



INSTITUTE FOR BEHAVIORAL HEALTHCARE IMPROVEMENT



Sinai Health System

**Improving Emergency Department Care
for Behavioral Health Clients -
Some structural and procedural Best Practices
A Webinar on Practice-based Best Practices
October 12, 2011**

Leslie Zun, MD Chair, Department of Emergency
Medicine Mount Sinai Hospital and Chicago
Medical School & **Chair - National Update on
Behavioral Health Emergencies**

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Aims for the Webinar

- Describe Approaches for Improving operations for BHC patients seen in EDs
- Share results for improved flow and reduced overall time
- Describe Mt Sinai Health System Experience
- Give a brief description of the Nov30-Dec2 program in Las Vegas
- Answer questions – Share ideas

Current Situation

- 2 Million people seek care for Behavioral Health Care problems each year in hospital EDs – cost about \$4 billion; 25% or 1 Billion is largely waste
- Much variation in ED expertise and training in MH/CD problems, leading to inadequate care and negative patient experience
- Staff often feel burdened by behavioral health patients
- Several other issues



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Opportunities

- EDs have many preventable staff Injuries
- The problem with behavioral health patients in the ED is multi-faceted; with challenges of access to care etc.
- Administrators often view BHC in the ED as inefficient, costly & under reimbursed.
- Data shows improvements in BHC improve care to general acute and primary care patients, and vice-versa. **And** it is a crucial first step to reducing loss of life, and improving other outcomes
- Persons with serious mental health issues lose 25 years of life expectancy. A lack of coordination between general and behavioral needs is a **prime contributor**.



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Starting Improvement Efforts

- The model for improvement: will, ideas execution &
- PDSA - Tests of Change
- The Importance of a team and top level support -Recruiting a team
- Understanding your ED as system of care
- Involving consumers
- Setting goals



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Measuring Outcomes

- Why this is crucial
- Establishing measures
- Getting data

IBHI Collaborative Measures

- Average Time of Patient Arrival to Triage
- Average Time of Patient Arrival to Interaction with Mental Health Professional
- Average Length of Stay in Emergency Room for Mental Health Patients
 - By Disposition
 - SPOE Evals only
 - Left Without Being Seen
- Number and Percent of Mental Health Patients Placed in Restraints in Emergency Room
- Average Time Mental Health Patient in Restraints in Emergency Room
- Willingness to Recommend

Achieving Improvement

- Where do Good Ideas come from?
- How do you Test and Adapt them?
- The importance of gradual implementation
- Key areas to consider – Agitation; suicide
- The value of the Change Package –Ready
Access to Good Ideas



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Program Improvements Innovations and Changes

- Changed policies on disrobing. Using paper pajamas and scrubs
- Train all staff on reducing agitation Including security staff
- Establishing crisis beds outside ED
- Use of a nurse practitioner
- Behavior health professional as greeter
- Distinguish medical or more severe psych pts from those to be referred to outpatient settings



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Achieving “Throughput”

- Keys to placement
- The In-patient connection
- Establishing community contacts



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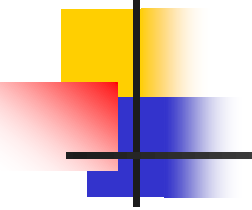
Program Improvements and Innovations

- Working with ED to see themselves as treatment setting as well as triage
- Developed a short suicide screening tool
- Made environmental changes, painted unit, improved lighting, redesigned entry door to prevent elopement

