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Improving Care for Behavioral Health Clients Treated in Hospital Emergency Departments

A Webinar on a Pioneering Learning Collaborative

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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

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ED Environment Hazards

- Of 104 California hospitals surveyed in the LA & Bay Area 65% reported injuries to staff, visitors or patients as a result of violence. In 41% of cases a gun was used
- A survey of 1,209 emergency room nurses, 69.5% reported at least one assault during their careers
- 36.3% had been assaulted at least once the previous year.
- Dealing with irate people, “people want everything done immediately. They always perceive themselves as in an emergency whether they are or not”.
- 32% of ER staff report at least one verbal threat each day; 18% said weapons were displayed threatening staff once a month or more. 43% report physical attack once a month.
- Patient death in restraint stories

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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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Change Package

- Change Package addresses Problems, Strategies, Change ideas, Barriers/ concerns/outcome measures. It is built on IHI ED work plus specific BHC issues
- Emphasis in Three Domains;
  - Clinical Outcomes and Operations,
- Patient Satisfaction and
  - Staff Satisfaction

Problem	Strategies	Change Ideas	Barriers/Concerns
1) Some psychiatric emergency patients present with agitation and aggression, which poses a risk to staff and self.	**A) Manage agitation and aggression effectively and with least invasive method.** B) **Work continuously to reduce use of restraints and seclusion**	-Train staff in de-escalation techniques -Develop standard operating procedures for step-wise approach to agitation& aggression consistent with JCAHO and Expert Panel recommendations -Identify environmental and ED process "trigger points" that tend to increase agitation -Adopt JCAHO standards for restraints -Adopt Expert Panel consensus on step-wise management of agitation, including the medication recommendations -Increase understanding of the long-term negative effects of excessive coercion	Highly agitated patients hard to address General care staff not prepared to address these patients Hospital protocols exacerbate problems ED culture creates false expectations

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Change Package: Example

- Manage agitation and aggression effectively
  - Train all staff in de-escalation techniques at least yearly
- Work continuously to reduce inappropriate use of restraints and seclusion
  - Develop standard operating procedures for step-wise approach to agitation
  - Identify environmental and ED process “trigger points”, or points that tend increase agitation and aggression
  - Promote a culture of respect:
    - Understand long-term negative effects of excessive coercion
    - Importance of obtaining patient collaboration and cooperation
    - Clothing removal – is it necessary?

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Measures Agreed Upon

- Time from door to “discharge” from ED
- Time from door to behavioral health assessment
- Number and percent of clients placed in restraint
- Average time in restraint
- Willingness to recommend to others (Satisfaction)

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Initial Key Observations From Hospitals:

- Need for community outreach and collaboration
- Standardization of lab tests and tox screens
- Medication protocols and algorithms- Need for more understanding on medication sedation
- Access to BH specialists (adult, adolescent, CD)
- Transportation improvements moving and receiving BH patients
- Police and security integration and education
- More emphasis on suicide assessment and measurement
- Patient rights concerns (disrobing)
- Lowering agitation levels and use of restraints
- Evaluating the physical environment in the ED
- Customizing existing patient satisfaction tools to BH patients

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Assessment Scale for Breakthrough Teams

Assessment/Description	Definition
1.0 Forming Team	Team has been formed and baseline measurement begun
1.5 Planning for the project begun	Plans for the project made
2.0 Activity, but no changes	Team actively engaged but no changes have been tested
2.5 Changes tested, but no improvement	Components being tested but no improvement
3.0 Modest improvement	Initial test cycles completed-Moderate improvement
3.5 Improvement	Some improvement in outcome measures
4.0 Significant improvement	Evidence of sustained improvement
4.5 Sustainable improvement	75% of goals achieved
5.0 Outstanding sustainable results	Outcome measures at national benchmark

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Team Overview – Where are we now?

Hospital Team	Chicago	San Antonio
• Hospital 1	2.5	?
• Hospital 2	1.0	?
• Hospital 3	2.0	?
• Hospital 4	3.0	?
• Hospital 5	3.0	?
• Hospital 6	3.5	?
• Hospital 7	1.0	?

