans in place. Navigators attended the ED if the patient returned to circumvent a lengthy ED visit and facilitate expedited discharge.

Peer support workers with lived mental health experience provided ad hoc emotional support and facilitated patients' recovery processes through their experiential knowledge. They worked collaboratively with the navigation team, carried their own caseloads and were assigned to cases by matching their lived experience with patient needs. The peer support workers provided psychosocial support and facilitated linkages to outpatient programming, peer groups, and counselling, while reinforcing established care plans. They provided important and nuanced insights to the clinical team from the perspective of lived experience, which helped guide resource matching and treatment planning for patients.

Two psychiatrists (RS and KW) provided dedicated psychiatric oversight by offering weekly supervision for challenging cases as well as on-call clinical backup to address questions related to risk, safety, or the need for further psychiatric assessment or admission. All cases were reviewed at weekly case consultations to facilitate team communication. In addition, two representatives from the North Toronto Sub-Region Advisory Council, a group of local health and social service agencies, partnering with the hospital to coordinate care for shared patients, provided input to the team to facilitate community-hospital collaboration using the broader lens of regional integration.

Of the 20 patients who were approached, 10 (n = 3 M, 7 F) provided verbal consent to participate, which was documented in the patient's chart. Patients were between the ages of 20–76 (M_{age} = 48.7). Patients presented with a range of mental health challenges ranging from mood and anxiety disorders, substance use disorders, intellectual disabilities, psychosis, personality disorders, along with numerous medical comorbidities.

Patients had an average of 19.8 contacts with a navigator and/or peer support worker (min = 1, max = 62). In these interactions, the type of care provided included support with care coordination/planning (78.3% of all interactions), mental health care (77.8%), quality of life (52.0%), family dynamics (24.2%), grief/bereavement (13.1%), decision-making (6.6%). The forms of education and resources provided during these interactions were mental health (82.8% of all interactions), education (50.0%), healthcare (31.3%), peer support (14.7%), financial assistance (4.0%), housing (1.0%), and transportation (0.5%).

Enrolled patients collectively accounted for 154 visits in the six months prior to their involvement in the intervention, and 104 visits in the six months following their involvement in the intervention. Thus, the

average number of ED visits among patients in the six months prior to engaging with the intervention was 15.4 (min = 2, max = 40). The average number of ED visits among patients in the six months following initial engagement in the intervention was 10.4 (min = 0, max = 23). Changes in observed individual ED use ranged from an increase of 80% (outlier)[1] to a decrease of 100%. Total reduction in SHSC ED use was 32.5% and median individual change in ED use equated to a reduction of 24.0%.

DISCUSSION

This pilot intervention demonstrated that frequent ED users connected with a navigator to facilitate linkages to community supports experienced a considerable decrease in the number of ED visits in a six-month timeframe. Patients connected frequently with their navigators for support with MHA service access and coordination in the community in lieu of coming to the ED. Navigators and peer support workers were available to patients by phone, thereby ensuring convenient access to immediate support for patients contemplating an ED visit. Inclusion of peer support ensured patients and families experienced accessible, responsive, and timely access to service; non-directive, non-judgmental, and culturally competent communication with the team; enhanced emotional support with the knowledge that someone was there for them who had been "in their shoes"; support, via navigation, of the concrete problems in patients' lives including underlying mental health concerns; and patient-centred care with choice and empowerment, personalized to the individual. Purposefully learning about patients' preferences and needs, fostering behavioural change, providing information about community resources, and facilitating access to appropriate mental health, primary care, and community supports, may have contributed to a reduction in ED visits for frequent ED users. The combination of navigation and peer support may have helped distressed patients consider alternatives to visiting the ED.

Stationing navigators in the ED after hours was associated with subsequent reduction in ED utilization. Navigators immediately and proactively connected with flagged patients upon initial presentation to the ED, contributing to their successful engagement with the ENCOMPASSED team. Additionally, use of phone coaching may have contributed to the successful diversion of patients from the ED. Frequent ED users often develop highly ingrained behavioural patterns for managing distress over a period of months and years. The instinctive response to call 911 inevitably results in presentation to the ED. Phone coaching and almost around-the-clock availability by navigators allowed patients to choose alternative behavioural approaches for managing crises. Furthermore, navigators took extended measures, not only to provide case management, but also distress tolerance and coping strategies, thereby increasing patients' self-efficacy and confidence. Positive reinforcement of patients' appropriate use of phone coaching, coupled with increased interpersonal connectedness to peers, resulted in modifications of long-standing behaviours and cognitions; for our subset of frequent users, the ED became less of a reflexive option over time. Collaboration between the hospital and its community partners facilitated information-sharing and care coordination for frequent ED users with complex needs. This work holds important promise for future hospital-community partnerships in addressing the complex mental health and physical needs of frequent ED users through enhanced care coordination and system navigation.

1. One patient displayed increased help-seeking behaviours.

REFERENCES

Arfken, C. L., Zeman, L. L., Yeager, L., Mischel, E., & Amirsadri, A. (2002). Frequent Visitors to Psychiatric Emergency Services: Staff Attitudes and Temporal Patterns. Journal of Behavioral Health Services and Research, 29(4), 490–496.

Boudreaux, E. D., Niro, K., Sullivan, A., Rosenbaum, C. D., Allen, M., & Camargo, C. A. (2011). Current practices for mental health follow-up after psychiatric emergency department/psychiatric emergency service visits: A national survey of academic emergency departments. General Hospital Psychiatry, 33(6), 631–633.

Urbanoski, K., Cheng, J., Rehm, J., & Kurdyak, P. (2018). Frequent Use of Emergency Departments for Mental and Substance Use Disorders. Emergency Medicine Journal, 35(4), 220–225.