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The Mt Sinai Experience

- What we did
- Who was involved
- What the result was

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MP 30 Model

Mount Sinai Hospital

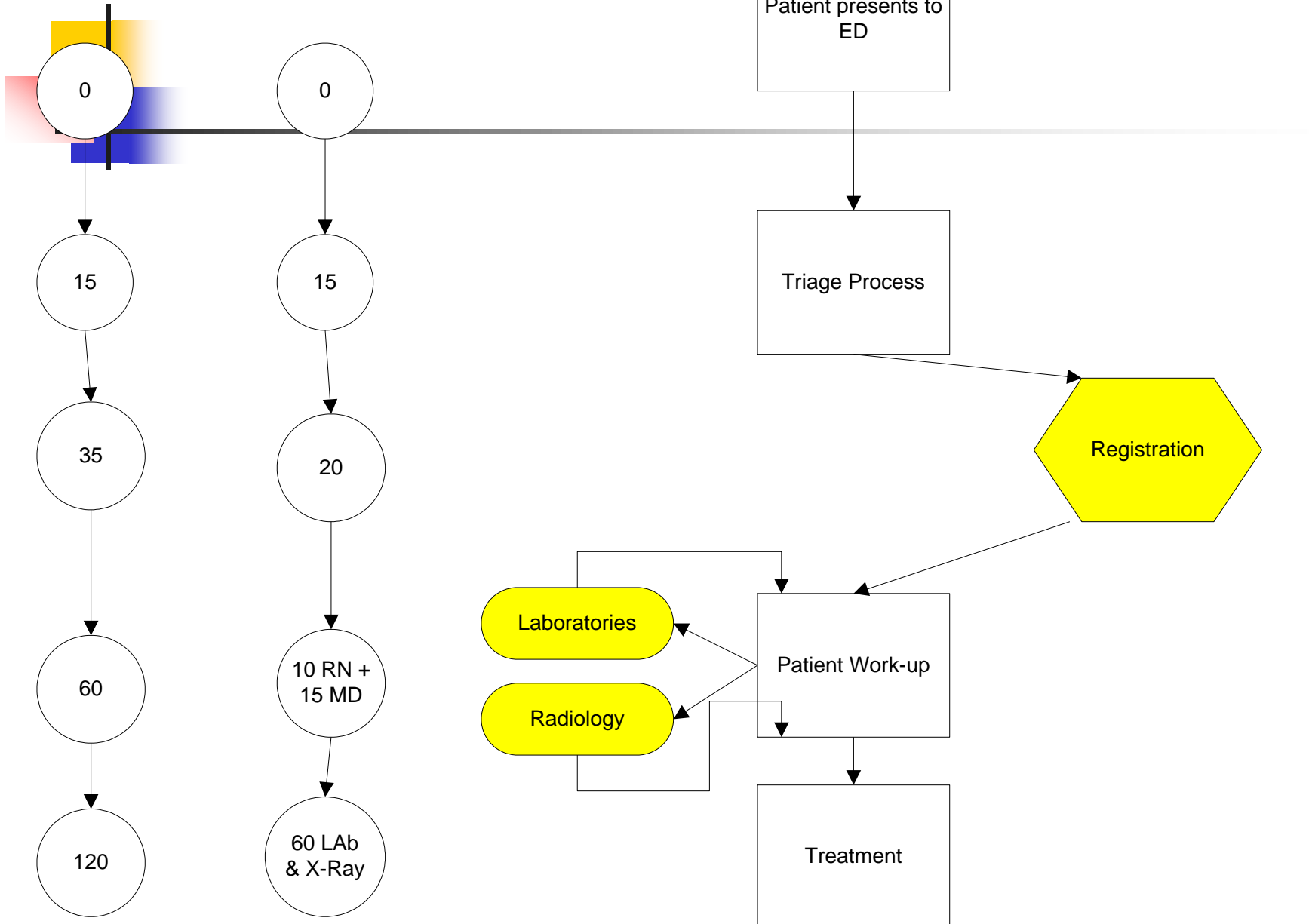
- What worked?
- What didn't?
- Where we still struggle?

