12-9-2018

Integrate Behavioral Health in the ED and Upstream

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**Recommended Citation**

Gilligan, Katie and Beazizo, Heidi, "Integrate Behavioral Health in the ED and Upstream" (2018). *Presentations, Posters, Etc..* 25.  
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About Us

Began in the Pacific Northwest in 1856 by Mother Joseph
Our Project Team

Back Row (Left to right)
• Liga Mezaraups – Sponsor
  Chief Nursing Officer
• Heidi Beazizo – Day to Day Lead
  Program Manager
• Julie Zarn – Content Expert
  Regional Direction ED, Trauma
• Louise Gilfillan – Measurement Lead
  Manager, Clinical Analytics
• Ryan Keay – ED Provider
  Medical Director, ED

Front Row (left to right)
• Laura Knapp – Behavioral Health Integration
  BHI Manager
• Gale Springer – Content Expert
  Clinical Nurse Specialist Psych ARNP
• Katie Gilligan – Community Provider
  Psychiatrist
• Emily Pinkham – Day to Day Lead
  ED Clinical Nurse Specialist

Not Pictured
• Lee Wilner, ED Crisis Counselor
Our Population: Snohomish County

**Total Population:** 836,638

**Race/Ethnicity Distribution:**
- White: 74.5%
- Other Race: 4.4%
- Black/African American: 3.2%
- Asian: 10.7%
- American Indian/Alaska Native: 0.6%
- Pacific Islander: 0.5%
- Population of 2 or more races: 5.2%

**Median Age:**
- Male: 38.9
- Female: 40.7

**Household Income:**

- $0 - $15,000: 25.57%
- $15,000 - $24,999: 17.57%
- $25,000 - $34,999: 17.57%
- $35,000 - $49,999: 25.57%
- $50,000 - $99,999: 25.57%
- $100,000+: 25.57%

**Payer Mix:**
- Self Pay: 0.50%
- Other Government: 2.67%
- Medicare: 53.76%
- Medicaid: 17.57%
- Commercial Payer: 25.57%

**Commercial Payer**
- American Indian/Alaska Native: 2.67%
- Black/African American: 53.76%
- Other Race: 4.4%
- Pacific Islander: 0.5%
- Population of 2 or more races: 5.2%
- White: 74.5%
Perspectives of Our Staff

“We have a safe place for severely psychotic patients but the ones who aren’t violent... we seem to ignore them. We usually remember to give them food, but we don’t treat their medical problems.”

“Even though we have seclusion rooms, they’re only really good for incredibly violent patients. One day we had an adolescent patient back there and the it felt like torture.... I would never want my adolescent back there with nothing to do. It’s like solitary confinement.”

“They tend to be forgotten. I think we just let them sleep because we have more medically ill patients. We just forget about them until they become frustrated and combative.”

“We do such a good job of quickly medically clearing them, getting urine and blood tests, but then we have a tendency to just forget about them.”

“There are hardly any medical psych facilities, it’s like we have to play their game to get patients admitted there... we do such large workups sometimes, even MRIs before we can admit patients for psychiatric treatment.”
Perspectives of Our Patients & Family/Caregivers

Trauma Informed Staff:

“I’ve been told in the past by nurses “I don’t get it” or “you should just love life” and it truly feels a bit ostracizing. I understand that not everyone has a deep understanding of how mentally ill patients function”

“Wants staff to take patients seriously and recognize patients “have schizophrenia and are not a monster”

“There are many negative assumptions made about families of individuals with substance abuse disorders. I felt that these assumptions colored interactions.”

Prescriptions:

“…see that something was clearly wrong with him, but they don’t give any medications in the ED for psychiatric issues”

“Only give meds for anxiety, but if it’s more than that they just refer you to a psychiatrist. Need med help right away.”

Discharge:

“See the biggest barriers are lack of resources outside of the ED, generally people are just given the local crisis line number and sent back to their medical doctor.”

