Fixing Behavioral Health Safely and Efficiently
IHI Session A2/B2

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Session Objectives

Identify challenges and solutions to the provision of high-quality Behavioral Health care

Learn how Telepsychiatry and other technology can be leveraged to improve Behavioral Health clinical management, flow, and boarding utilizing an Emergency Department based workflow.

Develop safety strategies around the inter-facility transport of patients with acute Behavioral Health symptoms
Disclosures

Jonathan Merson MD- no disclosures

Melissa Petrizzo LMSW- no disclosures

Jonathan Washko MBA NRMT-P AEMD- no disclosures
NEW HYDE PARK, NY — Michael G. Guttenberg, MD, an emergency services leader at Northwell Health and a Fire Department of New York (FDNY) first responder to the World Trade Center terror attacks on September 11, 2001, died Tuesday.

Dr. Guttenberg, of Jericho, NY, succumbed to pancreatic cancer at The Hospice Inn in Melville after a nearly four-and-a-half-year fight, his family said. He was 50. Despite the diagnosis, Dr. Guttenberg continued to serve as medical director of Northwell Health’s clinical preparedness and Center for Emergency Medical Services (CEMS) to the end.

Dr. Michael G. Guttenberg speaks to the media at Northwell Health’s 15th anniversary Sept. 11 remembrance ceremony in 2016.
Agenda

Patient Vignette- 2014

Improved Care- 2017

Behavioral Health Challenges and Solutions

#1 Nursing Triage
#2 Emergency Department Staffing
#3 Inpatient Beds
#4 Transport
## Behavioral Health in America

<table>
<thead>
<tr>
<th>Mental Illness</th>
<th>Suicide</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 20% of adults</td>
<td>• 43,000 per year</td>
</tr>
<tr>
<td>• 7% Major Depression</td>
<td>• More than motor vehicles</td>
</tr>
<tr>
<td>• 3% Bipolar Disorder</td>
<td>• #2 cause of death &lt; 35yo</td>
</tr>
<tr>
<td>• 1% Schizophrenia</td>
<td>• #10 cause all ages</td>
</tr>
<tr>
<td>• Half begins by age 14</td>
<td></td>
</tr>
</tbody>
</table>

**Emergency Department Visits:** 1 in 8 is for Behavioral Health

**Psychiatric medication:** 1 in 6 adults
New York State’s Largest Private Employer

School of Medicine, School of Nursing

<table>
<thead>
<tr>
<th>22</th>
<th>Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>6,675</td>
<td>Beds</td>
</tr>
<tr>
<td>550</td>
<td>Practices</td>
</tr>
<tr>
<td>62,000</td>
<td>Employees</td>
</tr>
<tr>
<td>15,000</td>
<td>Nurses</td>
</tr>
<tr>
<td>3,900</td>
<td>Physicians</td>
</tr>
<tr>
<td>800,000</td>
<td>ED Visits</td>
</tr>
<tr>
<td>25,000</td>
<td>ED BH Consults</td>
</tr>
<tr>
<td>10,000</td>
<td>ED BH Admissions</td>
</tr>
</tbody>
</table>
• Established in 1993
• Unrestricted CON for Nassau, Suffolk and all 5 boroughs of NYC
• Provide all levels of traditional ground EMS services including 9-1-1, specialty care and critical care response and transport
• Provide critical care rotor wing air medical transportation services via SkyHealth
• Universal service provision ethos: all patients - all health systems - all the time leveraging a high performance operations model
• Provide in and out of network ancillary services such as dispatch, call center, PERS, Community Paramedicine and logistic management services
• Providing telemedicine based mobile integrated healthcare & Community Paramedicine services since 2013
• Focused on value, quality, satisfaction and efficient delivery to embrace the future of a value based reimbursement environment
Patient Vignette- 2014
Patient Vignette

Eric B, a freshman at a local college, shares with his friend Michelle that he is having thoughts of ending his life. Michelle calls 911.
Patient Vignette

Eric is brought by EMS to the closest Emergency Department, a Northwell community hospital 10 miles from Manhattan.
Patient Vignette

He speaks briefly with the triage nurse about his depression while his vitals are taken. He is escorted to a general medical room.
Patient Vignette

While awaiting the EM Attending he takes a full bottle of pills out of his jeans and unscrews the cap. An environmental services employee notices and alerts the primary nurse.

Friday | Dec 12 2014 | 18:00
ED LOS: 1:00 hrs
Patient Vignette

With the help of security, the primary nurse secures the pill bottle. Eric is wanded, searched, and gowned. He is placed on 1:1 observation.
Patient Vignette

Eric meets with the Emergency Medicine Attending. He shares that he has been suffering from symptoms of depression for several months and has a specific plan to end his life the following day by swallowing pills. The EM Attending orders labs and a Psychiatry Consult.
Patient Vignette

The Psychiatrist is not available until the following morning.

Eric spends the night in the Emergency Department on 1:1 constant observation.
Patient Vignette

Eric meets with the Attending Psychiatrist who determines that Eric needs emergency admission to an Inpatient Psychiatry Unit for safety and treatment of his depression.
Patient Vignette

Emergency Department staff attempt to secure an inpatient bed. They fax seven hospitals with “potential beds” and await call-backs for several hours. Ultimately the search is unfruitful.

Sat | Dec 12 2014 | 12:00
ED LOS: 19:00 hrs
Patient Vignette

Eric spends the night in the Emergency Department again, on 1:1 continuous observation.

Sat | Dec 12 2014 | 23:30
ED LOS: 30:30 hrs
Patient Vignette

Overnight he becomes agitated and requires PRN medication.

The patient with abdominal pain in the room next to Eric is perturbed by the events and leaves without being evaluated by the EM Attending.

Sun | Dec 12 2014 | 3:00
ED LOS: 34:00 hrs
Patient Vignette

In the morning, Eric meets briefly with the Attending Psychiatrist again who reaffirms the need for admission.

Sun | Dec 12 2014 | 9:00
ED LOS: 40:00 hrs
Patient Vignette

ED staff learns of an available bed. However (a) the receiving Psychiatrist on the unit has just left for the day and (b) the receiving hospital requires insurance pre-authorization but the insurance company is closed on weekends.
Patient Vignette

Eric spends a third night in the Emergency Department, still on 1:1 constant observation.
Patient Vignette

The following morning, after the insurance authorization is obtained, Eric is slated for transfer.
Patient Vignette

The ED clerk calls EMS and answers general non-clinical transport questions.
Patient Vignette

A BLS crew arrives and loads Eric into a standard ambulance vehicle.

