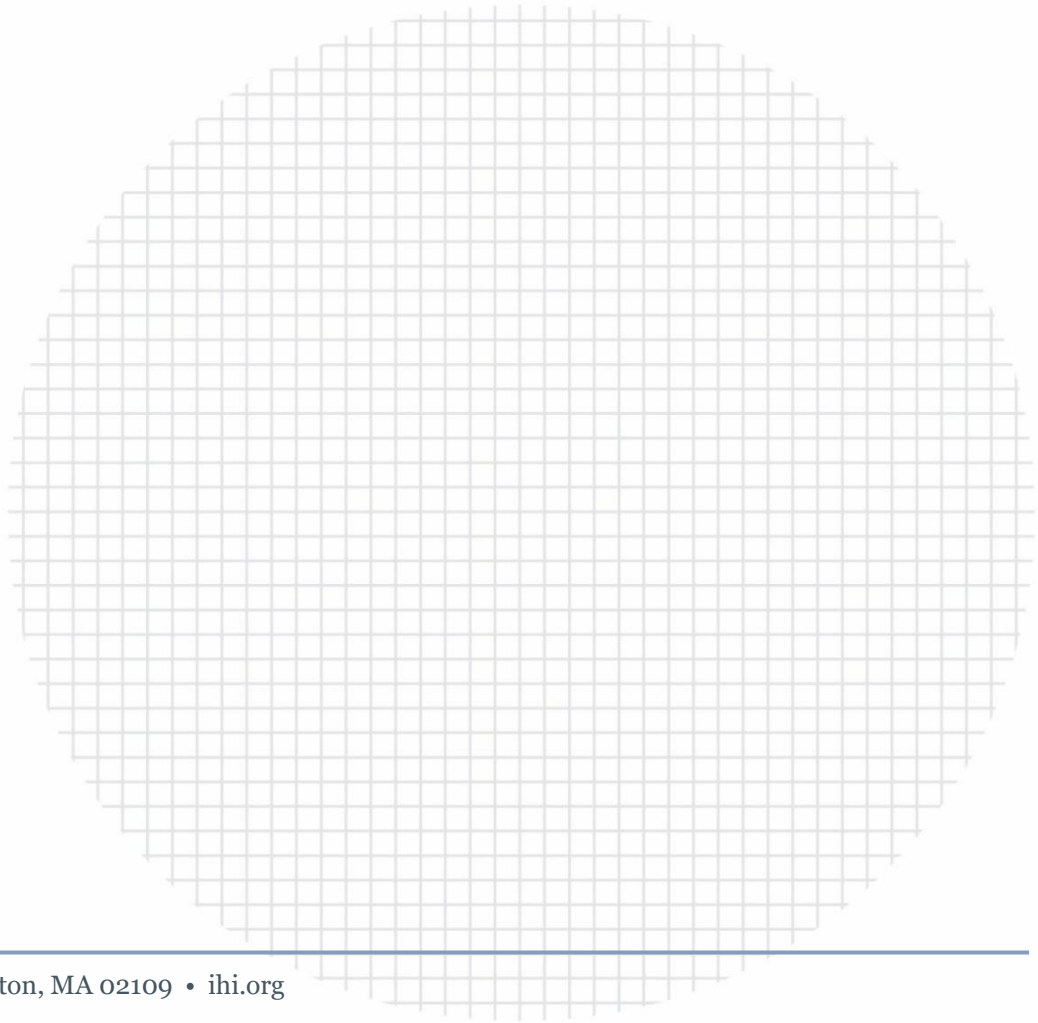
Institute for Healthcare Improvement

Improvement Stories:

Improving Behavioral Health Care in the Emergency Department and Upstream



AN IHI RESOURCE

53 State Street, 19th Floor, Boston, MA 02109 • ihi.org

How to Cite This Document: *Improvement Stories: Improving Behavioral Health Care in the Emergency Department and Upstream.* Boston, Massachusetts: Institute for Healthcare Improvement; 2020. (Available on ihi.org)

Acknowledgments:

IHI is thankful to Well Being Trust for their generous financial support of the Integrating Behavioral Health in the Emergency Department and Upstream (ED & UP) Learning Community, and for their thought leadership and partnership throughout the initiative. The content in this document does not necessarily represent the views of Well Being Trust, its board of directors, or its staff.

IHI is thankful to the US hospitals that participated in the ED & UP Learning Community, whose pioneering work and generosity enabled us to share their learning.

The authors would like to thank Rebecca Tuhus-Dubrow for her work on these improvement stories, and Val Weber of IHI for her editorial review of this content. We are also grateful for the thought leadership provided by IHI leaders and faculty for the ED & UP Learning Community.

Contents

Introduction

Throughout the United States, individuals with mental health conditions or substance use disorders frequently present at hospital emergency departments (EDs) for care, yet many ED teams lack the capacity to adequately support these individuals. To develop solutions to this challenge, the Institute for Healthcare Improvement (IHI), in partnership with Well Being Trust, convened eight US hospitals in the 18-month Integrating Behavioral Health in the Emergency Department and Upstream (ED & UP) Learning Community from March 2018 through August 2019.