“Need real resources accessible and readily available in 1-2 days”

“The ED was a sort of ‘holding’ prior to being hospitalized at an inpatient facility. I believe it would be helpful for individuals at the hospital to receive some type of information on how to take care of ourselves when we were transferred to either the next hospital or prior to going home.”

Care:

“The care that was received was more stabilization care rather than anything else. I believe that it’s important for those that are mentally ill to feel less like they are being “held” and more like they are being cared for.”

“…the nurses seemed to feel like it wasn’t their issue to deal with and just brushed the patient off waiting for the social worker to make the interventions.”
Perspectives from Our Chart Reviews

5 Charts were reviewed
(all had visits within the last 30 days; February 1\textsuperscript{st} - March 3\textsuperscript{rd})

- In all 5 cases, follow up appointments were recommended with specific providers (4 had primary care providers, the 1 who did not had been fired from her primary care provider.)
- All 5 returned with either suicidal/homicidal ideations or substance abuse (identical to their original presenting complaint)
- 3 had over 20 ED visits each in the prior 12 month period; all 3 of these had periods of homelessness.
- 3 of the 5 did not have frequent vital signs during their ED visit.
- 3 returned within one week of discharge; 2 of those within 1 day
Perspectives of Our Community Partners

“Documentation that gets sent back to us could be more streamlined. The hospital is on Epic and we use Athena Health as our EHR. We often get 4 separate fax notices, some of them with unhelpful or redundant information.”

Community Health Provider

“The quality of the patient transfer experience is dependent on the willingness and interest of the receiving RN to receive an oral report of our experience with this particular patient. At times, it can feel as if the nurses do not believe our report contains information that they can use in their care.”

Everett Fire District

“There was a case where a patient just picked up a controlled substance Rx from us and got another one at the ED.”

Community Health Provider
Known Challenges

• Long length of stay
  • Long wait for mental health evaluation
• No Inpatient Psychiatric unit
• Lack of standard medical clearance for IP admission
• Low staffing
• Inconsistent restraint documentation
• Low reporting of staff assaults
• Needed a way to identify our behavioral health population
• Low access for post discharge follow up – especially for Medicare and Medicaid
• Lack of community alternatives to Inpatient
Our Team’s Aims

In 18 months, we will better leverage our community partnerships to decrease our ED monthly mean LOS for behavioral health patients by 10%.

• Goal #1: In order to improve communication, develop a shared understanding of our community partners roles and influence on the patient’s journey while agreeing on a shared language.

• Goal #2: Standardize the ED experience/protocols in order to reduce the throughput cycle time by 10% - medical clearance to mental health evaluation complete.

• Goal #3: Research and implement improved transitions of care in order to reduce disposition to departure LOS by 10%.

• Goal #4: Research and implement a standardized suicide screen tool

Within 6 months, we will standardize screening to facilitate earlier appropriate treatment to decrease the duration of restraints and staff assaults by 20%.

• Goal #1: Select and implement standardized screening tool

• Goal #2: Develop clinical protocols based on screening outcome

• Goal #3: Train 40% of ED staff on AVADE (requirement to complete by 12/31/2018)
Our Measures

18-month Aim
- 10% reduction in mean ED LOS for BH patients
- ED Crisis Counselor 10% reduction in cycle time – medically clear to MHE begun
- 20% overall reduction in staff assaults
- % utilization of the suicide screen tool for patients seen for a primary mental health concern

6-month Aim
- 20% Reduction in Staff Assaults
- 20% Reduction in duration of restraints
- % utilization of BH patients with BARS assessment
- % of staff who have completed AVADE training
First 6 months
Define Population

**WIN:** Defined population using EPIC behavioral health track board

Clinician indicates a need for BH evaluation – that FLAG is what we use to define all of our dashboards
First 6 months
Define Population

LIP or RN or Crisis Counselor; must be clicked for all patients requiring BH Evaluation.