Flow Diagrams

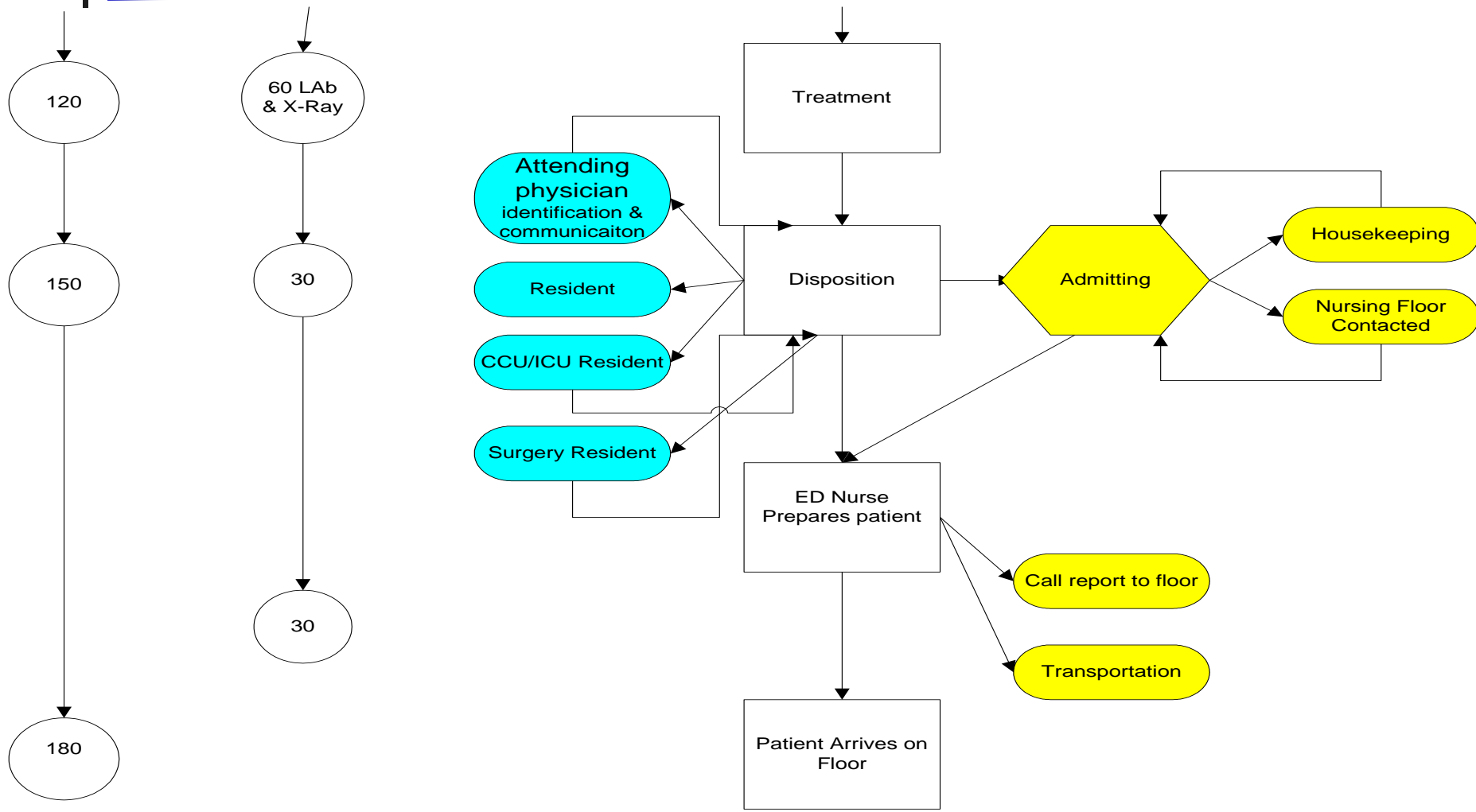


Time Elapsed

Time Allocated



Flow Diagrams



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Door to Physician in Minutes 30 Initiative

- Top down, bottom up initiative
- Rapid cycle time – 6 weeks
- No additional dollars to be expended
- Goals
 - Door to doctor < 30 minutes
 - Left without treatment < 2%
- Process
 - Every department and service represented
 - Self-directed change in efficiency
 - Efficiency ideas presented to ED management

