



INSTITUTE FOR BEHAVIORAL HEALTHCARE IMPROVEMENT

# **Emerging Strategies to Improve Care for Behavioral Health Clients in the Emergency Department**

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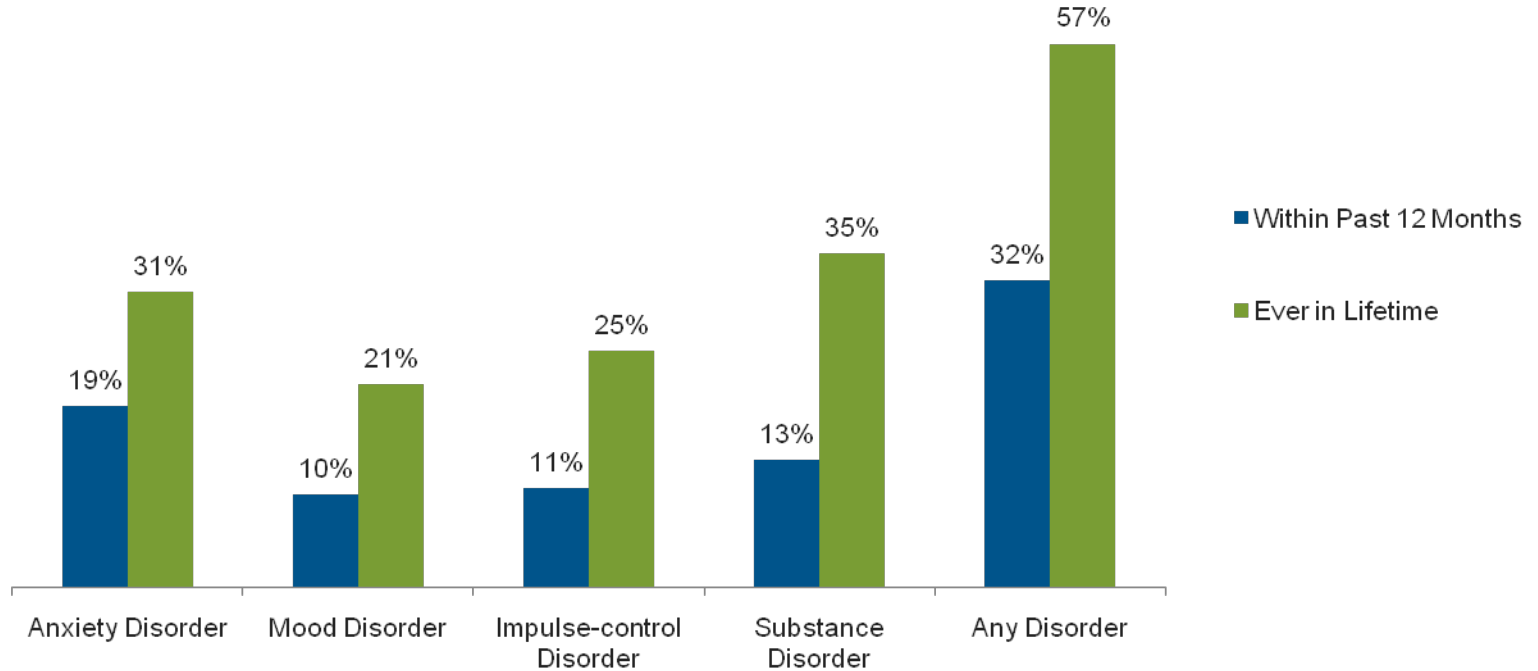
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# Today's Agenda

- Introductions to IBHI and speakers
- The need for emergency care improvement for behavioral health patients
- New Joint Commission expectations
- Performance improvement and cultural change
- Lessons from hospital learning collaborative
- Emergency Departments role in suicide prevention
- Upcoming IBHI Seminar on Dec 5 in Las Vegas

# Behavioral health conditions are prevalent among adults in the U.S.

Chart 1: Percent of U.S. Adults Meeting Diagnostic Behavioral Health Criteria, 2007



Note: Anxiety disorder includes panic disorder, agoraphobia, specific phobia, social phobia, generalized anxiety disorder, post-traumatic stress disorder, obsessive compulsive disorder, and adult separation anxiety disorder. Impulse-control disorder includes oppositional defiant disorder, conduct disorder, attention deficit/hyperactivity disorder, and intermittent explosive disorder. Substance disorder includes alcohol abuse, drug abuse, and nicotine dependence.  
Source: Kaiser Commission on Medicaid and the Uninsured. (April 2011). *Mental Health Financing in the United States: A Primer*. Washington, DC.