LIP: Click “Ready” when Medical Eval is clicked “Complete”
Crisis Counselors ONLY: Click “In Process” just before going to see patient; Click “Completed” once a disposition decision is made (i.e. detained; transfer; admit; send home)

Crisis Counselor ONLY: Click appropriate legal status as applicable.

LIP or RN or Crisis Counselor; must be clicked for all patients requiring BH Evaluation.

LIP or RN or Crisis Counselor; must communicate if risk of violence.
First 6 months
Community Partner Launch

Collaboration
The action of working with someone to produce or create something

Investment
An act of time, effort, or energy to a particular undertaking with the expectation of a worthwhile result
We realized we had some housekeeping to do before all of this energy could be leveraged.
First 6 months
Build measurement dashboard

- Total Population
- Admit counts
- Returns within 7 days
- Length of stay broken down
  - Arrive to medically clear
  - Medically clear to mental health eval complete
  - Disposition to departure
- Involuntary holds
- Restraint Use
- BARS use
- BARS + Medication
First 6 months  
BARS + Medication PDSA

**Plan:** Implement nursing assessment of level of agitation and introduce an agitation-based medication algorithm to decrease time in restraints and staff/patient injury.

**Do:** Tested the Behavioral Activity Rating Scale (BARS) for ease of use.

**Study:** The nurses found BARS easy to complete and thought it provided an accurate patient description.

**Act:** Adopted the BARS scale throughout the ED.

**Do:** Tested the BARS PLUS medications algorithm.

**Study:** The nurses and providers founds the medication algorithm easy to use and helpful in decision making.

**Act:** Adopted the BARS PLUS Medications Algorithm.

**Learnings:**
- BARS levels are difficult for providers to see (enlisted IT assistance).
- Medication algorithm difficult to obtain (placed at each provider's desk and on department website)
- Creating order sets for EPIC ordering ease
- Needed to collaborate closely with the county to ensure medication was not impacting ability to assess acute needs
First 6 months
Psych in the ED

Average LOS
Patient’s LOS
First 6 months Suicide Screening

**Plan:** Select an evidence based tool for suicide screening – Columbia Suicide Severity Rating Scale (CSSRS). Determine that all patients who present to the ED with a primary Behavioral Health Issue will be screened.

**Do:** Educated Staff on how to find the CSSRS screen in EPIC and how to complete the screening Tool. Helped staff to identify what a positive screen looked like and next steps for the RN to ensure patient safety.

**Study:** Monitor the CSSRS completion rate as well as the use of a patient safety attendant (1:1 sitter) for those with a positive screen. Also reviewing cases where a nurse may feel a patient safety attendant may be contraindicated.

**Act:** TBD

**Learnings:**
- We may have underestimated the staff resource requirements based on the need for patient safety attendants.
Current and Future Initiatives

**Build and leverage partnerships with community-based services**
- Weekly calls with county crisis counselors
- Community Needs Assessment based on patient gaps
- Community partner ED shadows

**Coordinate and communicate between ED and other health care & community-based services**
- Behavioral Health Steering Committee with community-lead subgroups
- BH Urgent Care
- Next Day Appointments

**Standardize processes from ED intake to discharge**
- Smart Medical Clearance
- Parallel assessments by MD and Crisis Counselor
- Psychiatric Triage (Australian)
- Suicide screening

**Engage and capacitate patients and family members to support self-management**
- Mental Health Community Care Plans
- Peer Support

**Create trauma informed culture among ED staff**
- Feedback form (survey)
- Tribal involvement
- Psychiatric Nurse Cohort
- ACES training
- Non-medical comfort interventions

IN PROCESS
IN PLANNING
Key Learnings

- Collaborative drove improved focus and attention
- Compelled internal engagement and connections
- Drew increased support for Psych services in the ED
- Many resources (internal and external) exist that aren’t aligned or unidentified
- Data collection is hard and people dependent
- Change is hard – sustainment and consistency require continued focus
- Scale is hard