Mon | Dec 12 2014 | 14:00
ED LOS: 69:00 hrs
Patient Vignette

En route, Eric pushes the EMT out of the way and jumps out the back of the ambulance in an attempt to hurt himself.
Patient Vignette

He is brought back to the ambulance by EMTs with the assistance of Fire Department personnel.
Patient Vignette

Eric reaches the inpatient unit and begins receiving specialized treatment by a multidisciplinary team.
**Patient Vignette**

- 911 call to Inpatient Unit = 72 hours
- Emergency Dept LOS = 69 hours
- Sitter time 1:1 observation = 68 hours
- Wait-time for Psychiatrist = 16 hours
- Holding time for bed = 50 hours
Patient Vignette

911 call to Inpatient Unit = 72 hours
Emergency Dept LOS = 69 hours
Sitter time 1:1 observation = 68 hours
Wait-time for Psychiatrist = 16 hours
Holding time for bed = 50 hours

Attempted overdose in ED
Agitation and IM medication in ED
Neighboring patient left without being evaluated in ED
ED boarding x 3 nights
Elopement from moving ambulance
Pushing of EMT
Empty specialized inpatient bed x 2 nights
Improved Care- 2017
Improved Care

Eric B, a freshman at a local college, shares with his friend Michelle that he is having thoughts of ending his life. Michelle calls 911.
Improved Care

He is brought in by EMS to the closest Emergency Department, a Northwell community hospital 10 miles from Manhattan.
Improved Care

Eric is interviewed by the triage nurse who completes an ED Behavioral Health Scale. Eric is a Level 2.
Improved Care

Eric is a BH Level 2 so he is wanded, searched, gowned, and placed on a 1:1 in a secure environment of care. Labs are drawn.
Improved Care

Eric meets with the Emergency Medicine Attending. He shares that he has been suffering from symptoms of depression for several months and has a specific plan to end his life the following day by swallowing pills. The EM Attending orders labs and a Telepsychiatry Consult.

Friday | Dec 8 2017 | 18:00
ED LOS: 1:00 hrs
Improved Care

Eric meets with the **Attending Telepsychiatrist** who determines that Eric needs emergency admission to an Inpatient Psychiatry Unit for safety and treatment of his depression.

Friday | Dec 8 2017 | 18:30

ED LOS: 1:30 hrs
Improved Care

The Telepsychiatry team consults the internal bedboard to determine the closest available bed for Eric.

Friday | Dec 8 2017 | 20:00

ED LOS: 3:00 hrs
Improved Care

Instead of obtaining insurance authorization prior to transferring Eric, the Telepsychiatry team sends a secure-email to a distribution list as part of an established next-day insurance authorization workflow.

Friday | Dec 8 2017 | 20:15
ED LOS: 3:15 hrs
Improved Care

The Emergency Department nurse calls EMS for a clinical behavioral health intake screening. An ALS crew is dispatched.

Friday | Dec 8 2017 | 20:30
ED LOS: 3:30 hrs
Improved Care

An ALS crew arrives and conducts a **pre-transport huddle** with the ED Attending, ED nurse, and Attending Telepsychiatrist. Eric is offered - and accepts - medication to help him relax for the ride.

Friday | Dec 8 2017 | 21:00

ED LOS: 4:00 hrs
Improved Care

Eric is secured on the stretcher utilizing a buckle guard device.
Improved Care

He is loaded into an ambulance equipped with special netting.

Friday | Dec 8 2017 | 21:45
ED LOS: 4:45 hrs
Improved Care

Eric wishes to leave the ambulance. However he is drowsy from medication and is secured by the buckle guard. The Paramedic is safe behind the net.
Improved Care

Eric reaches the inpatient unit for treatment.

There is no Psychiatrist so the same Telepsychiatrist completes receiving hospital legal paperwork under a New York State Office of Mental Health “TeleLegal” pilot.
Improved Care

911 call to Inpatient Unit = 72 hours
Emergency Dept LOS = 69 hours
Sitter time 1:1 observation = 68 hours
Wait-time for Psychiatrist = 16 hours
Holding time for bed = 50 hours

Attempted overdose in ED
Agitation and IM medication in ED
Neighboring patient left without being evaluated in ED
ED boarding x 3 nights
Elopement from moving ambulance
Pushing of EMT
Empty specialized inpatient bed x 2 nights
Improved Care

911 call to Inpatient Unit = 72 hours → 6.5 hours
Emergency Dept LOS = 69 hours → 4.75 hours
Sitter time 1:1 observation = 68 hours → 4.75 hours
Wait-time for Psychiatrist = 16 hours → 30 min
Holding time for bed = 50 hours → 0 min

Attempted overdose in ED
Agitation and IM medication in ED
Neighboring patient left without being evaluated in ED
ED boarding x 3 nights
Elopement from moving ambulance
Pushing of EMT
Empty specialized inpatient bed x 2 nights
## Improved Care

<table>
<thead>
<tr>
<th>Description</th>
<th>Original</th>
<th>Reduced</th>
</tr>
</thead>
<tbody>
<tr>
<td>911 call to Inpatient Unit</td>
<td>72 hours</td>
<td>6.5 hours</td>
</tr>
<tr>
<td>Emergency Dept LOS</td>
<td>69 hours</td>
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</tr>
<tr>
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</tr>
<tr>
<td>Wait-time for Psychiatrist</td>
<td>16 hours</td>
<td>30 min</td>
</tr>
<tr>
<td>Holding time for bed</td>
<td>50 hours</td>
<td>0 min</td>
</tr>
</tbody>
</table>

- Attempted overdose in ED
- Agitation and IM medication in ED
- Neighboring patient left without being evaluated in ED
- ED boarding x 3 nights
- Elopement from moving ambulance
- Pushing of EMT
- Empty specialized inpatient bed x 2 nights
Challenges and Solutions

Challenge #1: Triage

It is difficult to determine the acuity of ED BH patients prior to the Psychiatrist’s arrival. Who needs to be prioritized, placed on a 1:1, wanded, searched, gowned, etc.
Challenges and Solutions

Challenge #1: Triage

It is difficult to determine the acuity of ED BH patients prior to the Psychiatrist’s arrival. Who needs to be prioritized, placed on a 1:1, wanded, searched, gowned, etc.

