Creating an Urgent Care Pathway for Clients from the ED to a Mood and Anxiety Ambulatory Services at CAMH

Learnings from the Implementation of a Collaborative Service Model

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camh
Centre for Addiction and Mental Health

Objectives

- Learn about the ACSTP Urgent Care Initiative including its model of care
- Learn about the findings from the Early Implementation Phase
- Participate in an interactive discussion about key findings

Conflict of Interest

- None of the presenters has any conflict of interest to declare

Why the Need for an Urgent Response Service

- Rising volumes in the CAMH Emergency Department (ED)
- Limited options for individuals in need of urgent access to psychiatric care
- A timely response to clients can reduce ED and inpatient admission recidivism rates

Introducing the Mood and Anxiety Ambulatory Service (MAAS)

- A fast-paced outpatient service offering consultation and treatment to clients with a range of mood disorders and a wide spectrum of anxiety disorders (unipolar depression and bipolar disorder, seasonal affective disorder, obsessive compulsive disorder, panic disorder, generalized anxiety disorder, social phobia, co-occurring conditions such as addiction and personality issues)
- The service serves about 7000 new clients every year, 550 external referrals from community physicians each months through Access CAMH
- Approximately 60% of clients receive psychological treatments, and 40% return to the family physician with treatment recommendations
- Time-limited interventions focusing on diagnostic clarification, medication optimization and psychosocial interventions
- Psychosocial interventions include CBT for mood and anxiety disorders, MBCT, IPT, Bipolar Education groups, family groups and peer support, discipline specific interventions such as social work and occupational therapy

Project Goal

Provide a Responsive Model of Care for clients presenting at the Emergency Department with Urgent Mood and Anxiety Symptoms

Background

- In November 2013, the Mood and Anxiety Ambulatory Service at CAMH introduced an urgent care service based on an inter-professional, collaborative model.
- Primary goals of this service pathway are to promote stabilization, client safety and linkage back to the primary community provider within a six week period. The service aims to see clients within 72 hours following the ED referral.
- The urgent care service also offers a cost-effective alternative to hospitalization thus decreasing pressure on the CAMH ED.
- During the first three months of initiation, the urgent care service offered service to five new clients per week. The aim is to triple service capacity post evaluation.

Background- Program Rationale

Evidence in Support of Program

- Improve client care outcomes
- Increase safety for clients and staff
- Increase system efficiencies

(Dumesnil & Verger, 2009; Lacko, Henderson & Thorncroft, 2013; Livinston et al., 2013; Mann et al., 2005; Michaels et al., 2013)

Target Population

- Individuals 18+ years old presenting to ED with acute primary mood and anxiety presentations (may have other co-morbidities)
- Clients who otherwise would need to be admitted
- Clients who would benefit from a quick follow-up (within 72 hours)
- Clients that can be safely discharged from ED

Background – Program Objectives by Stakeholders

CLIENT:
- Increase stabilization
- Reduce symptoms and improve functioning
- Client satisfaction

CAMH:
- Reduce admissions through ED
- Reduce ED recidivism rates
- Appropriate care level matched to need
- Appropriate use of inter-professional services

HEALTH CARE SYSTEM:
- Optimal and efficient use of resources
- Improved community linkages (i.e., primary care)

Therapeutic elements

- Active engagement with clients
- Identification of priority goal(s) which can realistically be achieved within 6 visits for up to 6 weeks on average
- Diagnostic clarification and formulation
- Medication titration and monitoring
- Help with service linkages including primary care, community and internal services
- Psycho-education related to management of symptoms
- Immediate Consult with Addictions services as required
- Transition planning for follow-up beyond the brief intervention will occur quickly (i.e., linkage with primary physicians, assistance obtaining primary care if needed and referral to other community or CAMH services)

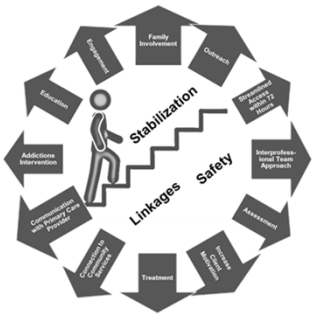
Original Addiction component

- Urgent Care team had daily access to a consult with an addiction clinician from a on-call roster of 60 WSW staff. Members of this team were on duty a week at a time, with commitment to respond to calls within 4 hours
- **Responsibilities:**
  - nature of the consultation: providing input on the care plan and advice on timely access to a 60 WSW intake interview that could open the door on placement in addiction services
  - Addiction clinician supported by concurrent disorders psychiatrist if need arose
  - Addictions service clinician on duty for the week attends the one-hour Urgent Care Team meeting.

