Emergency Department Clinical Pathways

The Emergency Department (ED) Clinical Pathways is an intervention that uses evidence-informed resources and decision-support tools. Its aim is to improve the quality of response to children and youth with mental health and addiction (MH/A) needs in the ED, and to ensure timely referrals and seamless transitions to relevant community follow-up services.\footnote{1,2}

<table>
<thead>
<tr>
<th>Brief Summary of Intervention</th>
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<tbody>
<tr>
<td><strong>Population</strong></td>
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<tr>
<td>Designed for children and youth (ages 17 and under) with MH/A needs.</td>
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<tr>
<td><strong>Gap addressed</strong></td>
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<td>Community–hospital / hospital–community transitions.</td>
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<td><strong>Core integration/transition strategies</strong></td>
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<td>Recommended minimum standards of care: a) access by ED staff to a child and youth MH/A clinician (CY MHC), 24/7; b) standardized self-screening tools for MH/A; c) a memorandum of agreement (MOA) between the ED and each community-based agency to define referral procedures and expectations.</td>
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<tr>
<td><strong>Services, sectors, levels of care involved</strong></td>
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<td>Health sector (hospitals); community (children and youth MH/A) services.</td>
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<td><strong>Resource requirements, feasibility</strong></td>
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<td>Human-resource intensive. Some components might be time-consuming to draft/implement (especially the MOA) and require system-level changes.</td>
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<tr>
<td><strong>Readiness for implementation</strong></td>
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<tr>
<td>Well-defined list of components but lacks detail on the processes involved. A variety of resources available that can be adapted.</td>
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<tr>
<td><strong>Effectiveness evidence</strong></td>
</tr>
<tr>
<td>Not yet implemented and tested in actual practice.</td>
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**Population**

The Clinical Pathways is designed for children and youth up to age 17 with MH/A needs, but could be adapted for young adults up to 24. It doesn’t address cultural diversity and health equity, although these could be considered when planning the implementation. It also doesn’t address discharge from inpatient units or the unique needs of individual service sectors, such as justice and education.

**Key Components**

The Clinical Pathways was developed by a working group of the Child and Youth Advisory Committee of the Provincial Council for Maternal and Child Health. The intervention is documented in the
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Committee’s final report,¹ and summarized in an overview document.² The report describes three key components to ensure smooth transitions, which they call “minimum standards” of care:

- ED staff must have 24/7 access to a specialized CY MHC to ensure that crisis services are available, either on-site or via mobile-crisis services or videoconference.
- Standardized triage and screening tools:
  - After triage, all MH/A clients and their caregivers are asked to complete three standardized self-screening tools. This information informs other assessments and referrals, and serves as a minimum information set that follows the client. The recommended screeners are:
    a. The Children’s Hospital of Eastern Ontario (CHEO) Caregiver/Youth Perception Survey (C/YPS) - A general MH/A screening tool;
    b. The Risk of Suicide Questionnaire (RSQ-4);
    c. In-depth short screeners - Paediatric Symptom Checklist (PSC) for children under 12 and Global Appraisal of Individual Needs - GAIN Short Screener (GAIN-SS) for youth age 12 and older.
- Each community should implement an MOA between the ED and each child/youth mental health agency to define referral procedures and expectations.

In addition to the three minimum standards, the report lists, but does not fully describe, several other recommendations for system improvement (e.g., use of tele-mental health, implementing wait-time strategies, and better communication among the wider circle of care).

The proposed process for the Clinical Pathways is as follows:

- The child/youth moves from triage and potentially treatment in the ED to a self-screening phase using the standardized tools that the youth/caregivers fill out in the waiting room;
- A MH/A clinician or physician assesses the child/youth and then decides whether to:
  - Refer immediately to a MH/A specialist with the possibility of admission;
  - Refer as an outpatient (with telephone follow-up within either 24 hours or 7 days); or
  - Offer follow-up with a primary care provider after the child/youth is sent home.
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**Resources Required/ Feasibility**

**Human Resources**
Some hospitals and community agencies may already have some of the necessary functions in place, but others may need to make changes, such as changing existing roles or creating a new 24/7 clinician position to:

- Conduct interventions;
- Plan treatment and discharge with the ED team; and
- Work with community MH/A providers to make sure clients have timely access to services.