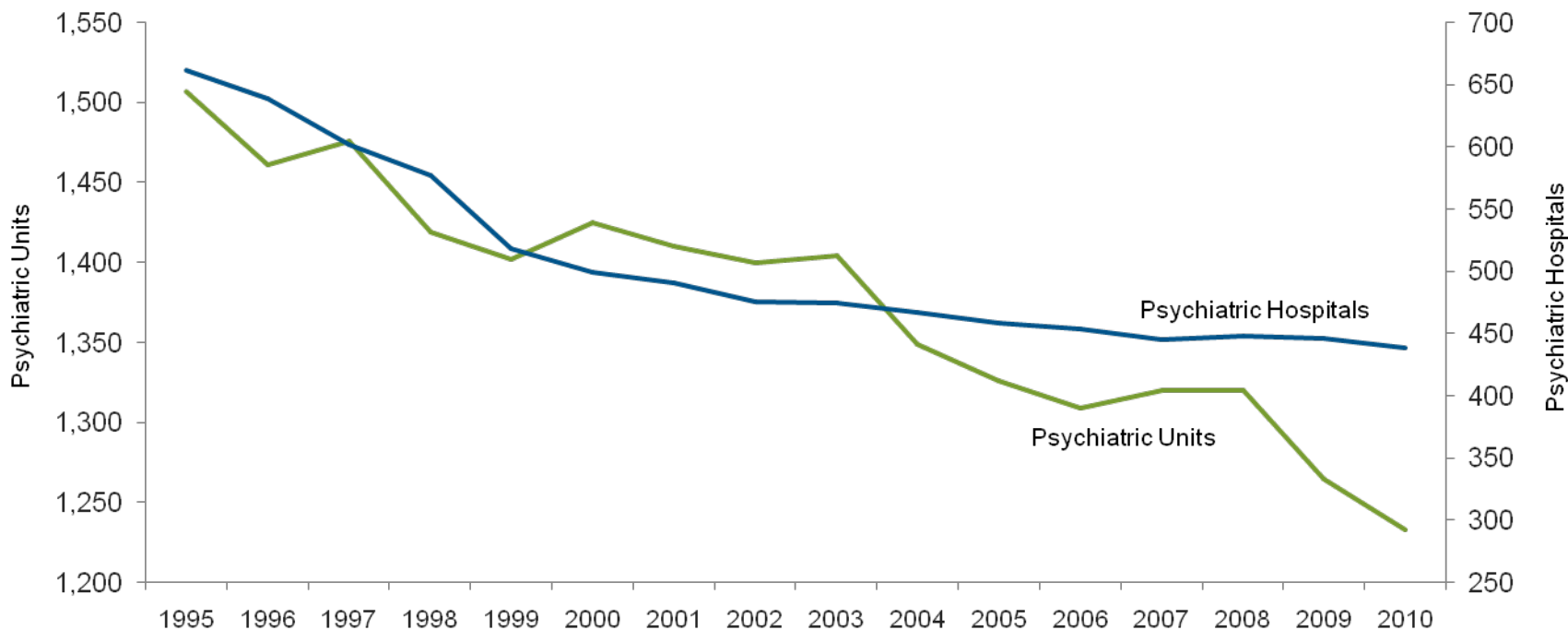


## Why are so many behavioral health patients coming to the ED?

- Reductions in the Safety Net throughout the country
- State mental health programs cut 4 % in 2009, by 5% in 2010, and are estimated to be cut more than 8 % in 2011 (Stateline.org) leading to less services

# The health care system's capacity to deliver mental health services has been shrinking.

Chart 5: Total Number of Psychiatric Units<sup>(1)</sup> in U.S. Hospitals and Total Number of Freestanding Psychiatric Hospitals<sup>(2)</sup> in U.S., 1995-2010



Note: Includes all registered and non-registered hospitals in the U.S.

(1) Hospitals with a psychiatric unit are registered community hospitals that reported having a hospital-based inpatient psychiatric care unit for that year.

(2) Freestanding psychiatric hospitals also include children's psychiatric hospitals and alcoholism/chemical dependency hospitals.

Source: Health Forum, AHA Annual Survey of Hospitals, 1995-2010.