Addiction contribution that emerged

- Two dedicated Addiction assessment/intake slots per week – one provided by CAITS staff and another by MAARS staff
- Two addiction services clinicians and APC available for follow up consultations
- On-call addictions consult not currently being used

Model of Care

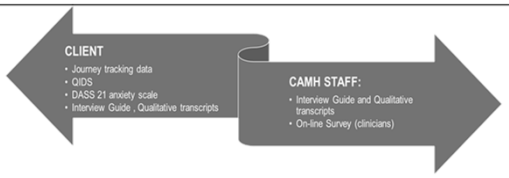


Evaluation Framework

Functional Areas of Mood and Anxiety Urgent Care Service

	ED Referral	Initial Assessment	Brief Intervention	Service Linkages	Interdisciplinary Collaboration
Purpose	To refer clients to Urgent Care service rather than admitting them into the hospital	Determine needs of clients newly admitted to the Urgent Care service	To stabilize clients within their six sessions of Urgent Care	Ensure clients have supports in the community or CAMH for their treatment and recovery	Create collaboration among professionals in managing Urgent Care clients
Activities	• ED assessment of clients • Referral to UC for appropriate clients	• Clients contacted for initial assessment within 72 hours • Client assessment package completed • Psychiatrist consultation • Management of medication • Priority goal setting for client in care • Develop treatment plan for 6 sessions	• Six sessions with each client • Client assessment package at discharge	• Refer clients to CAMH programs • Refer clients to appropriate community services • Connect client with Primary Care physician • Family involvement in recovery plan	• Steering Committee meetings • Team operations meetings • Create multidisciplinary Urgent Care teams • Consultations among teams • Scheduling sessions with clients • Evaluation
Outputs	• # referrals from ED to Urgent Care/week	• Referred clients contacted within 72 hours • # of attempts to schedule client • # of "no shows" • # of clients who attend initial assessment • # of pre-test clinical assessment packages completed • # of psych consultations with new UC clients • # of prescriptions written • # of clients with set priority goals	• # of post-test clinical assessment packages completed • # of sessions with psychiatrist • # of sessions with clinician • # of clients who complete 6 sessions	• # of referrals within CAMH • # of referrals to community services • # of clients linked with primary care physicians • # of clients with family support in place • # of addiction assessments	• # of steering committee meetings • # of team operations meetings • # of treatment teams • # of team consultations during clients treatment • # of sessions with psychiatrist and clinician • Evaluation framework
Objectives	• High number of appropriate referrals • Reduced number of hospitalization/admissions through ER • High level of client satisfaction	• Rapid response time (48 – 72 hours) • Reduced wait times • Experience of receiving "right service at the right time"	• Increased stabilization • Improved immediate functioning • Reduced symptomatology • Increased sense of safety • High level of satisfaction •	• Increased knowledge of how to access/refer to Urgent Care Services • Reduced wait times	• Appropriate staffing model • Provision of multi-modal services • Clear understanding of service pathways • Increased skills in identifying and managing urgent care cases • Increased sense of efficacy in roles • Clear understanding of service pathways • High level of satisfaction with pathway • Increased safety for staff

Evaluation Data Source



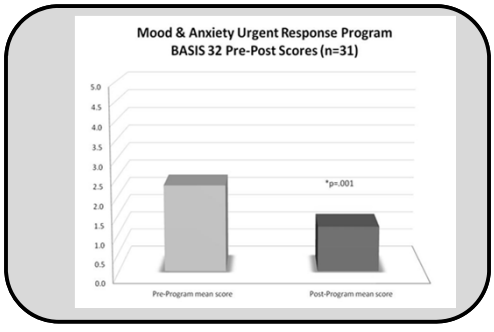
- DASS Social Support scale
- GAF
- Addictions Measure