Solution #1

Emergency Department Behavioral Health Nursing Triage Scale
ED BH Health Nursing Scale

The Australian Mental Health Triage Scale is an internationally validated Nursing Triage scale tying level of BH severity to operational management.

Level 1 = Immediate
Level 2 = Emergency
Level 3 = Urgent
Level 4 = Semi-Urgent
Level 5 = Non-Urgent
ED BH Health Nursing Scale

Enables up-front allocation of resources to ensure patient and staff safety and reduce morbidity/mortality

Minimizes unnecessary use of high-cost resources

Increases nursing and physician comfort with BH symptoms

<table>
<thead>
<tr>
<th>Level 1 - Immediate</th>
<th>Level 2 - Emergency (within 10 minutes)</th>
<th>Level 3 - Urgent (within 30 minutes)</th>
<th>Level 4 - Semi-Urgent (within 60 minutes)</th>
<th>Level 5 - Non-Urgent (within 120 minutes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definite danger to life</td>
<td>Probable risk of danger to self/others</td>
<td>Possible danger to self/others</td>
<td>No immediate risk to self or others</td>
<td>No danger to self/others</td>
</tr>
<tr>
<td>• Immediate CD → 1:1, flowsheet initiated and documented by RN</td>
<td>• Immediate CD → 1:1, flowsheet initiated and documented by RN</td>
<td>• Immediate CD → 1:1, flowsheet initiated and documented by RN</td>
<td>• Enhanced supervision</td>
<td>• Enhanced supervision</td>
</tr>
<tr>
<td>• MD (EM or BH) notification/evaluation</td>
<td>• MD (EM or BH) notification/evaluation</td>
<td>• MD (EM or BH) notification/evaluation</td>
<td>• Metal detection/separate from belongings</td>
<td>• Metal detection/separate from belongings</td>
</tr>
<tr>
<td>• Code Gray (As needed)</td>
<td>• Code Gray (As needed)</td>
<td>• Code Gray (As needed)</td>
<td>• May stay in low acuity area</td>
<td>• May stay in low acuity area</td>
</tr>
<tr>
<td>• Notify security (As needed)</td>
<td>• Notify security (As needed)</td>
<td>• Notify security (As needed)</td>
<td>• Use de-escalation techniques</td>
<td>• Use de-escalation techniques</td>
</tr>
<tr>
<td>• IF RESTRAINTS → follow PB.P.</td>
<td>• IF RESTRAINTS → follow PB.P.</td>
<td>• IF RESTRAINTS → follow PB.P.</td>
<td>• Consider direct transfer to BH area after triage (NOTIFY BH)</td>
<td>• Consider direct transfer to BH area after triage (NOTIFY BH)</td>
</tr>
<tr>
<td>• Metal detection/separate from belongings</td>
<td>• Metal detection/separate from belongings</td>
<td>• Metal detection/separate from belongings</td>
<td>• Remove clothing/search (gender sensitive, private, full skin visualized)</td>
<td>• Remove clothing/search (gender sensitive, private, full skin visualized)</td>
</tr>
<tr>
<td>• Remove clothing/search (gender sensitive, private, full skin visualized)</td>
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</tr>
</tbody>
</table>
ED BH Health Nursing Scale

Implementation

Formation of multi-stakeholder workgroup: EM/BH Service Lines, CIO, Site EM/BH leadership

Translation of scale into “radio button” type questions

Incorporation of scale into Sunrise Emergency Care documents with real-time generation of Level

Two-hospital Pilot November 2017
Challenges and Solutions

Challenge #2: Staffing

There is neither the volume nor the workforce to support after-hours Psychiatry, even in high density areas. Therefore patients have waited until morning for their initial Psychiatric assessment.
Challenges and Solutions

Challenge #2: Staffing

There is neither the volume nor the workforce to support after-hours Psychiatry, even in high density areas. Therefore patients have waited until morning for their initial Psychiatric assessment.

Solution #2  Emergency Department Telepsychiatry
Implementation

To date, no studies have identified any patient subgroup that does not benefit from, or is harmed by, mental healthcare provided through remote videoconferencing. (ATA Guidelines 2013)
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Implementation

Utilize Pre-Existing Resources

Phase I, 2012-16

Physician Staffing

Existing 24/7 BH staff. 0 new FTE.

Hardware and Software

T420 laptop, pryor cart, WebEx, phone

Non-Physician Staffing

None
Implementation

Phase I
2013-2016

7 Hospitals
5 Hospitals
2 Hospitals

Two hubs (existing staff)
Three hubs (existing staff)

Develop and Refine

Hospitals
- Lenox Hill
- CCMC
- LIJMC

Dec 12, 2017
n = 2804

Consults

Feb 2013
Mar 2013
Apr 2013
May 2013
Jun 2013
Jul 2013
Aug 2013
Sep 2013
Oct 2013
Nov 2013
Dec 2013
Jan 2014
Feb 2014
Mar 2014
Apr 2014
May 2014
Jun 2014
Jul 2014
Aug 2014
Sep 2014
Oct 2014
Nov 2014
Dec 2014
Jan 2015
Feb 2015
Mar 2015
Apr 2015
May 2015
Jun 2015
Jul 2015
Aug 2015
Sep 2015
Oct 2015
Nov 2015
Dec 2015
Jan 2016
Feb 2016
Mar 2016
Apr 2016

Implementation

Develop and Refine

Phase I
2013-2016

7 Hospitals
5 Hospitals
2 Hospitals

Two hubs (existing staff)
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Oct 2014
Nov 2014
Dec 2014
Jan 2015
Feb 2015
Mar 2015
Apr 2015
May 2015
Jun 2015
Jul 2015
Aug 2015
Sep 2015
Oct 2015
Nov 2015
Dec 2015
Jan 2016
Feb 2016
Mar 2016
Apr 2016
Implementation

Demonstrate Value

Phase I (2013-2016) reduced ED wait-time by 81%, clearly benefited patients, families, staff, and hospitals
Implementation

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Implementation

Demonstrate Value

Phase I (2013-2016) reduced ED wait-time by 81%, clearly benefited patients, families, staff, and hospitals

Align Stakeholders

Centralize and Expand

IHI 2016
Implementation

Utilize Pre-Existing Resources

Phase I, 2012-16

Physician Staffing

Existing 24/7 BH staff. 0 new FTE.