The health care organizations participating in the Learning Community developed and tested changes to work toward the initiative's overall aim: to improve patient outcomes and experience of care and staff safety while decreasing avoidable repeat ED visits for individuals with mental health conditions and substance use disorders who present to the emergency department. Hospitals participating in the initiative demonstrated that it *is* possible to address these barriers and improve outcomes and experience of care for patients, their families, and ED staff — even in a deeply fragmented health care system and with payment models that do not yet adequately support transformative efforts.

These improvement stories present the experiences of the seven health systems that completed participation in the Learning Community, describing the focus of their efforts to improve care for this patient population, some specific changes they tested in their emergency departments, and early results.

For more detailed information about the specific changes tested by the hospitals participating in the Learning Community, read the IHI White Paper, *Improving Behavioral Health Care in the Emergency Department and Upstream*.[1] The white paper also presents a framework for a better system of care, suggested measures, practical tips and examples, and selected tools and resources.

Note: While the term "behavioral health" is commonly used to encompass a wide range of conditions, the improvement stories refer specifically to patients with mental health conditions and substance use disorders presenting to the emergency department.

[1] Schall M, Laderman M, Bamel D, Bolender T. *Improving Behavioral Health Care in the Emergency Department and Upstream*. IHI White Paper. Boston: Institute for Healthcare Improvement; 2020. http://www.ihi.org/resources/Pages/IHIWhitePapers/Improving-Behavioral-Health-Care-in-the-Emergency-Department-and-Upstream.aspx

Abbott Northwestern Hospital (Allina Health) Minneapolis, Minnesota

"Ted" is a 38-year-old man with severe mental illness who lives in the Twin Cities area in Minnesota. He is in outpatient treatment, but every few weeks he experiences an increase in paranoia, anxiety, fear, and suicidal ideation. When this happens, he usually comes to the emergency department (ED) at Abbott Northwestern Hospital in Minneapolis. He has often been admitted to the hospital for three to seven days for minor medication adjustments and then discharged. Occasionally he has stayed in the ED for a day or two before stabilizing and returning home.

When Abbott Northwestern Hospital joined the ED & UP Learning Community, one major motivation was to help patients like Ted. The team felt that Ted and other patients with mental health conditions and substance use disorders — who presented in the ED but didn't require emergency or inpatient care — were not getting their needs met in the optimal way. "What do they need?" asked Jackie Cooper, DNP, APRN, PMHNP-BC, a psychiatric nurse practitioner who works in the ED. "They need a space where they can come and talk to somebody. They need to get out of the general ED space into a quieter environment."

To meet this need, the ED team established a new six-bed observation unit (called the HOPE unit) in an area adjacent to the inpatient psychiatry unit for patients who do not require an inpatient referral, but who do need some immediate care prior to discharge. The goal was twofold: to avoid unnecessary inpatient admissions and alleviate demand on limited ED staff and resources.

The first challenge in creating the HOPE unit was to establish admissions criteria — to cast a net that was neither too wide nor too narrow. The team determined that patients with mental health conditions and substance use disorders who were expected to stabilize within 24 to 48 hours were appropriate for admission to the unit. Patients who had significant medical issues or had exhibited aggression were not admitted and stayed in the regular ED.

The team engaged patients and their families in designing processes for the unit, asking them for feedback during several workshops. Before the unit opened, patients and families participated in walk-through simulations of the processes and identified opportunities to help patients feel safer in the environment.

From January through July 2019, 128 patients were admitted to the ED's HOPE unit. "A lot of them didn't want to be hospitalized," said Cooper. "They felt like avoiding a prolonged admission was a good [arrangement] for them, so they could get back to work." The unit was much calmer than both the ED and the inpatient environment, with much more one-on-one contact with staff. The new unit "encouraged patients to take more ownership of their care," Cooper noted, prompting patients to consider, "What can I do in the next 24 to 48 hours to get myself well?" The majority of patients admitted to the HOPE unit were discharged home, while a smaller number were admitted to inpatient care or to longer-term residential mental health treatment.

One patient who benefited from the new observation unit was Ted. On two occasions, he was transferred from the ED to the HOPE unit, where he was able to access increased support and supervision. He was able to make contact with his mother and other outpatient supports before stabilizing and returning home.

The ED team encountered several challenges in creating the new observation unit. One was the isolated and small location of the unit, on the opposite side of the hospital from the ED. The unit is

considered an “extension of the ED” and its remote location, apart from other hospital units, makes it difficult to deploy resources (i.e., security, certain medications, additional staff) in a timely manner, posing a safety risk in the event of behavioral incidents or needs for emergency response.

Another challenge involves staffing on the HOPE unit, which has a dedicated staff of one social worker, one registered nurse, and one mental health associate. However, when the unit has no patients, the unit staff float to other hospital departments. Since the number of patients admitted to the observational unit greatly fluctuates, the ED team encountered challenges with immediately reallocating staff resources when even one patient was admitted to the HOPE unit.