# Impact on the ED

- More visits for behavioral health problems: In 2007, according to US AHRQ, 12 million visits to the ED for behavioral health conditions.
- Visits per 1000 grew from 17.1 to 23.6 over the last 10 years (Larkin, GL., et al, Psych Services 2005).
- Longer stays : ACEP ED Behavioral Health Study/Survey found 79 percent psychiatric patients are boarded in their ED

# What Typically Happens in the ED

- Under treatment or no treatment because of lack of expertise
  - ACEP survey found 62 percent indicated no psych services while patients are in the ED. 59 percent had no substance abuse or dual diagnosis patient services available.
- Over admission to inpatient
  - In 2007, according to US AHRQ, 2.5 times the rate for other conditions.
- Discharge Problems : Often leaving without referral due lack of knowledge of community resources and relationships with behavioral health programs

# BH Patients Experience in the ED

- “why do I have to treat this person with a self inflicted wound instead of someone with a serious problem”
- “what do I do with them once I find they have a problem, they can’t live here”
- “here he comes again”
- “I waited hours to be seen...they saw other people while I waited...no one cared”
- “they don’t even ask why I cut myself, they just sent me to the hospital...I didn’t need to be in the hospital I needed someone to talk to”
- “even though I was hallucinating I could hear them talking about me as a crazy psych patient”
- “every time mom and dad get mad at me they drop me off in the ED”





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# Most Helpful Aspects of Treatment

**The most important aspect of a patient's experience is not only the quality of medical care but how they are treated by staff.**



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# New Joint Commission Expectations

Specifically, revisions to Standard LD.04.03.11 developed to address the following concerns for all patients, including those with behavioral health emergencies:

- Leadership use of data and measures to identify, mitigate, and manage issues affecting patient flow throughout the hospital
- The management of ED throughput as a system-wide issue
- Safety for boarded patients (the practice of holding patients in the ED or another temporary location after the decision to admit or transfer has been made)
- Leadership collaboration with behavioral health providers and authorities

For patients who have been boarded because of behavioral health emergencies, revisions to Standard PC.01.01.01 address safety in the following areas:

- Environment of care
- Staffing
- Assessment, reassessment, and the care provided

# The Power of Culture

Hospitals vary in organizational culture, and the type of culture relates to the safety climate within the hospital. These results suggest a healthcare organization's culture is a critical factor in development of its patient safety climate and in the successful implementation of quality improvement initiatives. *British Med Journal*

Organizational Culture: Variation Across Hospitals and Connection to Patient Safety

Climate <http://qualitysafety.bmj.com/content/19/6/592.abstract>

# Sample Questions from Hospital Survey on Patient Safety: Agree - Disagree

1. People support one another in this unit
2. We have enough staff to handle the workload
3. When a lot of work needs to be done quickly, we work together as a team to get the work done
4. In this unit, people treat each other with respect
5. It is just by chance that more serious mistakes don't happen around here
6. We work in "crisis mode" trying to do too much, too quickly  
Whenever pressure builds up, my supervisor wants us to work faster, even if it means taking shortcuts

Guide <http://www.ahrq.gov/qual/patientsafetyculture/usergd.htm>

# Guidelines for Cultural Change

- Get top management in support
- Evaluate the current culture
- Formulate a clear strategic vision
- Model culture change at the highest level
- Modify the organization to support organizational change: identify current systems, policies, procedures and rules to be changed to align with the new values & desired culture.
- Select and socialize newcomers and terminate deviants.
- Develop ethical and legal sensitivity
- Include a periodic evaluation process to monitor change progress, and identify areas that need further development.

# Needed: Systems Thinking

- “Every System is perfectly designed to achieve the result it gets.”
- “If you want a different result, you have to change the system.”

Donald Berwick, MD and others

# Key Elements of Breakthrough Improvement

- ***Will* to do what it takes to change to a new system**
- ***Ideas* on which to base the design of the new system**
- ***Execution* of the ideas**

# Key Questions

- **What** are we trying to accomplish?
- **How** will we know we have made an improvement?
- **What changes** can we make that we predict will result in improvement?