The report describes the role and recommended competencies of the CY MHC. The specific qualifications for this role can vary, as long as the individual is a registered health professional. The recommended qualifications range from a Bachelor or Master’s of Social Work, to Registered Nurse, to Psychological Associate or Psychologist. The report also suggests that an experienced BA-level child and youth worker can be employed as long as they’re supervised.

A hospital and community agency may find other ways to provide this function without creating a new full-time role. The ED and community agency may need to change staff roles and procedures to fulfill the elements of the MOA.

**Training Needs**
When assigning resources, it’s important to budget time for staff to train on how to administer, record, and interpret the information from the screening tools.

**Administrative and System Supports**
It may be necessary to change health records forms and charting procedures.

The MOA between the hospital and community agency is a collaboration tool that helps create system-level change. These agreements take a lot of effort to finalize as they define referral procedures, expected response by care providers, and agreements on information sharing, timeliness, and client support during the transition. It may be necessary to make system-level changes to fulfill all the elements of the MOA.

A major determinant of success is the buy-in and commitment from all stakeholders, especially from the hospital ED.
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The report also suggests a number of other components of the pathway that should be in place (e.g., terms of reference, standardized screeners, MOA between the hospital and community agency).

In addition to its three minimum standards of care, the report lists a number of other recommendations for system improvement. These are:

- Optimal use of tele-mental health;
- Streamlined access to inpatient beds;
- Implementation of a wait-time strategy;
- Diversion from EDs, when possible;
- Greater focus on addictions/substance use; and
- Better communication among the wider circle of care.

The report does not include any details or suggested interventions for these additional recommendations.

Evidence

The working group that developed the ED Clinical Pathways outlined a series of recommendations for ED staff to effectively care for children and youth with MH/A needs and ensure they transition successfully into the community. The working group included multidisciplinary experts from ten EDs and 11 community agencies from several Local Health Integration Networks (LHINs).

The report describes the methods used to develop the Clinical Pathways, which include the use of an interdisciplinary expert panel, a broad scan of current practice, and feedback from a wide group of stakeholders. The report’s authors interviewed representatives of ten EDs from six LHINs, and 11 community agencies from seven LHINs, and reviewed the research literature to identify suitable screening tools.

The report recommends procedures that appear to be founded on accepted best practice and informed by research literature and the experience of credible leader-practitioners (for example, standardized screening tools such as the GAIN-SS).

The Clinical Pathways hasn’t been tested as a complete intervention or implemented in actual practice. Currently, there is no evidence available on its effectiveness, including its impact on return visits to the ED and transition to community follow-up care.
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Readiness for Replication

The report provides a well-defined list of the intervention’s components as well as appendices with a variety of materials that can be adapted to the local environment:

- Detailed recommendations and templates for discharge/referral protocols, MOAs between service providers, and a template for scanning current state resources and capabilities;
- Copies of the screening tools (C/YPS, RSQ-4, PSC, and GAIN – SS).

These materials and tools provide enough detail to measure fidelity to the model and outcomes, and for users to decide whether the intervention will meet the local need for system improvement.

Sustainability

Once the Clinical Pathways is in place, it should be possible to sustain the new procedures (e.g., screening tools) with low cost. The role of CY MHC would need to be permanent and new ED staff would need training on how to use the screening tools. The MOA provides the basis for stakeholders to stay committed to the new procedures.

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References

We welcome your feedback!

This summary is one of a number of transition/continuity of care practice summaries developed by EENet and the Performance Measurement and Implementation Research (PMIR) team, which are part of the Provincial System Support Program (PSSP) at the Centre for Addiction and Mental Health (CAMH). The purpose is to support the selection of an evidence-informed intervention by Ontario’s Systems Improvement through Service Collaboratives (SISC) initiative. It was designed to give the reader a starting point in understanding the intervention along a number of dimensions.

The intervention summarized in this document was identified through a targeted search of the scholarly and grey literature, and key informant suggestions. The summary was developed from a selected review of reports and journal articles. The evidence review section examined quantitative effectiveness studies only. Other issues, such as acceptability to users and cost effectiveness, are also important to examine but were out of scope to review in the available time frame.

This summary is a living document and the information on which it is based may evolve over time. While great care was taken to prepare this summary, we acknowledge the possibility of human error due to search limitations and rapid timelines. Therefore, we do not warrant that the information contained in this document is fully current, accurate, or complete. If you have any comments or suggestions to improve its content, please contact us at eenet@camh.ca.