Another significant challenge was determining the right mix of patients in the unit. “It was really difficult trying to balance the type of patients that might benefit with being a small, six-bed unit with one [team of] staff,” said Cooper. The unit consists of three rooms with two beds each. The team set rules against placing an adult in the same room with an adolescent, or a male in the same room with a female. These restrictions presented obvious barriers to taking full advantage of the unit.

Despite these challenges, the team saw promising results. One was a reduction in ED boarding time for patients with mental health conditions and substance use disorders. “Even if it was one or two patients, it did have a positive impact on boarding time and patient flow,” said Dana Alston, Clinical Operations Manager. Moreover, preventable readmissions have decreased. The HOPE unit is currently on hiatus, with an evaluation underway to determine the next steps.

Ted and his mother have both expressed appreciation for the HOPE unit. They are able to engage with the small observation care team, as opposed to a larger inpatient team, and are grateful for the closer engagement with unit staff compared to the chaotic inpatient environment. Ted is treated in a less restrictive environment and able to more quickly transition back to where he wants to be — home.

Cohen Children's Medical Center (Northwell Health) New Hyde Park, New York

When children and adolescents are struggling with serious mental health issues, their families often bring them to the emergency department (ED) because they don't know where else to turn. But the ED is not always the most appropriate option. This is a common challenge at Cohen Children's Medical Center (CCMC), the largest provider of pediatric health services in New York State. For example, if a teenage boy with severe depression comes to the ED, he doesn't need emergency or inpatient care, but he does need to be linked with services immediately — something for which the ED is not necessarily well-equipped.

To fill this gap, in early 2018, CCMC established a behavioral health urgent care center known as the "BH Urgi" that is staffed by a full-time child and adolescent psychiatrist, a full-time licensed mental health counselor, and two full-time patient engagement specialists. "It was born from the idea that kids don't necessarily need the ED; they need access to mental health evaluation and a child psychiatrist… and then they need to be successfully transitioned to care in the community," said Dr. Vera Feuer, Director of Pediatric Emergency Psychiatry and Behavioral Health Urgent Care at CCMC.

When the CCMC team joined the ED & UP Learning Community, they had recently launched the BH Urgi and were working to establish and refine it. In the Learning Community, the team aimed to improve a related process: connecting patients with the appropriate level of care in the community. A key part of achieving that aim was building stronger community partnerships — with schools, pediatric practices, and community mental health centers. Several highlights from the team's improvement work as part of the ED & UP Learning Community are described below.

Relationships with Schools

Schools are the largest source of referrals for pediatric mental health treatment at CCMC. Their relationships with CCMC often start when schools request speakers about mental health, and Dr. Feuer visits the schools or Departments of Education to provide information about BH Urgi and other topics. At these presentations and through other channels, educators are equipped with knowledge on making appropriate referrals (thereby reducing unnecessary referrals to the ED). Sometimes "schools themselves want to come and see where this magical place is," said Feuer. "We've been having tours, introducing them to the care team." The CCMC team also tested creating a form requesting schools provide information about the reason for referral and background information on the patient.

Improved Access to Behavioral Health Care

After kids leave the ED or the BH Urgi, it's crucial that they transition to longer-term care. But historically, rates of post-ED follow-up have been very low. To change this, the team refers many patients to CCMC's outpatient clinic and established dedicated open-access hours for patients referred from the ED or the BH Urgi to ensure prompt follow-up appointment scheduling.

Some families, however, live farther away from the clinic and need referrals to external agencies. The team is working with agencies to which they commonly refer patients to improve the process of providing assessments, sharing recommendations, and transitioning care. They are also trying to establish efficient email communication channels and accelerate the process of setting up appointments. Dr. Feuer noted, "It's a work in progress."

Partnership with NAMI

Another way to increase follow up after ED discharge is to educate and engage families so they will understand the importance of ongoing care and emotional support. To pursue this goal, the CCMC team has cultivated a new partnership with a local chapter of the National Alliance on Mental Illness (NAMI). The NAMI representatives conducted a 12-week course at CCMC for parents taking care of children with a mental health diagnosis. Twenty families met weekly for 2.5 hours during the first course; a second offering is being scheduled. One parent commented, "The NAMI groups provided me with support, helpful information, and the opportunity to meet parents in my shoes, who were able to share their experiences. I finally was able to find the right help for my son. They were very helpful in providing me with direction during a difficult and confusing time."

Follow Up after ED Discharge

A final strategy is simple but important: making follow-up phone calls to mental health and substance use disorder patients after discharge from the ED. As a result of the team's work during the Learning Community, one of the ED's three social workers makes the first call within one week after ED discharge. If they don't reach anyone, they try two more times.

Because the team doesn't have the capacity to call all discharged patients, only about 50 percent, they've established a process where clinicians identify, during the ED visit, the families that will benefit most from a follow-up call. This change idea was the focus of the team's "first and most robust PDSA," Dr. Feuer noted. At first, the ED team tagged patients in the electronic health record by discharge acuity (i.e., the higher the acuity level, the sooner the social worker made a follow-up call). But, Dr. Feuer said, they soon realized that "in some ways that didn't really match the referral needs. A lot of kids who were high-acuity already had care and doctors."