Hardware and Software

T420 laptop, pryor cart, WebEx, phone

Non-Physician Staffing

None
Implementation

Utilize Pre-Existing Resources

**Phase I, 2012-16**
- Existing 24/7 BH staff. 0 new FTE.
- T420 laptop, pryor cart, WebEx, phone
- None

Centralize and Expand

**Program 2016/17**
- Centralized to 2 hubs
- Cisco DX70, Jabber Video, custom cart
- Care Managers Support Associates

**Physician Staffing**

**Hardware and Software**

**Non-Physician Staffing**
Implementation

- 8 Hospitals
- 10 Hospitals
- 12 Hospitals
- 14 Hospitals

24/7/365 Program

Centralized Physician

Centralized Non-Physician

Hubs:
- LIJMC
- CCMC
- Lenox Hill
- NYC Hub
- LI Hub

n=3392

Dec 12, 2017
Current Program
Current Program

North Shore Manhasset ED
Cohen Children’s ED
Plainview ED
Peconic Bay ED
LIJ Forest Hills ED
Glen Cove ED
LIJ Valley Stream ED
Syosset
Lenox Health Grn Village ED
Lenox Hill ED
Huntington ED
Phelps ED

Long Island Hub
Manhattan Hub

24/7

Dec 12, 2017
Current Program

Map showing locations such as Manhattan, Nassau, Suffolk, Westchester, Bronx, Queens, New Jersey, and Connecticut.
Current Program

Emergency Dept
Psychiatry Single Unit
Psychiatry Hospital

Manhattan
Nassau
Suffolk
Westchester
New Jersey
Bronx
Queens
Brooklyn

Northwell Health

Dec 12, 2017
Current Program

Distance from Primary BH Campus

<table>
<thead>
<tr>
<th>Location</th>
<th>Miles</th>
<th>Minutes</th>
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</thead>
<tbody>
<tr>
<td>Cohen’s Children Hospital</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>North Shore University Hospital</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>LIJ-Valley Stream Hospital</td>
<td>8</td>
<td>17</td>
</tr>
<tr>
<td>LIJ-Forest Hill Hospital</td>
<td>11</td>
<td>25</td>
</tr>
<tr>
<td>Glen Cove Hospital</td>
<td>13</td>
<td>30</td>
</tr>
<tr>
<td>Syosset Hospital</td>
<td>13</td>
<td>55</td>
</tr>
<tr>
<td>Plainview Hospital</td>
<td>16</td>
<td>25</td>
</tr>
<tr>
<td>Lenox Hill Greenwich Village ED</td>
<td>19</td>
<td>55</td>
</tr>
<tr>
<td>Huntington Hospital</td>
<td>22</td>
<td>39</td>
</tr>
<tr>
<td>Lenox Hill Hospital</td>
<td>22</td>
<td>48</td>
</tr>
<tr>
<td>South Side Hospital</td>
<td>33</td>
<td>50</td>
</tr>
<tr>
<td>Phelps Hospital</td>
<td>39</td>
<td>55</td>
</tr>
<tr>
<td>Northern Westchester Hospital</td>
<td>48</td>
<td>60</td>
</tr>
<tr>
<td>Peconic Bay Medical Center</td>
<td>60</td>
<td>68</td>
</tr>
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</table>
Current Program
Current Program
Current Program

Emergency Dept
Psychiatry Single Unit
Telepsychiatry Hub

Dec 12, 2017
**Clinical Operations**

<table>
<thead>
<tr>
<th>Licensing and Credentialing</th>
<th>Newly Rate-Limiting Processes</th>
<th>Partnership with bedside team</th>
</tr>
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<tbody>
<tr>
<td>Emergency Procedures</td>
<td>Consent, Involuntary admissions</td>
<td>Policies and guidelines</td>
</tr>
<tr>
<td>Room Setup</td>
<td>Rapport and empathy</td>
<td>Billing</td>
</tr>
</tbody>
</table>

Cisco DX70 Jabber Video AFC Cart
Quality Framework

Daily conference call: all hubs and spokes
Concordance with face-to-face: diagnosis and decision to admit
Reviews: chart, incident, readmit
FPPE/OPPE: hub and spoke
Compliance with core processes: sitter 1:1, privacy, handoffs
Satisfaction questionnaires: patient and staff
Daily conference call: all hubs and spokes

Concordance with face-to-face: diagnosis and decision to admit

Reviews: chart, incident, readmit

FPPE/OPPE: hub and spoke

Compliance with core processes: sitter 1:1, privacy, handoffs

Satisfaction questionnaires: patient and staff

De-Novo EHR Builds
* Hardwire quality and operational efficiencies
* Drive decision-making, reports, billing, pophealth
* Optimize clinician exp.
Patient Population

**Age**

- 18-25: 20%
- 26-36: 19%
- 36-45: 16%
- 46-55: 16%
- 56-65: 10%
- 66-85: 6%
- 7-15: 7%
- 16-17: 6%
- 5-7: 6%

**Primary Diagnosis**

- Depressive Disorders: 26%
- Schizophrenia Spectrum and Psychotic Disorders: 22%
- Trauma-Stress Related Disorders: 15%
- Substance and Addictive Disorders: 14%
- Bipolar and Related Disorders: 12%
- Anxiety Disorders: 6%
- Other: 5%

**Insurance**

- Commercial: 34%
- Managed Medicaid: 28%
- Medicare: 13%
- Medicaid: 10%
- Uninsured: 11%
- Managed Medicare: 4%

**Disposition**

- T&R: 50%
- Admit: 12%
- Transfer: 24%
- Hold/Admit: 3%
- Hold/T&R: 8%
- Med: 3%