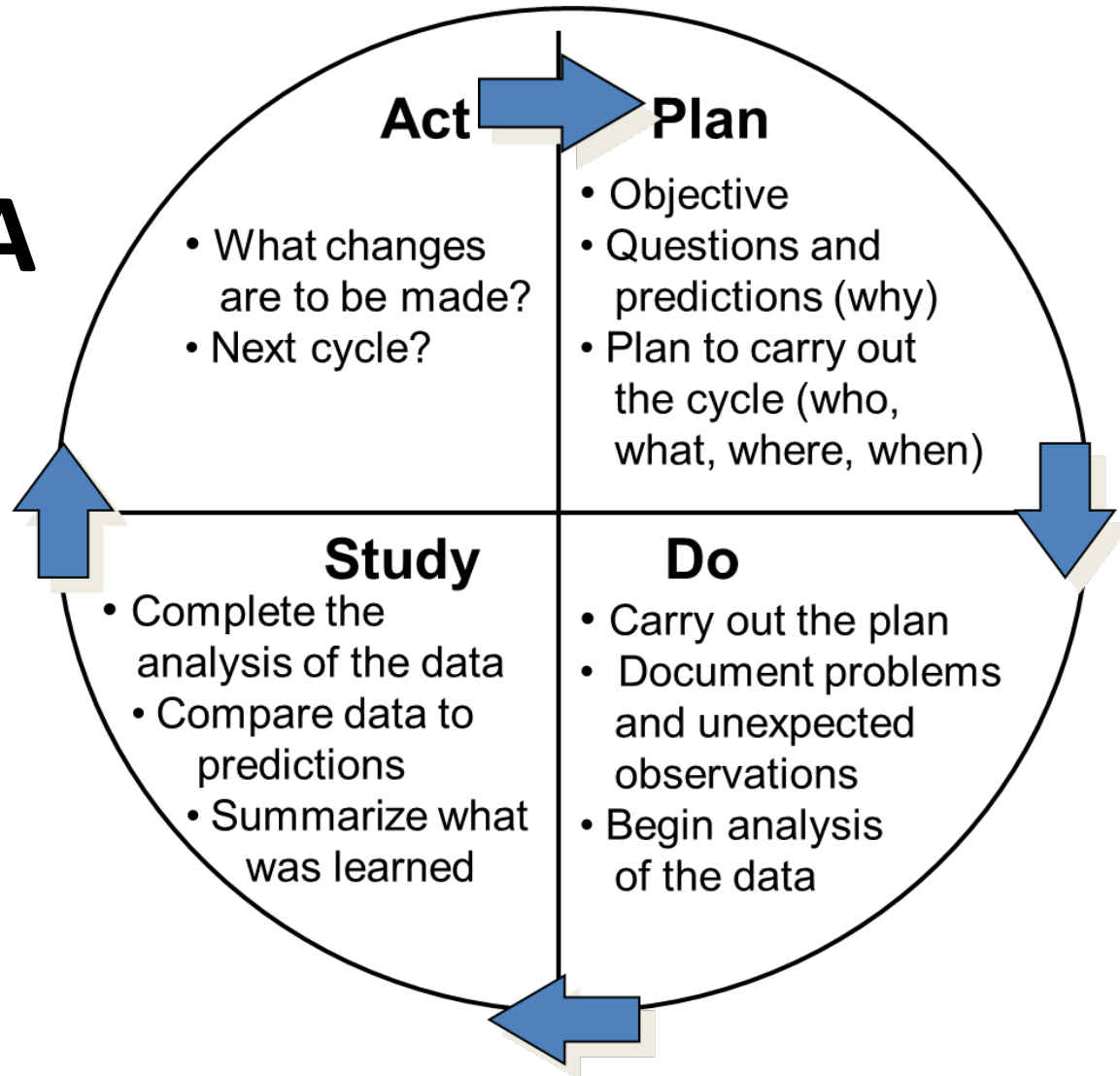
# Starting Improvement

- **Involve senior leaders**  
Leadership must align the aim with strategic goals of the organization.
- **Base your aim on data**  
Examine satisfaction and performance data within your organization.
- **Set Goals**  
Use the Improvement Charter to focus on issues that matter.
- **State your aim clearly and use numerical goals**  
Unambiguous aims make for better progress. Setting numerical targets clarifies the aim and directs measurement