The team discussed alternative approaches, eventually identifying a new process: prioritize families who seem resistant to follow-up care, patients who started on or changed medication, and patients who have been frequently returning to the ED. On the calls, social workers ask if there have been any other ED visits, any suicidal events, and whether the family has followed through with instructions such as locking up lethal means. Finally, social workers make sure families have appointments with clinics. "At this point it's really working quite seamlessly," noted Feuer. "It did take almost the full 18 months to get here."

Changing staff culture has been a challenge at times. For example, initially it was difficult for social workers to continue calling families, especially when calls went unreturned. To the social workers, it felt like "sort of forcing themselves on the families," said Dr. Feuer. It was important to engage the staff in the process, solicit their ideas about how to make changes and overcome challenges, and then provide them with the supervision and the support to follow through.

The CCMC team has achieved impressive results, reducing the time to get a follow-up appointment after a visit to the ED or the BH Urgi from about 14 days to 8 days. At the CCMC outpatient clinic, the average time to get a follow-up appointment is now less than four days. Over eight months, the team has referred 200 children and adolescents, with 90 percent keeping their appointments — an exceptionally high rate. With external clinics, the process is more complex and presents more challenges, but there has been a significant decrease in the number of days to get an appointment.

The team has also reduced the percentage of patients admitted to inpatient psychiatry. Before BH Urgi was established, about 21 percent of patients were admitted, and that figure has fallen to about 16 percent to 18 percent. Seven-day revisits to the behavioral health ED also declined from 7 percent in the first quarter of 2017 to 4 percent in the second quarter of 2019.

All of this work at CCMC is focused on one overriding goal: ensuring that children with behavioral health needs receive the right care.

"The Learning Community was an invaluable resource and helped us think about what we do differently, to embark on a systematic improvement journey, measure the change, and educate and engage our team," said Feuer. "Learning from the other teams as well as the camaraderie and working toward a common goal has been especially helpful. This journey is by no means over for us. The skills and knowledge gained will no doubt continue to help in making further improvements and creating community partnerships."

Hoag Memorial Hospital Presbyterian (Providence St. Joseph Health)
Newport Beach, California

For several years, the staff at Hoag, a health network in Orange County, California, noticed that the population of patients with mental health complaints (referred to as neurobehavioral health patients at Hoag) was growing. Throughout the network, about one third of all patients have a mental health or substance use diagnosis, but the health system does not have any psychiatric beds and many of these patients come to the emergency department (ED). At the same time, several incidents of workplace violence added urgency to the question of how best to care for agitated patients.

When Hoag was invited to participate in the ED & UP Learning Community, the response from Deb Diaz de Leon, Senior Program Manager of Performance Improvement, was, "That would be amazing — we need to do this work." Under the leadership of Dr. Michael Brant-Zawadzki, Senior Physician Executive, Hoag began making changes in their Newport Beach ED. Sponsored through the Neurobehavioral Health Institute, the Hoag ED & UP team included members from several departments and services, including community benefit, nurses, physicians, and many others involved in the different improvements that were tested and implemented.

One key change to improve care in the Newport Beach ED for neurobehavioral health patients involved a partnership with the National Alliance of Mental Illness (NAMI) to establish NAMI Connects. This program brings "NAMI peers" — individuals who have also struggled with mental health issues and are trained to support others — within the ED patient areas to talk with patients and provide information about local NAMI classes, which help patients and their families better understand their diagnoses and get on the path to recovery. Supported by a grant from Hoag, NAMI peers are available 40 hours per week in the Newport Beach ED and the team is hoping to spread the program to their Irvine ED. While NAMI peers serve as volunteers in some programs, at Hoag they are contracted, paid employees of NAMI.

Another major change was the introduction of trauma-informed care training developed by Hoag staff for nurses and patient care assistants at the Newport Beach ED. Kambria Hittleman, PsyD, Director of Neurobehavioral Health at Hoag, defines trauma-informed care as "creating an environment that understands what trauma is and the impact it has on our patient's functioning." The training — a two-hour, in-person, interactive session with a maximum of 12 people — is offered by Hoag staff for Hoag staff. It includes exercises, videos, and other activities to help people better understand the patients and themselves as staff. "If I'm a nurse and I have a patient who's agitated and aggravated and upset because they're in the ED, that may trigger something in me," said Diaz de Leon. Trauma-informed care "gives us tools in de-escalation and how to manage our own emotions."

For example, a 24-year-old male patient with exacerbation of schizophrenia was waiting in the ED for placement. He was highly agitated, yelling at and threatening staff, and spitting on the glass. Scott Surico, BSN, RN, Education Coordinator for Emergency Services and a neurobehavioral health advocate, asked the patient what might help make him calmer, discovering the patient believed Ativan was blowing through the air conditioning vents into his room, trying to drug him. Surico assured the patient that he would look into this. Within five minutes, an engineering staff member arrived and informed the patient that he added a filter to ensure that nothing could get through and the air conditioning was now clean. The patient stayed calm, watched TV, and did not

require medication or restraints. Although a filter had not in fact been added to the air conditioning, the patient felt that he was being taken seriously and calmed down. The patient accepted his oral medications and was transferred to an outside facility without further incident.