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Prior to Start (February 2006) Benchmarks

	Current	Goal
■ LWOT Rate	10.1%	<2.0%
■ Door to ED Room	72 min	30 min
■ Door to Fast Track	57 min	30 min
■ Decision to Bed	159 min	1 Hour
■ Door to ED Dispo	6.8 hrs	3.0 Hrs
■ Door to Fast Track Disposition	3.4 hrs	1.5 Hrs

Nursing Interventions

- RN standing orders in triage
- Shortened triage process
- In-room registration
- Changed role of the charge nurse
- Staff cross trained to do resp care, transport, ABGs or EKGs
- Proper medications kept in ED
- Ensure enough equipment and supplies - carts
- Quick fill of open RN positions
- Move equipment close to staff
- Quick fill of RN positions

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Fast Track/Minor Care Interventions

- Added one exam room
- Changed patient flow in the fast track
- Registration in fast track
- Additional staff to include RN and MD (pediatrician)
- Moving patients to waiting room awaiting test results



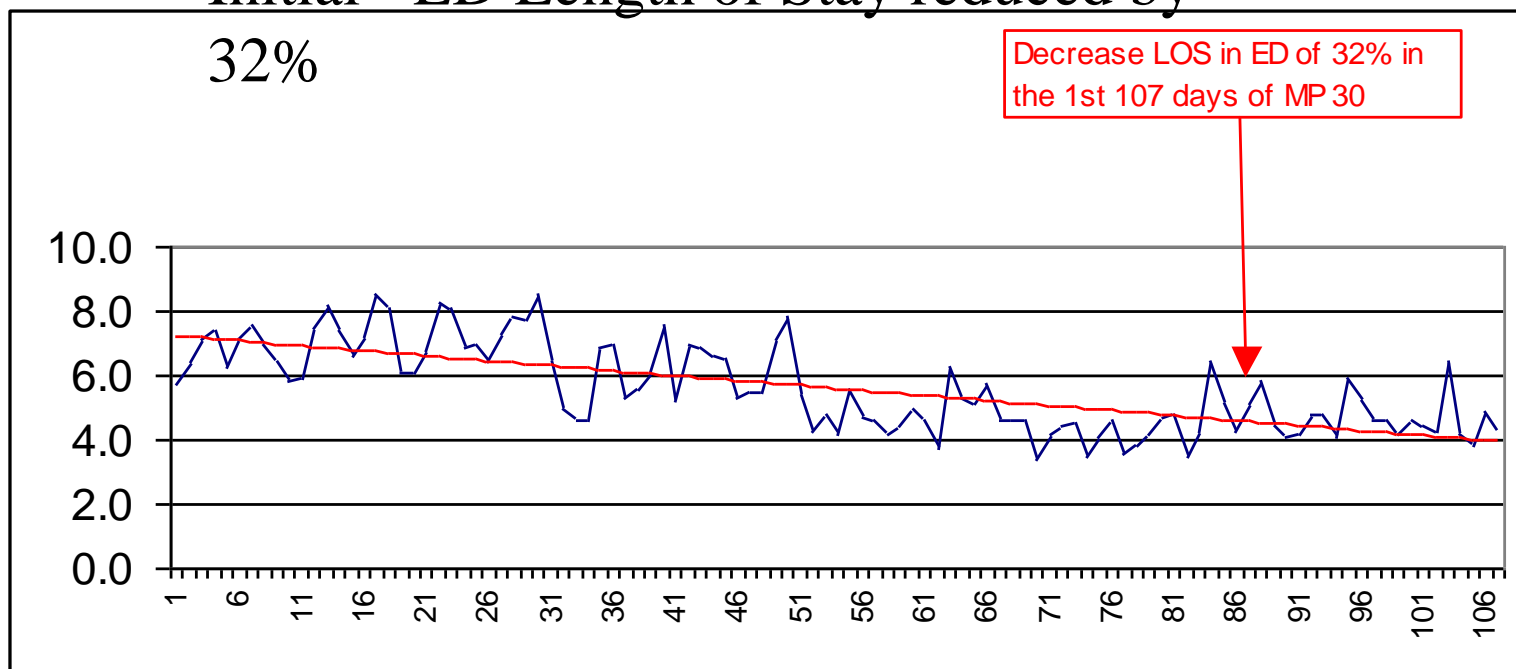
Hospital Interventions

- Bed Control
 - Started Bed Resource Coordinator
 - Changed who controls beds
 - Bed meetings
 - "A bed is a bed"
 - Bed cleaning priority
 - Telemetry and Critical care admission criteria
- Admissions
 - Admit unit
 - Admitting nurse
 - Fax report to the floors

Results

Initial - ED Length of Stay reduced by

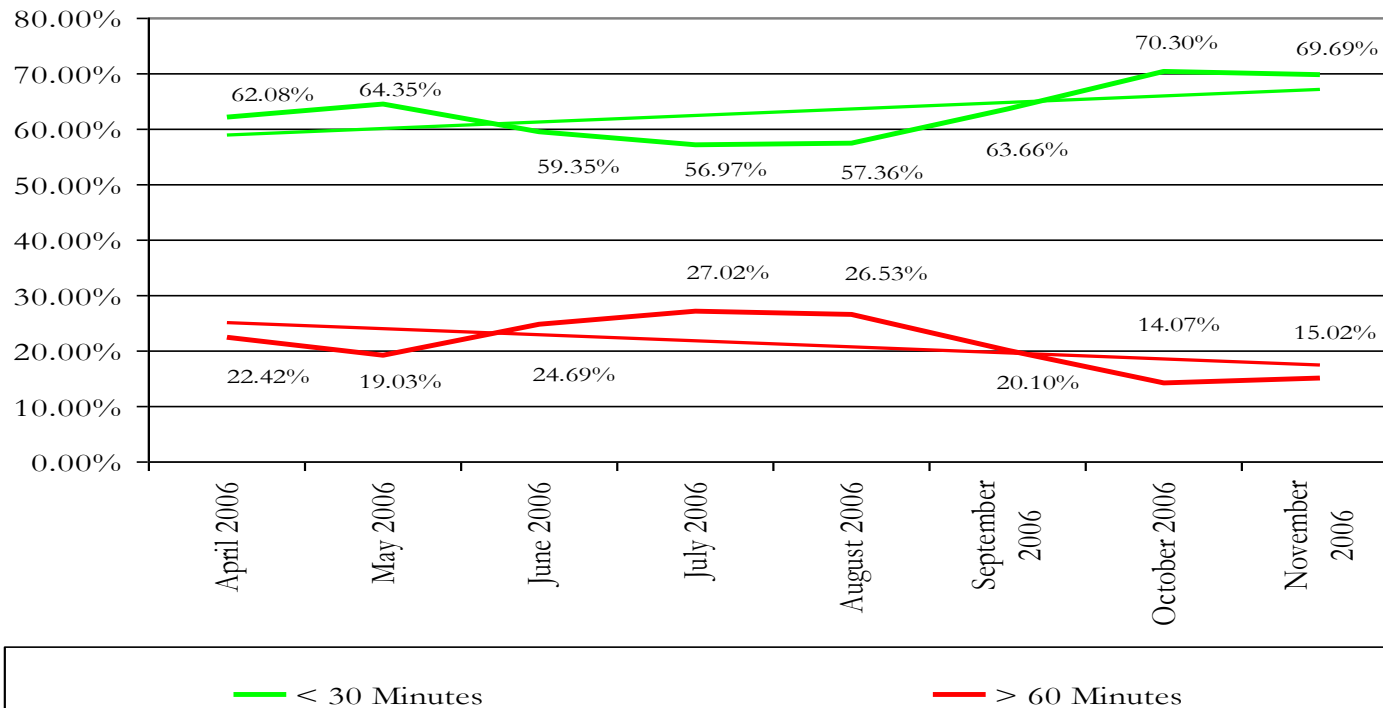
32%



Recent – 242 minutes (4.03 hrs)