# Creating a Team

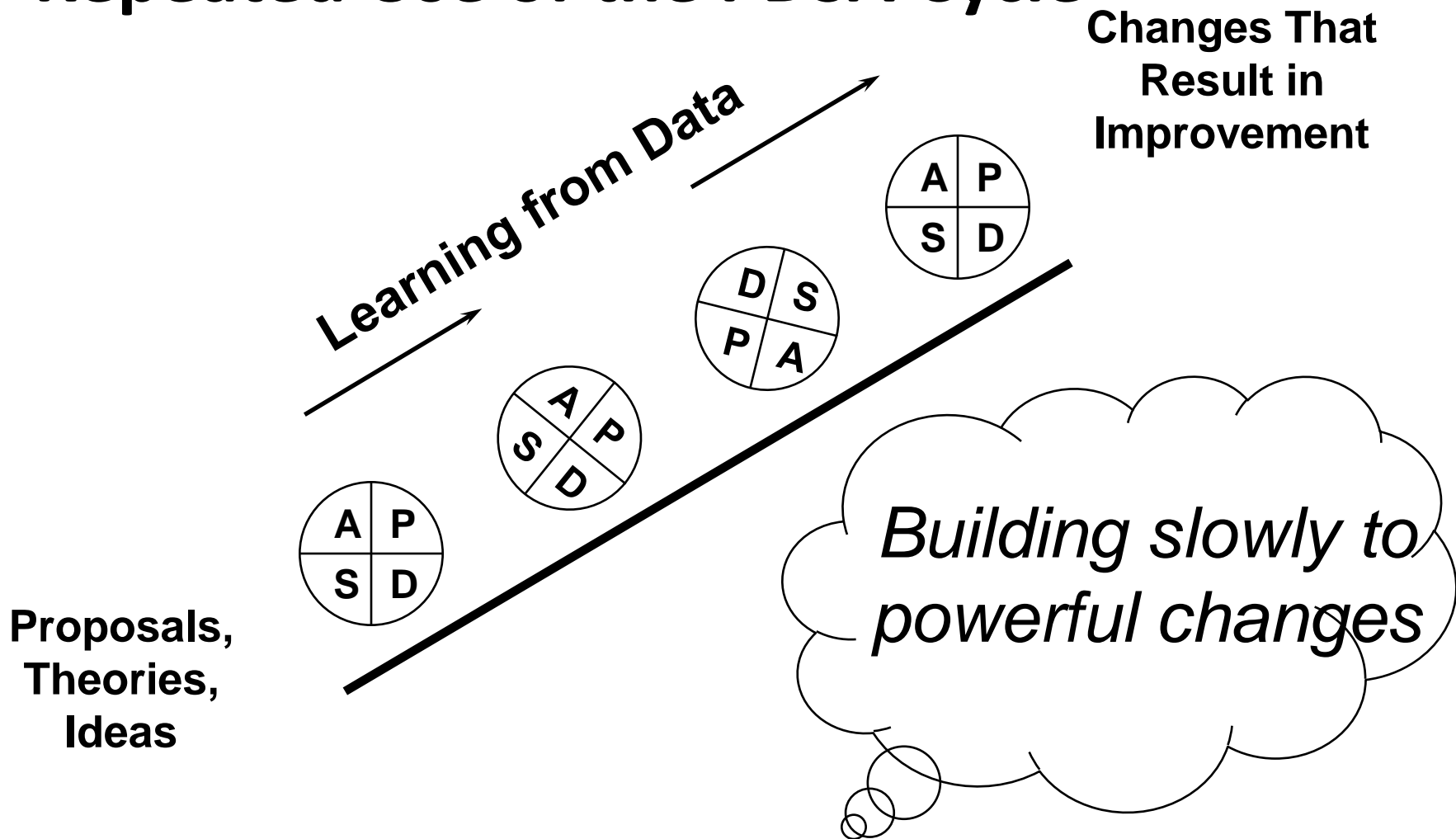
- Senior Executive Champion (CEO, COO, CFO, Someone similar)
- Team Leader with authority: ED Director
- Key technical leaders: Physician champion  
behavioral health leader, general  
medical leader
- Others with imagination

# The PDSA Cycle





# Repeated Use of the PDSA Cycle



# Why Test?

- Increase the likelihood the change will result in improvement
- Predict how much improvement can be expected from the change
- Minimize resistance upon implementation
- Learn how to adapt the change to conditions in the local environment
- Evaluate costs and side-effects of the change

# IBHI ED Learning Collaborative

- Formed an “Expert Panel” which met six months prior to the start
- Started with hospitals from various regions in the country: NY, Virginia, Louisiana, Colorado, Washington, Oklahoma, and Minnesota
- Met for 11 months, three face to face mtgs. in Chicago, New Orleans, and San Antonio
- First three months every other week phone calls then monthly calls



# 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)

## Changes in operations to improve flow

- Use of a nurse practitioner
- Behavioral health professional as greeter -have social worker in the waiting area
- New triage system to distinguish medical/and or more severe psych pts. from those who can be referred to outpatient settings
- Phone screening
- Expediting movement into in-patient care
- Improve access to behavioral health specialists, a general problem (adult, adolescent)
- Use paper pajamas and scrubs, change policies on disrobing
- More emphasis on suicide assessment & measurement
- Create behavioral crisis or swat teams to deal with behavioral emergencies
- Establish protocols and workflow for medicating agitated patients