Admit/Transfer: 63% Voluntary
## Patient Population

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>29%</td>
<td>Accompanied by family</td>
</tr>
<tr>
<td>39%</td>
<td>Brought by EMS</td>
</tr>
<tr>
<td>75%</td>
<td>Reside in private home</td>
</tr>
<tr>
<td>28%</td>
<td>Suicidal Ideation</td>
</tr>
<tr>
<td>9%</td>
<td>Auditory Hallucinations</td>
</tr>
<tr>
<td>10%</td>
<td>&lt;30d since admission</td>
</tr>
<tr>
<td>9%</td>
<td>High School Students</td>
</tr>
<tr>
<td>4%</td>
<td>College Students</td>
</tr>
<tr>
<td>6%</td>
<td>Retirees</td>
</tr>
<tr>
<td>41%</td>
<td>Alcohol</td>
</tr>
<tr>
<td>16%</td>
<td>Cocaine</td>
</tr>
<tr>
<td>11%</td>
<td>Heroin</td>
</tr>
</tbody>
</table>
Results

Wait Time by Consult Request Time

Shift Change

Consult Request Time

Peak Volume

Shift Change

Wait Time in Minutes

- 300+
- 240-300
- 180-240
- 150-180
- 120-150
- 90-120
- 60-90
- 30-60
- 0-30

n=1338

Dec 12, 2017
Results

Consult Wait Time

Average = 53 min
Std Dev = 46 min
Median = 22 min

Consult Request to Start Time (min)

Frequency

0-30: 59%
30-60: 17%
60-90: 7%
90-120: 6%
120-150: 5%
150-180: 2%
180-240: 2%
240-300: 0%
300+: 1%

n=3392
Impact

Wait Time for After-Hours Emergency Department Behavioral Health Consult

Wait Time in Minutes

Without Telepsychiatry: 585
With Telepsychiatry: 47

91% reduction in wait time with telepsychiatry

n=1338
Impact

1:1 Sitter Savings
• 11 hospitals

FTE Reduction
• 2 hospitals

FTE Avoidance
• 4 hospitals

FTE Opp Cost
• 2 hospitals

Additional Inpatient d
• 11 hospitals

Does not include
• Cost of in-person 23:00-9:00 staffing
• Reduction in LWOBE, incidents, etc
• ED Billing
• Consult Billing
Impact

- Increased access to Specialized Attending
- Increased access to inpatient beds
- Reduction in ED length of stay
- Reduction in agitation and IM medication
- Reduction in patients on 1:1 observation
- Reduction in avoidable admissions
- Reduction in patients leaving ED unseen
Impact

- Increased access to Specialized Attending
- Increased access to inpatient beds
- Reduction in ED length of stay
- Reduction in agitation and IM medication
- Reduction in patients on 1:1 observation
- Reduction in avoidable admissions
- Reduction in patients leaving ED unseen

Improves Health

Better Patient Experience

Cost Effective

Better Provider Experience
# Impact

<table>
<thead>
<tr>
<th>Improvement</th>
<th>Improves Health</th>
<th>Better Patient Experience</th>
<th>Cost Effective</th>
<th>Better Provider Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased access to Specialized Attending</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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</tr>
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<td>✓</td>
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<td>✓</td>
</tr>
</tbody>
</table>

Dec 12, 2017
Challenges and Solutions

Challenge #3
After-hours transfers are impeded by lack of clarity regarding bed availability, the need for insurance pre-authorization, and the absence of Psychiatrists to sign commitment paperwork. This leads to ED boarding.
Challenges and Solutions

Challenge #3
After-hours transfers are impeded by lack of clarity regarding bed availability, the need for insurance pre-authorization, and the absence of Psychiatrists to sign commitment paperwork. This leads to ED boarding.

Solution
Inpatient Bedboard
Next Day Insurance Authorization
NYS-Sponsored “Telelegal” Pilot
Inpatient Beds

Understand each stakeholder’s perspective

Develop a solution and Pilot

Replicate and establish as the new normal
## Inpatient Beds

<table>
<thead>
<tr>
<th>Is there a bed available?</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
</table>

- Can the patient arrive on the unit after hours?
  - No
  - Yes

- Can the patient move without insurance pre auth?
  - No
  - Yes

- Is there a bed available?
  - No
  - Yes

[Inpatient Bedboard]
Bed Availability

Understand each stakeholder’s perspective

- Finance Director
- Operations Director
- Concierge Program Director
- Nursing Director
- Parent of Hospitalized Patient
- Psychiatric Nurse Per Diem
- Psychiatrist Per Diem
- Psychiatry Director

Dec 12, 2017
Bed Availability

“Please take all transfers 24/7- our occupancy target is 95%- but no denials”

Understand each stakeholder’s perspective

- Finance Director
- Operations Director
- Concierge Program Director
- Nursing Director
- Parent of Hospitalized Patient
- Psychiatric Nurse Per Diem
- Psychiatrist Per Diem
- Psychiatry Director

Dec 12, 2017
Bed Availability

“Please take all transfers 24/7- our occupancy target is 95%- but no denials”
“Please block 3 beds for potential ED admissions and Med-Surg floor transfers”
Bed Availability

“Please take all transfers 24/7- our occupancy target is 95%- but no denials”

“Please block 3 beds for potential ED admissions and Med-Surg floor transfers”

“Please reserve at least 2 beds for potential concierge program patients”

Understand each stakeholder’s perspective

Finance Director
Operations Director
Concierge Program Director
Nursing Director
Parent of Hospitalized Patient
Psychiatric Nurse Per Diem
Psychiatrist Per Diem
Psychiatry Director
Bed Availability

“Please take all transfers 24/7 - our occupancy target is 95% - but no denials”
“Please block 3 beds for potential ED admissions and Med-Surg floor transfers”
“Please reserve at least 2 beds for potential concierge program patients”
“Please don’t accept potentially violent patients- we can’t have another staff injury”
Bed Availability

“Please take all transfers 24/7- our occupancy target is 95%- but no denials”

“Please block 3 beds for potential ED admissions and Med-Surg floor transfers”

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“My daughter’s last roommate was terrifying – she can only be with someone like her”
**Bed Availability**

“Please take all transfers 24/7- our occupancy target is 95%- but no denials”

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“Please don’t accept potentially violent patients- we can’t have another staff injury”

“My daughter’s last roommate was terrifying – she can only be with someone like her”

“If we make room swaps to take a male, we’ll have 3 agitated patients, so tell them no”
Bed Availability

“If you accept all transfers 24/7 - our occupancy target is 95% - but no denials”

“If you block 3 beds for potential ED admissions and Med-Surg floor transfers”

“If you reserve at least 2 beds for potential concierge program patients”

“If you don’t accept potentially violent patients - we can’t have another staff injury”