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Program Improvements, Innovations, and Changes

- Secret shopper assess engagement of BH patients
- Using paper pajamas and scrubs while some changed policies on dis-robing
- Training all staff on reducing agitation; Including security staff in training programs (one facility uses the Broset Scale)
- Establishing crisis beds outside ED
- Expediting movement into in-patient care
- Earlier discharges from inpatient psych facilities and earlier availability of discharge meds
- Begin development of rapid community placement

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Program Improvements & Innovations

- Developed a short stay unit 1-5 days
- Many experiments in triage; e.g.
  - 1) use of a nurse practitioner
  - 2) behavior health professional as greeter
  - 3) new triage system helps distinguish medical and/or more severe psych pts from those who can be referred to outpatient settings
  - 4) phone screening
  - 5) Having social worker in the waiting area

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Program Improvements & Innovations

- Developed and training specialized behavioral health crisis team to respond to BH emergencies. (“Code Purple”) Noted reduction of assaults on staff.
- Established protocols and workflow for medicating agitated patients and bringing in outside expert to discuss with MDs
  - Medication guidelines in the use of atypical anti-psychotics in addition to “typicals”
  - Adding Zydis ODT to Pyxisis
- Developing a psych transport vs police transporting patients
- Monitoring restraint process from common definition: to correct orders and documentation.
- Meeting with community physicians, community mental health programs, community agencies, and outpatient programs.
- Gero Community Diversion Program
- PES recidivist – system case conferences

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Program Improvements and Innovations

- Working with ED to see themselves a 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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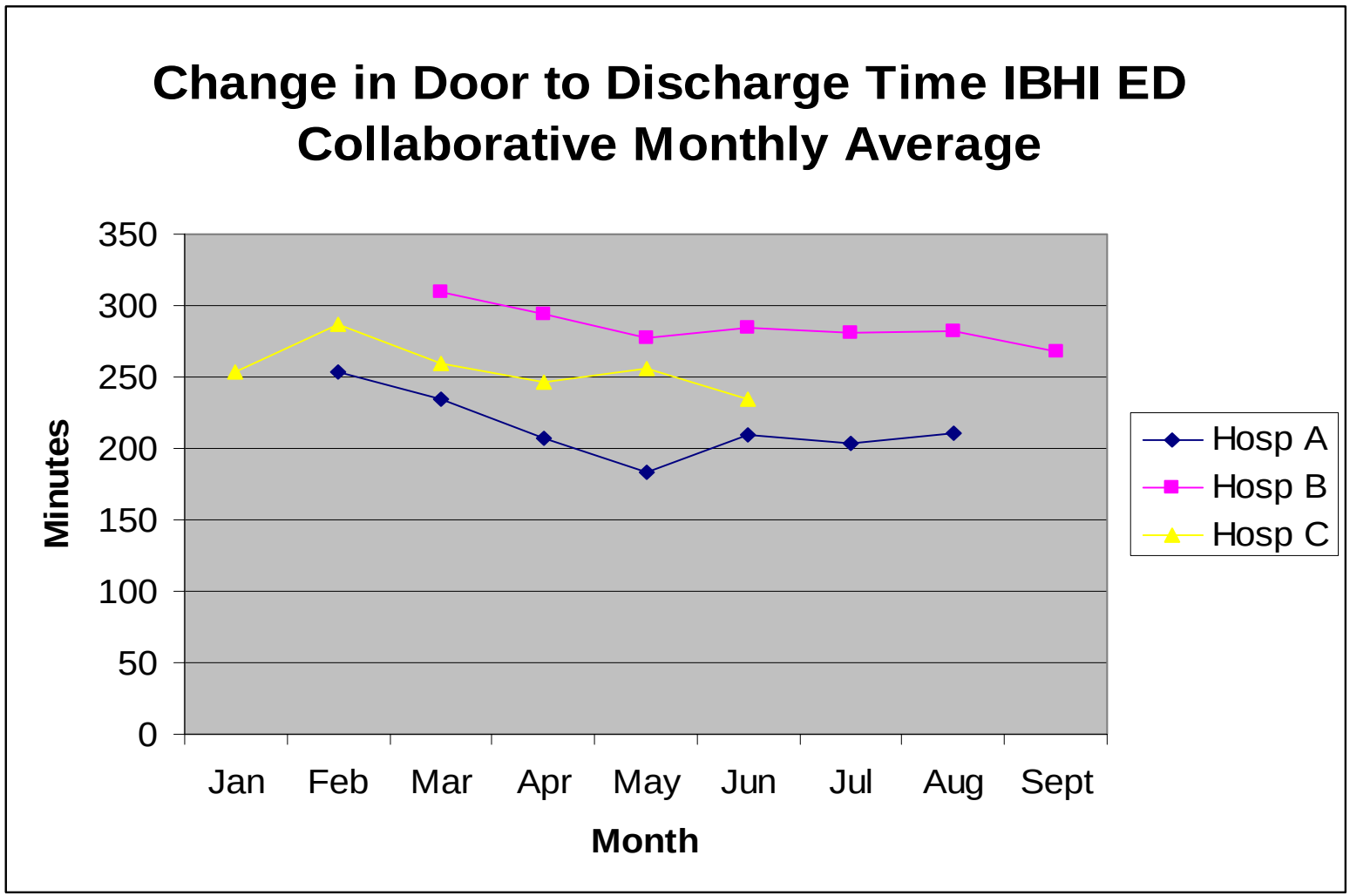
We Have Made Some Progress