## Changes in physical space and organization

- Establishing crisis beds outside ED
- Developed a short stay unit 1-5 days
- Develop standardized lab tests and toxicology screens
- Create medication protocols and algorithms to lower agitation levels and reduce the use of restraints
- Transportation improvements in moving and receiving BH patients -psych transport vs. police transporting patients important

## Changes in discharge planning processes

- Create community outreach and collaboration for discharge
- Develop rapid community placement process
- Earlier discharges from inpatient psych facilities and earlier availability of discharge meds
- Customizing existing patient satisfaction tools to BH patients' needs
- Measure rate of diversion and LWOBs

# Community Interventions

- Meeting with community physicians, community mental health programs, community agencies, and outpatient programs.
- Developing a Gero-Community Diversion Program
- System-wide treatment conferences for high use consumers

# Key Training Changes

- Police and security integration and education
- Training all staff on reducing agitation
- Including security staff in training programs
- Bringing in outside expert to discuss with MDs
- Suicide screening

# Suicide: General Statistics

- **WHO estimates that someone commits suicide every 40 seconds**
- **Suicide accounts for 11 deaths/100,000 people in US/yr**
  - Rate varies with sex, age, ethnicity
- **1.3% of all deaths in the U.S.**
- **2<sup>nd</sup> (25-34 yr olds) 3<sup>rd</sup> among 25-24 yr olds - 11<sup>th</sup> leading cause of death in U.S.**
- **Method of death by far is firearm**
- **CDC funded 16 state study: leading precipitating circumstances: Intimate partner problems, physical health problems, job problems, financial problems**



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The Joint Commission recognizes the trend for suicide in health care settings

National Patient Safety Goal 15.01.01 requires behavioral health care organizations, psych hospitals, and general hospitals to identify individuals at high risk for suicide

- Risk assessment
- Immediate safety needs
- On discharge provide suicide prevention information

## ED plays an important role in Suicide Prevention:

- 1 in 10 suicides are by people seen in the ED within 2 months or less of dying. Many were never assessed for suicide risk (Nat'l Suicide Prevention Lifeline)
- A recent unpublished study in an HMO found 25% of people committing suicide were seen within 3 days of death by the health care system, 50% in the ED.
- One ED screening study found ED screening using PHQ 2 yielded 25% of pts with medical chief complaint with depressive sx's, while a little over 5% had active or passive suicidal ideation
- 10% of all ED patients have suicidal thoughts



# Suicide Prevention Measures: Communication

- **The most important anti-suicidal measures are the sensitivity and alertness of the staff to the suicidal danger and the indication of interest and concern for the patient as a person.**
- **Nurses or doctors asking about suicidality directly is the most effective method of uncovering thoughts of self-harm.**





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Patients may not spontaneously report suicidal ideation, but 70% communicate their intentions to significant others, police, EMS Personnel. Seek collateral information.



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# US Prevalence Suicidal Behavior (CDC 2007 data)

<u>Type</u>	<u>%/yr</u>	<u>#/yr</u>
Serious Thoughts	3.7	8,300,000
Made Plan	1.0	2,300,000
Suicide Attempt	0.5	1,100,000
Suicide	~0.01	34,598

# World Mental Health Surveys (WHO)

- Mental disorders increase the odds of experiencing Suicide
- After controlling for psychiatric comorbidity – disorders characterized by anxiety and poor impulse control predict the transition to suicidal behavior
- Depression predicts suicidal ideation not plans, or attempts in ideators while disorders with severe anxiety/agitation or impulse dyscontrol predict ideators that proceed to both impulsive and planned attempts
- **Depression + agitation = suicidal behavior**
- Similar in developed and undeveloped countries

Nock et al. PLOS Medicine, 2009



# Interventions

- Active non-judgmental listening, acceptance of pt's feelings, eliciting patients thoughts about suicidality, ideas about what would lessen his or her suicidality.
- Move patient to a quiet area, reduce stimulation, remove objects that can be used as weapons, verbal de-escalation, medication, restraints  
DO NOT WAIT TO BEGIN TREATMENT
- Use of medication in treatment of agitation
  - Benzodiazepines – such as Lorazepam - preferred when sedating a patient with violence from unknown causes. Rapid onset, short half-life can be given IM or IV
  - Typical Antipsychotics – Haldol orally or IM 2-10mg onset within 30-60 min. Caution b/c of EPS (Cogentin, Benadryl), youths, elderly. Benzo plus typicals to achieve rapid sedation.
  - Atypical Antipsychotics – such as Olanzapine (Zyprexa), Risperidone (Resperidol), Aripiprazole (Abilify)