Quantitative Results:
Program Client Tracking Data – Approach #1

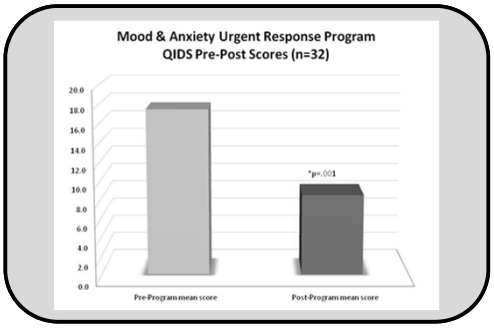
APPROACH #1:
DATA FILTERED BY REFERRAL DATE (≤ AUGUST 31, 2014)
Overall Nr of clients seen: Nov. 23 2013 – May 31 2015: 250

- Valid cases = 211
- Average # of attempts to reach = 2.0
- Client hospitalized = 7.1%
- Med stabilization = 60%
- Average # of total sessions = 3.8
- Canceled sessions = 70% did not cancel, 30.2% canceled at least once
- No-shows = 30% no-showed once
- Addiction consult = 16%
- Completed service, reason for discharge = 38.0%
- Pre/Post completed = 12.8%

Quantitative Results:
Pre/Post Measures



Quantitative Results: Client
Pre/Post Measures



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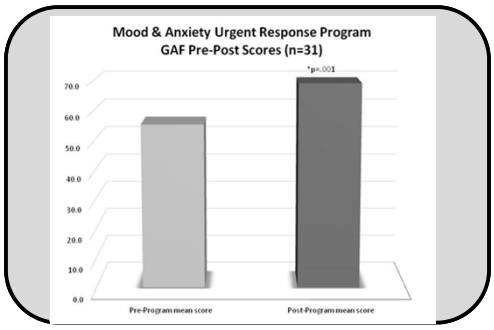

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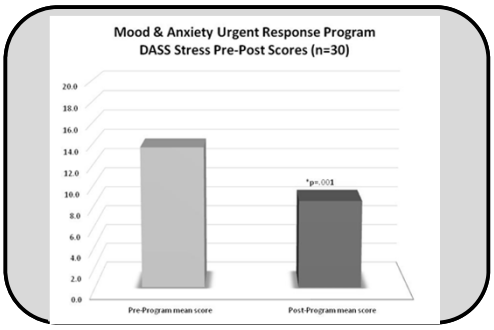

Client Journey Characteristics
Dec. 2013–Aug. 2014

Demographics
- total number of clients seen by UR = 211
- 50% male : 50% female (based on data from 143 clients)
- median age of client = 32 years, range 17–60 (based on data from 143 clients)
- Number of clients returning between November 2013 and May 2015: 6

Referral and appointment
- # of referrals offered to the ED = 5 per week during the early implementation phase; leading to 15 per week post August 2014, serving up to 720 new clients per year
- The number of people referred to UR was higher than 211; few clients are not reached due to contact information issues, and others

Time Indicators
- *100% of clients* were contacted for an appointment within 72 hours

Qualitative Data

- Interviews with stakeholder groups conducted between April and May 2014
- Stakeholder groups: clients, ED staff, Urgent Care clinicians and psychiatrists, addiction clinicians
- Client interviews over the phone
- Clinicians and psychiatrist completed online survey with open and closed questions

Qualitative Data: Clients

- **Program Strengths**: Clients overall were very satisfied with the fast response time, clients commented on experiencing a reduction in symptoms, experienced the staff team as understanding and supportive
- **Suggested Improvements:** more flexible scheduling, re-evaluate after 3 and 6 months, some challenges with post-discharge follow-up wait times

Qualitative Data: ED Staff

- **Program Strengths**: Increased confidence in client safety through the Urgent Care model, positive reception by clients
- **Suggested Improvements**: Increase numbers of referrals from ED, clarify the ED physician responsibility in urgent care cases