After seeing excellent results at the Newport Beach ED, Hoag leaders expanded the trauma-informed care training to the Irvine ED as well and have subsequently broadened the training to include all Hoag staff: "Anybody who touches patients clinically as well as at registration," said Diaz de Leon. Their goal is to train about 2,600 staff members by the end of 2019.

A third focus of improvement in the Newport Beach ED was reforming prescription practices for opioid painkillers, reducing both the number of prescriptions and the number of pills per prescription. "Those pills that are in the community will often end up in other people's hands," noted Diaz de Leon. "We're making sure that the patients get what they need," such as alternative methods of pain relief, while also reeducating physicians and changing their default for prescribing opioids. In 2016, Newport Beach ED physicians wrote 16,547 prescriptions for a total of 267,424 pills. In 2019, those numbers are projected to be 12,510 prescriptions and approximately 151,120 pills — a remarkable reduction.

The results of the NAMI Connects program have also been striking. After discharge, Newport Beach ED neurobehavioral health patients and their family members have reported a total of 251 engagements with NAMI programs and services over the past 11 months. Of the 292 neurobehavioral health patients seen in the ED, 212 did not have a return ED visit. Of the 140 patients with a history of readmission, 60 have not returned after being connected with NAMI.

"The culture shift has been phenomenal," Diaz de Leon remarked. She describes the overall experience of the Learning Community as "amazing — I don't know how else to say it. It makes me feel so grateful that I'm part of this organization and that we're doing this for our community."

Maine Medical Center (MaineHealth)
Portland, Maine

Like many US health systems, MaineHealth has been struggling to care for the growing number of patients with mental health issues who come to their emergency department (ED). The ED team wanted to make sure that these patients were receiving the same quality care as every other patient. “The fact that it’s a behavioral health patient shouldn’t make a difference,” said Nancy Goudey, RN, Manager of Emergency Services at MaineHealth.

While participating in the ED & UP Learning Community, the team introduced changes in multiple key areas. One major effort involved standardizing and streamlining ED processes for patients with mental health conditions and substance use disorders. With an ED staff of several hundred, the team realized it was crucial to clarify policies and protocols (e.g., the protocol for a suicidal patient, from door to discharge, and for patients who are in the ED longer-term). As a result, the ED team established guidelines for behavioral health programming for children and adolescents staying for prolonged periods in the ED; standardized an ED clinical pathway for patients with psychotic disorders; and developed ED protocols for ligature risk reduction.

It wasn’t enough to merely establish these new ED policies and protocols. The team also had to work continually to disseminate and reinforce them among ED staff using a variety of channels: written forms, orientation tools, and training. “We highlighted it in staff meetings and through individual supervision,” said Goudey.

One specific new protocol the team tested was interdisciplinary rounds for behavioral health patients in the ED. Initially, rounds were conducted twice daily, at 8:30 AM and 6:00 PM. All relevant staff members were expected to huddle in one designated location, to share information about each behavioral health patient in the ED. However, the team quickly discovered that the 6:00 PM rounds did not work as planned because, at that time of evening, shift changes occur and the ED is typically at its busiest and most chaotic. The 8:30 AM rounds, however, were successful. As a result, the team decided to conduct rounds once per day, in the morning only.

The ED team also worked with community partners, to educate them about what the ED can and can’t do for patients with mental health conditions and substance use disorders; to communicate about their respective roles in supporting these patients; and to identify ways they might collaborate. In-person meetings were especially helpful, to enable staff to put faces to the names and feel more comfortable reaching out afterward.

In particular, the ED team has a longstanding partnership with Opportunity Alliance (OA), a mobile crisis team for Maine’s Cumberland County. For years, the medical center’s ED has referred patients to OA in “warm handoffs.” Together, they developed a one-page referral form that includes the patient’s name, the reason for the patient coming to the ED, and what post-discharge support the ED is seeking for OA to provide the patient. Following ED discharge and handoff to OA, the OA team follows up with the patient. According to Maria Long, Manager of Hospital Social Work Services in the Department of Psychiatry, during the Learning Community the ED team worked with OA to ensure that patients referred from the ED to OA were a good fit for OA’s services. This project reinforced the value of their partnership and reminded ED staff members of the option to deploy warm handoffs.

One patient’s experience illustrates the success of all of these changes. “Jordan,” a 23-year-old man with schizophrenia who lives in a residential treatment facility, came to the ED for the third time in a month as a result of treatment non-adherence, exacerbation of psychosis, and behavioral

dysregulation. He has a history of difficult inpatient stays, often requiring use of restraints and seclusion. This time, when he arrived at the ED, the care team implemented the psychosis treatment pathway and order set and was able to initiate treatment early in his stay. The patient's behavioral health plan was discussed by the interdisciplinary team during morning rounds. He did not require restraints or seclusion during his stay. The patient stayed in the ED for four days and then the ED team completed a warm handoff to OA.

More broadly, the changes have resulted in impressive progress. The ED process standardization and streamlining have led to smoother operations. "There's a lot less question among ED staff about who's doing what and when," Goudey noted. "That's improving patient flow. I think patients are happier." From 2018 to 2019, during the ED's participation in the Learning Community, the average length of stay for mental health patients in the ED decreased by 16.8 percent.