## Discharge Planning for a Suicidal Person

- Admission to psychiatric hospitals or hospital alternative programs: what care are you providing while boarding the patient?
- Do you have outpatient referral resources?
- Develop and document a crisis plan
- Follow-up is essential in preventing suicide, develop a network of community and professional resources: National Suicide Prevention Lifeline – 3-5 follow-up phone calls

# Suicide Assessment & Screening tools

- Item 9 on the PHQ9: suicidal thinking – nearly every day, more than half, several days, not at all. Some using the PHQ2
- C-SSRS – Columbia Suicide Severity Rating Scale 12-13 minutes to do
- NGASR – Nurses’ Global Assessment of Suicide Risk – 15 items with scores that rank risk level
- SAFE-T Suicide Assessment Five-step Evaluation and Triage (SAMHSA download [www.sprc.org](http://www.sprc.org))
- Assessment and Warning Signs: IS PATH WARM ([www.suicidology.org](http://www.suicidology.org))
- Peer Advocate - patients are willing to discuss suicide in a more trusting engagement and environment.

# Summary: Opportunities

- EDs need a change process and leadership to produce cultural change to improve behavioral health care
- It is important that EDs recognize that the problem with behavioral health patients in the ED is multi-faceted, with challenges of access to care, and unlikely to change in the short run
- Data supports that improvement in BH care reduces overall health care costs, and is a crucial step to reducing loss of life and improving other outcomes.
- People with serious mental health issues lose 25 years of life, and lack of coordination between behavioral and general healthcare needs is a prime contributor.
- EDs can help recognize and prevent suicide

# IBHI Seminar IMPROVING EMERGENCY DEPARTMENT FLOW

## & NEW JOINT COMMISSION STANDARDS

December 5, 2012

8:30-4:30

Flamingo Las Vegas Hotel, Nevada

Are you ready for the Joint Commission new requirements?

(Standard LD.04.03.11, Standard PC.01.01.01)

How well are you serving people with mental health conditions in your ED?

Are your HCAPHS scores suffering from ED Behavioral Health complaints?

### Topics include:

- Understanding new commission standards
- Offering examples of successful behavioral health improvements in hospitals
- Identifying common difficulties in behavioral health treatment in ED
- Evaluating your current system of care and establishing goals for improvement
- Developing breakthrough change in your ED
- Measuring results to achieve improvement
- Providing adequate treatment
- Establishing community resources for better transitions and follow up

### Faculty includes:

- **Lynne Bergero**, MHSA Project Director, Dept. of Standards and Survey Methods, Division of Healthcare Quality Evaluation, Joint Commission, Oakbrook Terrace, IL
- **Stuart Buttlair**, PhD, MBA, Regional Director of Inpatient Psychiatry & Continuing Care, Kaiser Permanente Northern California
- **Darcy Jaffe**, MN, ARNP, NE-BC, Chief Nursing Officer (int.) Harborview Medical Center UW, Seattle, WA
- **Larry Phillips**, D.C.S.W. Program Manager, St Anthony Hospital, Oklahoma City, OK
- **Peter Brown**, Executive Director, Institute for Behavioral Healthcare Improvement

Cost for IBHI Seminar: Pre-registration \$395 At door \$495

To register, click: <https://secure.qgiv.com/for/shsbe/event/4450>

Visit IBHI, click: [www.ibhi.net](http://www.ibhi.net) or contact Peter Brown, click: [peter@ibhi.net](mailto:peter@ibhi.net) or 518-732-7178

Stay for the *National Update on Behavioral Health Emergencies* December 6 & 7 at Flamingo Las Vegas Hotel

To register for *National Update*, click: <https://secure.qgiv.com/for/shsbe/event/4414>







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# Come to Las Vegas December 5-7

IBHI Seminar on Improving ED Flow for  
Behavioral Health Consumers

AND

**3rd Annual National Update on Behavioral  
Emergencies**

Link to register for the IBHI Seminar <https://secure.ggiv.com/for/shsbe/event/4450>

Link to register for the National Update on Behavioral Health Emergencies

[www.Behavioralemergencies.com](http://www.Behavioralemergencies.com) or <http://www.sinai.org/conference/conference.asp>

# Addendum

- The following three slides are the actual changes in Accreditation Standards put forth by the Joint Commission
- These changes are
  - Standard LD.04.03.11
  - Standard PC.01.01.01