Initial Results

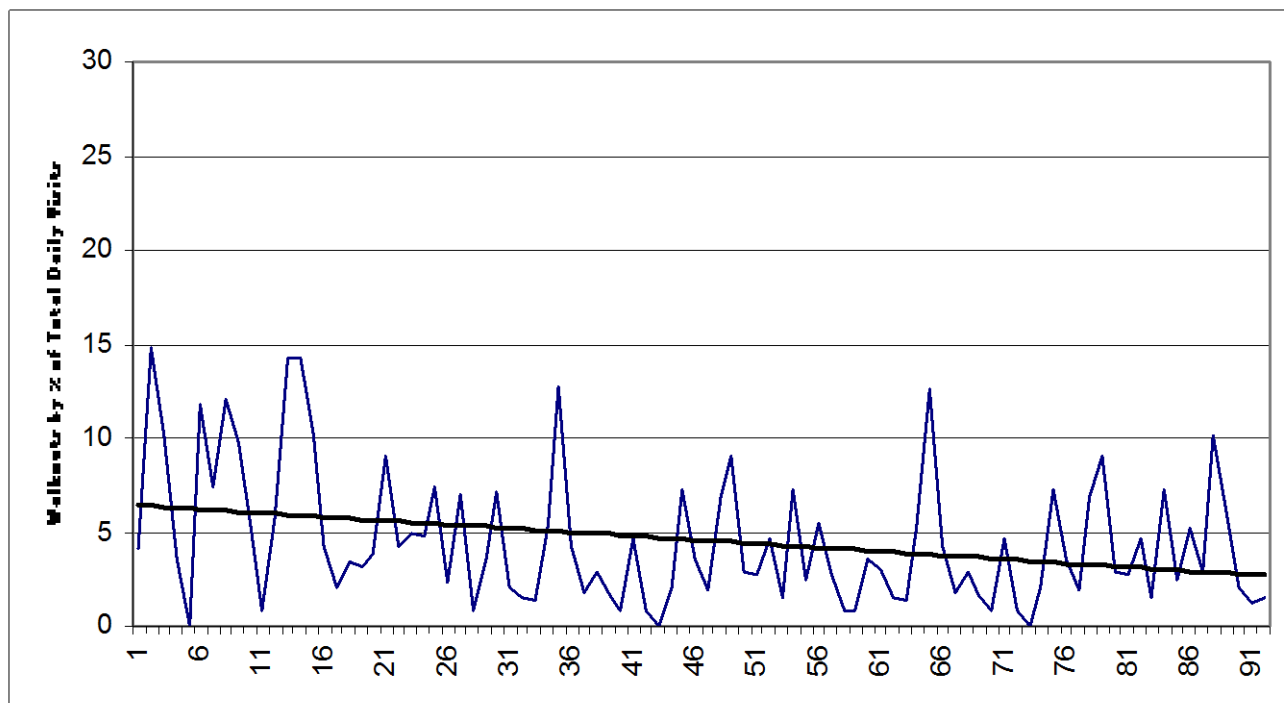
Door to ED Provider Daily Average Since MP30 Inception (Goal < 30 Minutes)



Recent Results – 53%

Results

Initial - Left without treatment reduced by 60%



Recent results – 1.6%

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Recommendations

- Who to involve?
 - Full engagement from the top down
 - Input of line staff
 - Involvement of all departments
 - Commitment from the medical staff
- What process to use?
 - Rapid process redesign
 - Lean management
 - Look for “low hanging fruit”
 - Quick fixes

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Recommendations

- Understand patient flow
 - Consider best practices
 - Where are the opportunities
 - ED and inpatient considerations
- ED Considerations
 - Quick triage
 - Bedside registration
 - Urgent care area with dedicated staff
 - Point of care testing
 - Increasing physical plant not necessarily the solution

National Update on Behavioral Emergencies

Conference objective – to improve the knowledge about psychiatric patients and to enhance collaboration among care givers in the emergency department for patients with behavioral emergencies.