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Results

- Decrease for some hospitals in overall time in the ER
- No significant change noted in time to BH assessment
- No significant change in restraint number
- Decrease in average length of time in restraint
- Almost no data collected on “satisfaction”

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Challenges

- Discharging from the ED and establishing timely placement and a hot handoff to community care
- Assessing suicide – there is no standard tool
- Obtaining patient satisfaction
- Implementing Agitation and Medication Protocols
- Involving peer counselors
- Modifying the physical environment
- Using small rapid tests of change
- Setting up System to Measure Results & Outcomes

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Things We Found Difficult and Suggestions

- Using rapid tests of change
- Measuring results particularly satisfaction
  - Identify key questions on satisfaction already collected by a data measurement and management team such as Press Ganey
  - Hold four week trial/pilot using standard manual data collection with three questions to be asked of consumers leaving the ED

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Work Group Recommendations

- Leadership didn't educate people well enough before we started
  - Time requirements
  - Data collection process
  - Importance of involving senior leadership

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Hospital 1

- Collegial relationship betw. ED and Psych and tensions lessened
- Operations Comm Mts Monthly
- Bi-weekly dashboard reports of 20 measures
- Community focus with increased crisis stabilization beds, new facility with 16 beds
- Increased patient satisfaction
- Quarterly Mtgs with Community is helping with reduced time to discharge
- County funded Gero Diversion program quite promising

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Hospital 2

- Single point of entry program has decreased avg time of pt arrival to triage, time to MH Prof, and increased number of patients evaluated, reduced number of patients who leave without being seen
- Lowered number of patients who are sent to the ED
- Total time in the ED has decreased
- Restraints have declined along with avg timje in restraints
- Worked with Press Ganey willingness to recommend
- EDIT (Emerg de-escalation interv tr) everyone trained
- Developing 2nd triage area

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Hospital 4

- Moved from on site to consultation model
- Patients must be medically cleared before transfer to MHERE
- Alcoholics discharged from the ER vs transferring to MHERE
- Decreased number of restraints thru IMAB training and use of de-escalation techniques, early use of anti-psychotics, use of time out room, and one to one psych aide, use of diversion activities,
- No longer extended stay in MHERE
- Increased focused on community resources and discharge planning including NAMI, referral form, vouchers for transportation, 2 ACT teams, homeless shelter, and med refills
- Overall ED/MHERE alos has reduced

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Hospital 5

- Psych ED, 70 adult inpatient beds in the NCB hospital
- Demographics largely Hispanic and Blacks
- Restraints – Intensive 2 day training involved hospital security
  - Monthly mtgs to review all secl/rest
  - Viol reduction protocol
  - Results in lower number of restraints compared ot other hospitals in corporation without incr in staff/pt injuries
- Focusing on continuous educ of staff and incr flexibility, eg free phones, healthy snacks, grooming supplies, showering as requested, Changing nursing culture
- Decreased los by approx 2.5 hrs
- Evaluating readmissions and working on dual dx dispos
- Studying pts with multiple visits and engaging community resources including comm residential providers, mobile crisis teams
- 71.7% of pts found care excellent or good.

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Hospital 6

- Improved ED/BH relationships, bi weekly workgroup meeting, monthly MD mtg
- Increased ED Psych bed capacity, opened short-stay unit, improved physical space to incr safety
- Increased ED Crisis SWs, added psych w/e call rotation, moving from uniformed security guards to psych aids
- Incr. educ/training to identify hi-risk pts, teach de-escalation, use meds in earlier and standardized fashion
- Psychiatrists will manage pts vs consultation model
- Psych emergency response protocol
- Sampling restraints unable to consistently measure, issues of definition of beh vs medical restraints
- Showing increased of use of psychotropics
- Developed round table leading to ability to divert ambulance traffic to other hospitals
- Decreasing inpt. also, psychiatrists taking more responsibility- noon d/c
- Working more with referral resources. Showing good improvement
- Decreasing wait time in ED for BH intervention
- Challenges including budget reduction, decr in ED BH beds,