“My daughter’s last roommate was terrifying – she can only be with someone like her”

“If we make room swaps to take a male, we’ll have 3 agitated patients, so tell them no”

“If I take this transfer then I won’t sleep, and I need to sleep, so let’s wait until morning”

Understand each stakeholder’s perspective:

- Finance Director
- Operations Director
- Concierge Program Director
- Nursing Director
- Parent of Hospitalized Patient
- Psychiatric Nurse Per Diem
- Psychiatrist Per Diem
- Psychiatry Director
Bed Availability

“Please take all transfers 24/7- our occupancy target is 95%- but no denials”
“Please block 3 beds for potential ED admissions and Med-Surg floor transfers”
“Please reserve at least 2 beds for potential concierge program patients”
“Please don’t accept potentially violent patients- we can’t have another staff injury”
“My daughter’s last roommate was terrifying – she can only be with someone like her”
“If we make room swaps to take a male, we’ll have 3 agitated patients, so tell them no”
“If I take this transfer then I won’t sleep, and I need to sleep, so let’s wait until morning”
“Please keep the moonlighters content, we rely on them”

Understand each stakeholder’s perspective

- Finance Director
- Operations Director
- Concierge Program Director
- Nursing Director
- Parent of Hospitalized Patient
- Psychiatric Nurse Per Diem
- Psychiatrist Per Diem
- Psychiatry Director
Bed Availability

• Stakeholder consensus that there can be no ED boarding when there are beds in the system

• Online bedboard established in 2014

• 500 beds, 24 units, 7 hospitals. Contemporaneously updated

• Physician unit leaders are responsible for accuracy

• Lists number for dedicated cell phone carried by receiving physician, to overcome communication barriers

• Lists escalation tree in order to hold front-line staff accountable.
Inpatient Beds

Is there a bed available?

| No   | Yes |

Can the patient move without insurance pre-auth?

| No   | Yes |

Inpatient Bedboard

Next-day Auth Workflow

Dec 12, 2017
Insurance Authorization

Understand each stakeholder’s perspective

• Primary concern for receiving hospitals was risk of high-cost insurance denials
  → Addressed pre-pilot by demonstrating low denial rate and building trust

• Primary concern for sending hospitals was difficulty in justifying admission to insurance company
  → Addressed by customized EHR documentation templates with specific insurance-related mandatory elements
Insurance Authorization

Develop a solution and pilot

• Next-day authorization workflow piloted in 2013 and became standard in 2014.

(1) Behavioral Health providers transfer patients 24/7

(2) For after-hours transfers, they send secure-email with patient demographic info to the SW/CM working the next day

(3) SW/CM obtains authorization within 24hrs, which they send via secure email to receiving hospital

• Over 4000 patients have been transferred up to 72hrs sooner
Inpatient Beds

- Is there a bed available?
  - No → Yes

- Can the patient move without insurance pre-auth?
  - No → Yes

- Can the patient arrive on the unit after-hours?
  - No → Yes
Admission Legal Paperwork

New York State Mental Hygiene Law requires 4 independent signatures for involuntary hospitalization

<table>
<thead>
<tr>
<th>PART A</th>
<th>Application for Admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>I hereby apply for the admission of __________________________ (Name of person) to __________________________ (Name of Hospital) providing services for the mentally ill. My reasons for applying for admission of this person are as follows:</td>
<td></td>
</tr>
<tr>
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<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Under penalty of perjury, I attest that the information supplied on this application is true to the best of my knowledge and belief.</td>
<td></td>
</tr>
</tbody>
</table>

**Signature of Applicant**

**Address**

<table>
<thead>
<tr>
<th>Part B</th>
<th>Psychiatrist’s Confirmation of Need for Involuntary Care and Treatment in a Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>I HAVE EXAMINED THE ABOVE-NAMED PERSON PRIOR TO ADMISSION* AND CONFIRM:</td>
<td></td>
</tr>
<tr>
<td>* that the person is in need of involuntary care and treatment in a hospital providing inpatient services for the mentally ill; and</td>
<td></td>
</tr>
<tr>
<td>* that as a result of his or her mental illness, the person poses a substantial threat of harm to self or others (“substantial threat of harm” may encompass (i) the person’s refusal or inability to meet his or her essential need for food, shelter, clothing, or health care, or (ii) the person’s history of dangerous conduct associated with noncompliance with mental health treatment programs),</td>
<td></td>
</tr>
</tbody>
</table>

| Signature |
| Date |
| Time |
| A.M. |
| P.M. |
Admission Legal Paperwork

New York State Mental Hygiene Law requires 4 independent signatures for involuntary hospitalization

- Family member or hospital administrator
- Physician Licensed in New York State
- Physician Licensed in New York State

Understand each stakeholder’s perspective
Admission Legal Paperwork

New York State Mental Hygiene Law requires 4 independent signatures for involuntary hospitalization

- Family member or hospital administrator
- Physician Licensed in New York State
- Physician Licensed in New York State
- Receiving hospital Psychiatrist

PART A  Application for Admission

I hereby apply for the admission of ____________________ (Name of patient) to ____________________ (Name of Hospital), a hospital providing services for the mentally ill. My reasons for applying for admission of this person are as follows:

Under penalty of perjury, I attest that the information supplied on this application is true to the best of my knowledge and belief.

Signature of Applicant

Address

PART B  Psychiatrist's Confirmation of Need for Involuntary Care and Treatment in a Hospital

I HAVE EXAMINED THE ABOVE-NAMED PERSON PRIOR TO ADMISSION* AND CONFIRM:

- that the person is in need of involuntary care and treatment in a hospital providing inpatient services for the mentally ill; and
- that as a result of his or her mental illness, the person poses a substantial threat of harm to self or others ("substantial threat of harm" may encompass (i) the person’s refusal or inability to meet his or her essential need for food, shelter, clothing, or health care, or (ii) the person’s history of dangerous conduct associated with noncompliance with mental health treatment programs).