Qualitative Data: Psychiatrists

- **Program Strengths**: Client stabilization, pathway from ED to Mood and Anxiety created; unintended early identification of very acute cases, i.e., EIC clients
- **Suggested Improvements**: addressing the issue of clients "jumping the queue"; more communication between teams

Qualitative Data: Clinicians

- **Program Strengths**: Client stabilization, appropriate ED assessments, transitioning clients to appropriate services/linkages
- **Suggested Improvements**: Increased physician time, clear understanding of "urgent care" among staff, barriers to creating service/program linkages

Qualitative Data: Addiction Staff

- **Program Strengths**: timely access to addiction assessments, clients have support in place
- **Suggested Improvements**: more interaction with multidisciplinary treatment teams, increased staff involvement from the addiction side

Case Study

- 27 year old male university student
- Brought to the ED by parents on July 14
- Presenting Problem:
- Anxiety issues since childhood
- Severe substance use issues
- Parents became aware of substance issues in the spring of 2014
- Brought to a detox but became overwhelmed and left
- Hence parents brought the client to ER
- Client denied safety concerns in ER
- ER made a referral to the MAAS Urgent Care Service

Case Study

Client History:

- Post high school graduation, client attended university, dropped out in second year due to anxiety, dread of crowds, fear of being judged by others
- Continued to work part-time
- Anxiety interfered with friendships and intimate relationships
- Returned to university and noted a resurgence of anxiety
- Began taking Percocet, then moved to snorting heroine in September 2013
- Later started injecting heroine

Case Study

- Seen in MAAS Urgent Care Service for diagnostic clarification, treatment recommendation and brief follow-up (July 24)
- Initial consult by psychiatrist and social worker
- **Diagnosis:** Social Phobia, Major Depression, Polysubstance abuse and dependence
- Referred to addiction service clinician attached to the MAAS Urgent Care Service (July 15), seen on July 29

Case Study

Plan:

- Start on medication
- Referral to Addiction Service
- Referral to CBT for Social Phobia
- Urgent Care social worker to offer psychosocial support, psych education and bridging to Social Phobia group
- Seen for opiate clinic assessment on September 23
- Began CBT for Social Phobia on October 2
- Continues treatment in addiction service
- Discharged from Urgent Care Service on October 1

Stakeholder Comments

Client:

- "I went to the CAMH ED and I explained why I was there and they made the referral. I got a call the next day. So it was fast, it was a fast process."

Family Member:

- "The urgent care staff was my life line while my son was treated for his first episode of mania. We live in Montreal and were grateful for the regular phone updates".

ED Staff:

- "The clients are pretty receptive to the Urgent Care referral because they are happy to hear they will be getting help quickly"

Urgent Care Psychiatrist

- "...clear pathway for the ED to refer for mood and anxiety is helpful. The other thing that was helpful was having that multidisciplinary approach..."

Urgent Care Clinician:

- "Clients are receiving good service and seem satisfied with the service. Clinicians are enjoying the work and experiencing satisfaction.

Addiction Therapist

- "I think it really works...."

Key Findings

- Significant symptom relief
- Significant decrease in risk
- Effective integrated and collaborative care
- Efficient care to clients
- High client satisfaction
- Improved system efficiencies

Program Implementation Discussion

- Stakeholder feedback indicates positive consensus around the Urgent Response Model of Care
- Preliminary and ongoing data suggest promising results on client outcome measures
- Mechanisms have been developed to address some of the program's operational issues and challenges (i.e., daily communication processes between the urgent response team and the ED staff)

Learnings and Next Steps

- **Model of Care**
  - Evidence shows this model reduces inpatient admissions and swiftly redirects patients to effective treatment.
  - Success is dependent on inter-professional team collaboration
- **Resource Management**
  - Flexible and responsive scheduling is required and new models of scheduling will be explored
- **Quality Improvement**
  - Standardized measures that are most clinically useful and explore methods that facilitate uptake by clients and staff Provide client context and feedback
  - Share findings with all stakeholders
- **Communication**
  - Information processes, inputs, and exchanges will be identified and streamlined among and between the Urgent Care program, ED, and the Addiction program
  - Optimize use of new Clinical Information System (I-CARE) for communication
  - Explore extent of support systems available to this population and explore best methods of communicating back to primary care

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