An ongoing challenge is changing the ED culture. "We're very quick to revert back to whatever we used to do before," remarked Goudey. "We're continually hammering away at, 'That was then, this is now.' Our population has changed; we need to change along with it."

Participating in the Learning Community was valuable in a variety of ways, particularly in highlighting alternative approaches to ED care processes. In a fast-paced environment, it's easy, said Goudey, "to get very locked into 'that's the way we've always done it.' So, to hear what other [hospital ED teams] are doing and how those [changes] might fit in [our ED], and being willing to try something different, I think has been very helpful."

Another important element was establishing connections with other hospital's EDs, outside of their own health system. "We have a new resource bank," said Maria Long. "If I delve into problems with child psychiatry, I know exactly who to call" from one of the other teams in the Learning Community. Long noted, "That's one of the most valuable things. You have someone else to call."

Memorial Hermann Northeast Hospital
Houston, Texas

Memorial Hermann Northeast Hospital is a 242-bed facility in the suburbs of Houston, Texas, located in close proximity to a major hub of health care facilities throughout the city. Over the past five years, an increase in the number of behavioral health patients presenting to the hospital's 37-bed emergency department has created new challenges for appropriately managing these patients' mental health issues and disposition once they are medically stabilized.

The Memorial Hermann Health System (Memorial Hermann) does not have psychiatric facilities or inpatient psychiatric beds. In order to meet the needs of this patient population, in 2000 Memorial Hermann launched a Psychiatric Response Team (PRT), a mobile team that provides 24/7 psychiatric consultation and dispositions to all psychiatric patients in the system's acute care hospitals (EDs and medical units). Behavioral health patients presenting to the ED often experience prolonged waiting times before they are accepted and transferred to an inpatient psychiatric facility. Managing the behavioral health population requires collaboration with community partners and the challenges the health system faces are further exacerbated by the general lack of adequate resources for mental health in Texas.

"There was a feeling that we weren't doing enough for these patients," said Stephanie Masson, a nurse and Director of High Reliability and Safety at Memorial Hermann. This feeling, together with the system's core value of safety, supported the motivation to join the ED & UP Learning Community. Masson noted, "We wanted to learn what is the best practice, what is the way to give the best quality care given the resources that we have."

Over the course of the Learning Community, the team learned and adopted valuable information, including standardizing the ED intake process for behavioral health patients. "If a patient's coming in with chest pain, the whole [ED] team knows just what to do," said Jennifer Braren, BSN, RN, Clinical Manager of the ED. The ED team wanted to ensure a similarly reliable response for mental health conditions. Now, when a behavioral health patient arrives at the ED, the team follows a standard series of steps: assess agitation level; consult a medication algorithm and provide medication, if appropriate; and contact the psychiatrist for a consultation. If necessary, the ED team can implement de-escalation techniques. Taken together, all of these steps improve care delivery, reduce the risk of a safety event, and help reduce length of stay.

While Memorial Hermann had already integrated telepsychiatry (i.e., telehealth for psychiatric consults) in 2005, during participation in the Learning Community, the health system recognized a need to expand and enhance PRT telepsych operations more broadly. Over the 18-month Learning Community, the organization integrated wireless telepsych carts throughout the health system and expanded telepsych remote access to all medical units within the organization. "Our system's promise to enhance models of care delivery in order to meet patient care needs and support operations is key to our culture," remarked Theresa Fawvor, LCSW, Senior Director of Behavioral Health Services at Memorial Hermann. "Today, more than 60 percent of all consults are performed via remote access."

When behavioral health patients arrive in the ED, they need a "safer room," which contains nothing that could be used to harm themselves or others. However, the sheer number of behavioral health patients required the ED team to implement another change: standardize and rehearse the process of transforming a regular patient room into a safer room. To make a patient room safer, the team removes all equipment that is not medically necessary, such as storage bins for tongue

depressors or ace bandages, and locks cabinets and locks or removes contents from drawers. The team assembled a room prep checklist and rehearsed it until they were able to consistently transition a room within two minutes (usually two staff members, a technician, and a nurse are responsible for this transition). Braren empowered the ED staff to share solution ideas throughout the Learning Community and they were highly engaged, taking it upon themselves to try new ideas for room safety and readiness. Several staff members bought magnet child locks to keep supplies safely locked in the cabinet.

Another important ED process improvement was establishing a post-psychiatric response consultation huddle, in which the nurse, ED provider, and the psychiatric response representative (a social worker or psychiatrist) discuss next steps after a psychiatric consultation. When the huddle was first introduced, the intended participants did not necessarily all convene at the same time. "Getting everyone in one place was difficult," said Masson, because of the chaotic nature and demanding pace of the ED. It took several weeks to prioritize a real huddle, for the participants to say, "We're all going to pause and have a conversation," as Masson put it. Now, immediately following the consultation, the psychiatric response representative consistently huddles with both the nurse and the ED provider to discuss the consultation plan, overall assessment, disposition recommendation, safety plan (if applicable), and other details. The psychiatric response nurse then finalizes plans with the patient prior to documenting the note, which has resulted in improving throughput on discharged patients.