Signature
Admission Legal Paperwork

New York State Mental Hygiene Law requires 4 independent signatures for involuntary hospitalization:

- Family member or hospital administrator
- Physician Licensed in New York State
- Physician Licensed in New York State
- Receiving hospital Psychiatrist

Understand each stakeholder’s perspective
Admission Legal Paperwork

New York State Mental Hygiene Law requires 4 independent signatures for involuntary hospitalization

1. Family member or hospital administrator
2. Physician Licensed in New York State
3. Physician Licensed in New York State
4. Receiving hospital Psychiatrist

Understand each stakeholder’s perspective

Available 24/7
ED Physician
ED Physician
Admission Legal Paperwork

New York State Mental Hygiene Law requires 4 independent signatures for involuntary hospitalization

- Family member or hospital administrator
  - Available 24/7
- Physician Licensed in New York State
  - ED Physician
- Physician Licensed in New York State
  - ED Physician
- Receiving hospital Psychiatrist
  - Unavailable after-hours
Admission Legal Paperwork

New York State Mental Hygiene Law requires 4 independent signatures for involuntary hospitalization

- Family member or hospital administrator
- Physician Licensed in New York State
- Physician Licensed in New York State
- Receiving hospital Psychiatrist

Available 24/7
ED Physician
ED Physician
Telepsychiatrist

Unavailable after hours
Admission Legal Paperwork

• Partnership with primary stakeholder (NY State) around patient-centric goal of expediting patient’s movement to specialized treatment setting

• Since initiation in Aug 2017, 47 patients have been transferred from EDs to specialized inpatient beds that would have remained empty

---

Michael J. Dowling
President and Chief Executive Officer
Northwell Health
2000 Marcus Avenue
New Hyde Park, NY 11042

Dear Mr. Dowling:

I am pleased to announce the participation of member hospitals from Northwell Health in a demonstration initiative authorized by the New York State Office of Mental Health (OMH) to assess the use and effectiveness of telepsychiatry for involuntary inpatient admissions pursuant to Article 9 of the NYS Mental Hygiene Law (MHL). Through this initiative, OMH will allow participating hospitals to satisfy one of the MHL Article 9 required physician certificates via telepsychiatry, which is the use of real time audio visual communication as a face-to-face encounter.

This is an innovative project which furthers the goal of New York State to assist in time-sensitive psychiatric care, and to inform future efforts of bringing telepsychiatry into the public mental health system. I commend you for taking on this worthwhile endeavor.

ANDREW M. CUOMO
Governor

ANN MARIE T. SULLIVAN, M.D.
Commissioner

MARTHA SCHAEFER
Executive Deputy Commissioner

December 9, 2016
Challenges and Solutions

Challenge #4
Transporting potentially volatile patients in a confined space over large distances poses a risk of harm to patients and staff. In NYS ambulance must remain unlocked so there is an added risk of elopement.
Challenges and Solutions

Challenge #4
Transporting potentially volatile patients in a confined space over large distances poses a risk of harm to patients and staff. In NYS ambulance must remain unlocked so there is an added risk of elopement.

Solution  
EMS Phone Screen  
EMS Pre-Transport Huddle  
EMS Buckle Guard and Net
Safe Transportation of Emergency Psychiatry Patients

Transporting patients from Emergency Departments to locked Inpatient Psychiatry Units via unlocked ambulance over large distances is a high-risk process

“Man escapes ambulance”
“Mentally Ill Woman killed jumping from ambulance”
“Paramedics injured subduing psychiatric patient”
“Schools locked down after mental patient escapes EMS”

YouTube Video of Patient escaping can be shown privately
Root Cause Analyses of EMS Elopement Have Concluded...

- Prehospital management is different than inter-facility management by EMS
- EMS is not properly trained nor equipped for the management of inter-facility psychiatric transport elopement
- Ambulances are not designed to prevent elopement
- Local regulations may inhibit implementation of safe transport countermeasures
- Elopement countermeasures are often misunderstood, misused, unavailable or unused
- Hospital staff accustomed to hospital safeguards may underestimate the true dangers involved
- EMS may be unaware of the dangers a patient presents and are caught off-guard
To Prevent Future Tragedy, EMS Must Employ Change Across All Strategic Domains of Corrective Action

HIERARCHY OF RISK REDUCTION STRATEGIES/CORRECTIVE ACTIONS*

<table>
<thead>
<tr>
<th>STRONGER ACTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Architectural/physical plant changes</td>
</tr>
<tr>
<td>Engineering controls (forcing function)</td>
</tr>
<tr>
<td>Simplification of processes by removing unnecessary steps</td>
</tr>
<tr>
<td>Standardization of equipment</td>
</tr>
<tr>
<td>Standardization of order sets, processes or care maps</td>
</tr>
<tr>
<td>Tangible involvement and action by leadership in support of patient safety</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>INTERMEDIATE ACTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase staffing</td>
</tr>
<tr>
<td>Decrease workload</td>
</tr>
<tr>
<td>Software enhancements</td>
</tr>
<tr>
<td>Reduce distractions</td>
</tr>
<tr>
<td>Checklist/cognitive aid</td>
</tr>
<tr>
<td>Enhanced documentation/communication</td>
</tr>
<tr>
<td>Read back</td>
</tr>
<tr>
<td>Redundancy</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>WEAKER ACTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Double checks</td>
</tr>
<tr>
<td>Warnings and labels</td>
</tr>
<tr>
<td>New procedure/policy/memo</td>
</tr>
<tr>
<td>Training</td>
</tr>
</tbody>
</table>

*National Center for Patient Safety
Protocol & Training Changes

- TeamStepps training provided to all EMS staff
- Aggression reduction training provided to all EMS staff
- Development of the “Guttenberg Protocol” which included development of a pre-screening call-intake algorithm, medical staff training, checklist and deployment of new physical countermeasures
Pre-Transport ED Huddle Determines Restraint / Medication

CEMS Transport Process

PRE-TRANSPORT HUDDLE PROTOCOL

Rationale:
- Transporting psychiatric patients in a confined, unsecured space, i.e., by ambulance or security vehicle, especially for a prolonged period of time, and with minimal staff support must be considered a HIGH RISK SITUATION.
- Although the overwhelming majority of patients suffering from psychiatric illness are not violent, precautions to ensure the safety of the patient, staff, and potential bystanders merit a review of the decision to transport such patients at a particular time and under particular circumstances warrants review.
- A Huddle, incorporating TeamHuddle methodology, provides a platform for this review.