Standard LD.04.03.11 Element of Performance for LD.04.03.11

1. The hospital has processes that support the flow of patients throughout the hospital.
2. The hospital plans for the care of admitted patients who are in temporary bed locations, such as the post anesthesia care unit or the emergency department.
3. The hospital plans for care to patients placed in overflow locations.
4. Criteria guide decisions to initiate ambulance diversion. The hospital manages the flow of patients throughout the hospital.
5. The hospital measures ~~the following~~ components of the patient flow process:
  - The available supply of patient beds
  - ~~The efficiency of areas where patients receive care, treatment, and services~~
  - The safety of areas where patients receive care, treatment and services
  - Access to support services
- 5. The hospital measures and sets goals for the components of the patient flow process, including:**
  - **The available supply of patient beds**
  - **The throughput of areas where patients receive care, treatment, and services (such as inpatient units, laboratory, operating rooms, telemetry, radiology, and PACU)**
  - **The safety of areas where patients receive care, treatment and services**
  - **The efficiency of the non-clinical services that support patient care and treatment (such as housekeeping and transportation)**
  - **Access to support services (such as case management and social work)**
6. ~~Measurement results are provided to those individuals who manage patient flow processes. (See also NR.02.02.01, EP 4)~~

**6. This element of performance will go into effect January 1, 2014: The hospital measures and sets goals for mitigating and managing the boarding of patients who come through the emergency department. (See also NPSG.15.01.01, EPs 1 and 2; PC.01.01.01, EPs 4 and 49; PC.01.02.03, EP 3; PC.02.01.19, EP 1 and 2).**

**Note: Boarding is the practice of holding patients in the emergency department or a temporary location after the decision to admit or transfer has been made. The hospital should set its goals with attention to patient acuity and best practice; it is recommended that boarding timeframes not exceed 4 hours in the interest of patient safety and quality of care. (See also NR.02.02.01, EP 4)**



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## Hospital Accreditation Program

7. The individuals who manage patient flow processes review measurement results to determine that goals were achieved.

**8. Leaders take action to improve patient flow processes when goals are not achieved. (See also PI.03.01.01, EP 4)**  
**Note: At a minimum, leaders include members of the medical staff and governing body, the chief executive officer and other senior managers, the nurse executive, clinical leaders, and staff members in leadership positions within the organization. (See the glossary for the definition of Leader)**

**9. This element of performance will go into effect January 1, 2014: When the hospital determines that it has a population at risk for boarding due to behavioral health emergencies, hospital leaders communicate with behavioral health care providers and/or authorities serving the community to foster coordination of care for this population. (See also LD.03.04.01, EP 3 and 6)**

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**Standard PC.01.01.01**

The hospital accepts the patient for care, treatment, and services based on its ability to meet the patient's needs.

**Element of Performance for PC.01.01.01**

2. The hospital has a written process for accepting a patient that includes the following: Criteria to determine the patient's eligibility for care, treatment, and services.

3. The hospital has a written process for accepting a patient that includes the following: Procedures for accepting referrals.

4. Hospitals that do not primarily provide psychiatric or substance abuse services have a written plan that defines the care, treatment, and services or the referral process for patients who are emotionally ill or who suffer the effects of alcoholism or substance abuse.

**4. Hospitals that do not primarily provide psychiatric or substance abuse services have a written plan that defines the care, treatment, and services or the referral process for patients who are emotionally ill or who suffer the effects of alcoholism or substance abuse. (See also LD.04.03.11, EP 6)**

5. The hospital provides or refers patients who are emotionally ill or who suffer from alcoholism or substance abuse for care, treatment, and services, consistent with its written plan.

6. Administrative and clinical decisions are coordinated for patients under legal or correctional restrictions on the following:

- The use of seclusion and restraint for nonclinical purposes
- The imposition of disciplinary restrictions
- The restriction of rights
- The plan for discharge and continuing care, treatment, and services
- The length of stay

7. The hospital follows its written process for accepting a patient for care, treatment, and services. (See also LD.01.03.01, EP 3)

**24. If a patient is boarded while awaiting care for emotional illness and/or the effects of alcoholism or substance abuse, the hospital does the following:**

**- Provides for a location for the patient that is safe, monitored, and clear of items that the patient could use to harm himself or herself or others. (See also LD.04.03.11, EP 6; NPSG.15.01.01, EPs 1 and 2)**

**- Provides orientation and training to any clinical and non-clinical staff caring for such patients in effective and safe care, treatment, and services (for example, medication protocols, de-escalation techniques). (See also HR.01.05.03, EP 13; HR.01.06.01, EP 1)**

**- Conducts assessments, and reassessments, and provides care consistent with the patient's identified needs. (See also PC.01.02.01, EP 23)**