One change that both staff and patients most appreciate is the integration of trauma-informed care into the ED. This approach helps staff better understand that behavioral health patients, in particular, have previously experienced some kind of trauma, in addition to the ED environment itself being potentially traumatizing. The training equips staff with techniques to communicate with more compassion and understanding.

Looking for ways the team could take trauma-informed care further, Braren toured local behavioral health facilities to better understand the environment they create for patients. This knowledge enabled her and the team to make ED patient rooms safer while still incorporating emergency equipment as necessary. Lockers were added to store patient and family belongings.

The ED team also introduced a specific, less obvious element of trauma-informed care: a chalkboard wall and non-toxic chalk are now provided in four ED patient rooms. The chalkboard walls have been a big satisfier for both patients and staff. After helping the patient through their acute phase, patients can decompress and have an outlet by drawing, coloring, or communicating frustrations on the wall. Staff are also able to communicate via the chalkboard through notes of encouragement or "next steps." Several patients have played tic-tac-toe with staff on the chalkboards, one patient wrote scientific equations in Chinese, and many have drawn pictures which can give staff and the Psychiatric Response Team an insight into their mental wellness.

For the team at Memorial Hermann, a key takeaway from the Learning Community, noted Masson, is that "the challenges that we thought were unique to us really are not." Although the organization does not have inpatient psychiatric services, the team learned that even EDs that do have such services share many of the same challenges. "It's not just about having a psychiatric bed," said Braren. "It's really about, 'How do we best deliver care to these patients?'"

Providence Regional Medical Center Everett
Everett, Washington

In 2017, the Providence Regional Medical Center Everett (PRMCE) realized the emergency department had a problem. "We collectively recognized that our population coming to the ED with mental health complaints was growing," said Emily Pinkham, a clinical nurse specialist who works in the ED. Pinkham and her colleagues felt ill-prepared to meet the needs of this growing population. "Their needs are very different from our other medical patients," she said.

This recognition motivated PRMCE to join the ED & UP Learning Community. Once they joined, the Providence leadership team assessed their current state and started developing small tests of change.

One key insight was the need to standardize the intake process for patients presenting with mental health complaints. As a first test of a new process, a small group of ED nurses administered the Behavioral Activity Rating Scale (BARS) assessment to evaluate levels of agitation with a few patients. The tests were successful, so the nurses recommended expanding the use of BARS to all mental health patients.

The next test of change focused on using de-escalation techniques. Most ED staff had already been trained in de-escalation techniques through a class called MOAB (management of aggressive behaviors). De-escalation didn't always work, and this left staff without a standard approach to next steps. Psychiatry and ED medical directors consulted the most current evidence and developed a medication algorithm for tailored treatment of acute agitation. "We were very clear that the medication was meant to treat the underlying condition, not to sedate the patient," said Pinkham.

In the new standardized process, if the patient's BARS score is higher than 4 and de-escalation techniques are not effective, ED staff consult the medication algorithm. There are different medications to treat, for example, psychosis, dementia, or drug-induced psychosis. For each condition, there are various medication choices from which the provider can select based on presentation, diagnosis, and patient's previous medication history.

Another important aspect of the team's improvement efforts involved training ED staff in trauma-informed care practices. The initial training in November 2018 was a brief introduction in an ED staff meeting. Now the training is a more formalized two-hour class, conducted by four staff members. All PRMCE emergency physicians will have attended the class by December 2019, and the team plans to introduce more formalized education for ED nurses in 2020.

One lesson ED staff learned is that changing the policy alone is not always enough. ED staff habits are so ingrained that, at times, it took a lot of re-education and coaching to get staff members to adopt the new policies, such as consistently performing the BARS assessment and consulting the medication algorithm. The ED has almost 200 nurses, many of whom don't work full time, which adds another layer of complexity to rolling out the changes.

Pinkham noted, "Starting small and working through one small thing at a time is really the only way to make a difference in the long term. We can implement all of these really great things that are shown to improve outcomes, but accountability and ingraining that change into culture is the piece that we will still be working on for a long time." The team has been measuring completion rates for BARS assessments, have gradually raised the rates, over the course of the past year, to about 60 percent.

Following the changes the team put in place, the police brought a young man in his 20s into the ED who was under the influence of illicit drugs and had an anticipated long metabolization time. He was extremely agitated and still in the ED the following day, awaiting a behavioral health evaluation. An ED nurse noticed he was escalating again and, because of the new standardized processes in place, she knew what to do. She found a physician and they went through the medication algorithm. The patient did not require restraints. "The patient was very thankful for the help and the medication, because his condition made it difficult to manage his agitation levels," said Pinkham.

Overall, the Learning Community was tremendously helpful to ED staff at PRMCE. Pinkham remarked, "To me the most beneficial piece to the Learning Community was having that structure and the recommendations with the framework and clear goals. And the power in having the right contacts, having people across the US with experiences that were similar to ours. The level to which that's beneficial was eye-opening to me."