Procedure:
- The following procedure applies whenever a patient with a psychiatric disorder is transported by vehicle from any of the Health System Emergency Departments (EDs) to another secure location. Typically, this procedure applies to patients who have been evaluated by a physician and deemed to be in need of acute psychiatric hospitalization.
- This procedure applies regardless of the patient's psychiatric legal status or anticipated legal status.
- A “Huddle” will be called by the staff of the sending ED prior to the patient's transport. The huddle may take place at any time before transfer, but must occur before the patient is placed on a transport stretcher (in the case of an ambulance) or leaves a secure area of the ED (in the case of security transport).
- A minimum of participants in the huddle will include an ED physician, ED nurse, and EMS staff.
- The huddle will review historical and clinical factors related to aggression risk (see attachment – AGGRESSION RISK REVIEW).
- Based on this review, the individuals in the huddle will arrive at a consensus regarding the following:
  o Current stability of the patient for transport
  o Requirement of additional measures (if any), as applicable and clinically appropriate, to ensure patient stability, including:
    ▪ Psychological/environmental supports and interventions, e.g., reassurance, nutrition, toileting
    ▪ Placement in hospital gown/bareness
    ▪ Medication
    ▪ Mechanical restraint
    ▪ Additional staff to accompany patient
    ▪ Debrief/modification of transport plan
  o Involvement of family/significant others
    ▪ The participants in the huddle will develop a stabilization and transport plan after considering all of the above.
    ▪ The transport plan must comply with EMTALA, CMS, and DOH regulations pursuant to the protection of patient rights.
  o Sample script (to be used just prior to entering the ambulance)
    ▪ Every effort should be made to establish rapport with the patient prior to transport. At a minimum, this would include:
      ▪ Introduction of all staff involved in the transport

Use of last names and appropriate titles when speaking with the patient, e.g., Mr. Smith
Explanation of what is happening and what the patient can expect, e.g., we will be driving you to Zucker Hillside Hospital. It should take about 20 minutes. You will be reclining in the stretcher, facing the back door, with stretcher belts—bela the belts are for your safety. Mr. Jones is a member of the ambulance crew and will be riding with you. Please let Mr. Jones know if you need anything during the ride, etc.
Before getting onto the ambulance, ask the patient if they need to use the bathroom, would like something to drink or eat, etc.
Is there anything else you need before we go onto the ambulance?
- If a consensus regarding a transport plan cannot be reached, each discipline will escalate the huddle to the next supervisory level
- Time out/Confirmation of consensus
  o The reaching of consensus will be confirmed by having each huddle participant stipulate that the plan for transport has been adequately reviewed and the patient is ready for transport.

AGGRESSION RISK REVIEW

The following factors should be considered in determining aggression risk:

- Medical status, with special attention to higher-risk conditions, including
  ▪ Substance-induced intoxication or withdrawal
  ▪ Delirium
  ▪ Dementia
  ▪ Mental retardation/developmental disorders
  ▪ Traumatic brain injury
- History of violence prior to presentation in the ED, including legal history
- History of victimization (history of having been physically or sexually abused)
- Higher risk psychiatric symptoms/behaviors/diagnoses
  ▪ Paranoid delusions
  ▪ Delusions of being controlled
  ▪ Command hallucinations
  ▪ Mania
  ▪ Antisocial Personality Disorder
  ▪ Borderline Personality Disorder
- Behavior in the ED, including
  ▪ Evidence of physical tension (pacing,grimacing, fist or jaw clenched, fixed nostrils, flushed face, darting eyes, close proximity to clinician, agitation)
  ▪ Evidence of psychological tension (laughing, incoherent speech, hyperventilation)
  ▪ Other symptoms/behaviors (inability to outburst, threats, glaring, hostility, aggression)
- Patients who do not have a psychiatric history may be at higher risk for aggression account.
Phone Screening Determines Ambulance Staffing

<table>
<thead>
<tr>
<th>Response Level Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the patient a flight risk or does the patient have a history of elopement?</td>
</tr>
<tr>
<td>- No</td>
</tr>
<tr>
<td>- Yes</td>
</tr>
<tr>
<td>Is the patient being involuntarily committed?</td>
</tr>
<tr>
<td>- No</td>
</tr>
<tr>
<td>- Yes</td>
</tr>
<tr>
<td>Does the patient have a history of violent behavior?</td>
</tr>
<tr>
<td>- No</td>
</tr>
<tr>
<td>- Yes</td>
</tr>
<tr>
<td>Is the patient violent at this time?</td>
</tr>
<tr>
<td>- NO</td>
</tr>
<tr>
<td>- Yes</td>
</tr>
<tr>
<td>Will the patient require four point restraints for transport?</td>
</tr>
<tr>
<td>- No</td>
</tr>
<tr>
<td>- Yes(ALS)</td>
</tr>
</tbody>
</table>

READ TO CALLER: "Please have the Physician place an order for Four Point Restraints for transport."
- OK

Has the patient received IV, IM or PO sedation or anti psychotic medications due to agitation within the past three hours?
- No |
- Yes(ALS)

Does the patient have recent psychotic symptoms
- No |
- Yes(ALS)

- Do any of the above answers indicate an ALS Level Response?
- No |
- Yes
Deploy Physical Countermeasures

Interior
• Secure non essential equipment in outside compartments
• Remove sharps and liquids from patient reach

BuckleGuard vs Restraints

Safety Net

Stronger Action

Provide
“Panic” button on EMS radio
Summary
Summary

The road to high-quality Emergency Department Behavioral Health care is paved with challenges.

These challenges can combine to create long lengths of stay for patients in non-optimal settings, impacting the health and safety of patients, families, and staff.

Persistent collaboration and the harnessing of technology can yield solutions to these challenges – examples include specialized triage, emergency telepsychiatry, bed transparency, “TeleLegals”, and clinical transport-related huddles.
References


Thank You

Michael Dowling
Mark Solazzo
Gene Tangney
Marty Doerfler MD
Blaine Greenwald MD
John D’Angelo MD
Iris Berman RN MSN CCRN
Paula Fessler RN MSN
Mark Fauth MBA
Kate O’Neil RN MSN FNP
Rachael Spooner MBA
Regional Executive Leadership
Regional Medical Leadership
Telehealth Project teams
Hospital Emergency Medicine Leadership
Hospital Behavioral Health Leadership
Hospital Nursing Leadership
Hospital Administrative Leadership
Office of the Chief Information Officer
Center for Emergency Medical Services
Our staff, patients and their families