Invited participants – emergency physicians and nurses, physician assistants, psychiatrists and psychiatric nurses, mental health workers, psychologists and social workers.

Speakers

Les Zun, MD – Conference Chair

Jon Berlin	David Howes	Denak Robinson
Benjamin Bragman	Pat Lee	Richard Shih
Peter Brown	JD McCourt	Ed Sloan
Sadie Bruch	Joseph Monahan	Amy Swartz
Glenn Currier	Tony Ng	Chuck Weiss
Suzanne Doolley-Hersh	Jagoda Petic	Michael Wilson
Aurien Fildes	Seth Fowles	Scott Zeller
Roberta Glick	Michael Pulla	
Clarke Gray	Divy Ravindranath	

Endorsements

Sinai Health System
The Chicago Medical School
American Academy of Emergency Medicine
American Association for Emergency Psychiatry

CME Approved for ACEP & ABMA Category 1 Credit
CEUs available for RNs, PNs & SWs

Registration Fees \$495 in advance

\$600 at the conference

Reduced fee for residents and students
(All fees are non-refundable)

For more information contact: Thana Burke, Conference Coordinator
Phone: (773) 257-6588 • E-mail: burth@sinai.org

To register on-line go to www.behavioralemergencies.com

SAVE THE DATES!

December 1st & 2nd

Flamingo Las Vegas

Pre-Conference Seminar - November 30

\$250 in advance \$350 at the conference

Systems Change and Flow Improvement for Behavioral Health Clients in the ED. Sponsored by Institute for Behavioral Healthcare Improvement
For more information: www.ihbi.net/ibhabe2011seminar

The only 2-day conference on Behavioral Emergencies

Topics and Schedule (Tentative)

Day 1 - Thursday, December 1

- Is Testing Needed: Medical Clearance Process
- Reducing My Agitation with the Agitated Patient
- What Does the Toxicology Screen and BAL Mean?
- Is the Patient on Drugs or Withdrawing?
- Psychiatric Boundaries in the ED
- Identifying and Assessing Suicidal and Depressed Patients
- They are Not Little Adults: Pediatric Psychiatric Emergencies
- PTSD: Psychology Manifestations of Disorders and Terrorism
- Collaborating with Inpatient Psychiatry
- The Delirious Patient
- Transfer and EMTALA Regulations
- Gaining Consensus on the Agitated Patient: BETA project
- Caring for the Psychiatric Patient - How Does It All Add Up
- Adverse Events Associated with Psychiatric Medications

Day 2 - Friday, December 2

- Difficult Psychiatric Presentations: Personality, Factitious and Sociopathic Disorders
- Behavioral Issues in Traumatic Brain Injury
- Role of Telepsychiatry
- I Feel Anxious and Panicky
- I Hear Scary Voices
- Informed Consent, Civil Commitment and Other Legal Issues
- Process Improvement Examples
- How to Evaluate and Treat the Eating Disorder Patient
- Using Advanced Interviewing Techniques
- Effective De-escalation Techniques
- Safe and Appropriate Restraint and Seclusion Utilization
- Brief Interventions in the ED
- Scientific Session/Research in Emergency Psychiatry

Competency Examination (additional fee)





Contact Information:

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- **Peter Brown**, Executive Director, IBHI peter@ibhi.net; (518) 732-7178 www.ibhi.net

- **National Update on Behavioral Emergencies**
November 30-December 2, 2011, Las Vegas, NV
<http://www.sinai.org/conference/conference.asp>

- Thank You