In November 2019, PRMCE opened a behavioral health urgent care center in a medical office building attached to the hospital, intended for patients with behavioral health needs who do not need emergent care. For this innovation, PRMCE was inspired by Cohen Children's Medical Center in New York, another participant in the Learning Community, which had successfully established a similar center. Providence's director of behavioral health services and medical director of psychiatry visited Cohen to observe their approach. "This wouldn't have been possible, at least to this extent," Pinkham remarked, "without that collaboration."

South Seminole Hospital (Orlando Health) Longwood, Florida

South Seminole Hospital (SSEM), a 206-bed hospital near downtown Orlando, is also the home of Orlando Health's 80-bed psychiatric hospital.

In December 2017, Jesse Radloff, a licensed mental health counselor (LMHC), was hired in a new role in the SSEM emergency department: ED LMHC/Care Coordinator. At the nursing station he sits facing the entrance to the ED, and it's his responsibility to ensure behavioral health patients get what they need. When patients arrive, he will "talk with them, get a sense of what's going on with them, and get telepsychiatry involved." Since this is a new role at the hospital, it was something of an experiment to see exactly what it would entail.

SSEM joined the ED & UP Learning Community to improve care for patients suffering from mental health diseases and disorders. The addition, and continual evolution, of Radloff's role formed a major part of SSEM's work in the Learning Community, along with related changes. For example, the team instituted a standard ED triage assessment that includes administration of the Columbia-Suicide Severity Rating Scale and a mechanism to identify victims of human trafficking. Radloff is one of the ED staff members who administers the triage assessment.

Prior to participation in the Learning Community, SSEM established 24/7 access to telepsychiatry to determine whether patients need to be admitted or referred elsewhere, and whether patients need to start on medication. In the past, only ED doctors were allowed to determine whether a patient was eligible to be evaluated by telepsychiatry. Recognizing that other ED staff members are also capable of doing so, and that this would make the process more efficient, the team instituted a change. Now, Radloff, the psychiatric triage nurses, and another ED nurse are permitted to initiate telepsychiatry.

SSEM had also already established an emPATH (emergency Psychiatric Assessment, Treatment & Healing) unit for ED behavioral health patients. This unit enables ED providers to triage and begin initial treatment for behavioral health patients in a special area of the ED with a calm and supportive atmosphere, away from the often-chaotic environment in the main part of the ED where medical patients are seen. Although Radloff spends most of his time in the main ED, he sometimes visits the emPATH unit to check on patients and sit with them.

During the Learning Community, a major aim of the team's work was to improve the process of connecting patients with outside resources. Previously, patients were often discharged with little more than a list of numbers to call themselves. Now, Radloff meets with patients (and, for adolescents, their parents). If the decision is made to discharge, "I'll get to work trying to find someone in the community who can see them in a reasonable amount of time," said Radloff. He has developed relationships with community clinics, and he tries to set up follow-up appointments for patients ideally before they leave the ED.

For example, a 16-year-old boy was brought into the ED on involuntary status due to a school staff report of suicidal ideation. Radloff met with the boy, performed a psychosocial assessment, and recommended evaluation by telepsychiatry. The patient spoke with the telepsychiatrist, who then overturned the involuntary admission order, prescribed medication, and recommended outpatient follow up. Radloff assisted the boy's parents with scheduling an outpatient follow-up appointment before they left the ED.

Another important change the team instituted is for Radloff to make follow-up phone calls, within two weeks after ED discharge, to all patients identified as having mental health concerns who were not admitted to inpatient care. “I call to see how they’re doing. Were they successful in obtaining follow up? If not, what happened? Do they want help?” He calls providers’ offices to confirm that they’re in the patient’s insurance network, knowing that he cannot necessarily rely on the information on websites. Sometimes he fields patient complaints, sometimes he receives compliments. “You never know how someone’s gonna be feeling on any given day,” he says. “Whatever comes up, if I can help them, I do.”

Of course, there have been challenges. For instance, one challenge, notes Radloff, was “getting our ED physicians at first to buy in to my position and embrace it and start to engage.” They had to learn about his capabilities, “what my boundaries are, what I can and cannot do.” It was not always easy to adapt to a change in routine, and he tried to find ways to be helpful without being asked. “Once they started seeing that I could help them solve problems, they started asking if I could help with this or that problem.” When Radloff shared with ED physicians that he thought telepsychiatry should be involved in determining a patient’s disposition, he made sure to present reasonable, justifiable, and clinically appropriate reasons. “Above all,” he says, “approaching the ED docs with respect and confidence was critical.”

Over the course of 35 weeks, Radloff reached out to approximately 400 patients who presented to the ED with mental health concerns and were discharged without admission. Every week, he assisted at least one patient with obtaining mental health follow-up appointments and further support; sometimes he was able to help three or four.

During the Learning Community, he was working five eight-hour shifts per week, from Saturday through Wednesday. SSEM is now expanding his position to cover seven days per week. They plan to hire another person to cover on his days off. After the initial challenge of getting ED physicians to embrace his role, Radloff says, “Now when I take a few days off, it’s like, ‘Where have you been?’”