Performance Improvement

Improving Processes to Reduce LOS for Behavioral Health Patients in the ED: St. Anthony Hospital, Oklahoma City, Oklahoma 4/2010

Summary
By changing internal processes and **without adding new staff or new costs**, St. Anthony Hospital in Oklahoma City - as part of the Institute for Behavioral Healthcare Improvement (IBHI)'s Collaborative on Improving Care for Behavioral Health Clients in Emergency Departments - achieved the following:

- Successfully reduced the amount of time mentally ill patients spend in its ED in a crisis situation.
- Cut in half the time these patients wait before they can get to a bed.
- Dramatically decreased the time these patients must wait in the ED before they can meet with a mental health professional.

Community and Hospital
Oklahoma City is the capital and largest city of Oklahoma. The city's estimated population as of 2008 was 551,789, with an estimated metro-area population of 1,206,142. The 1999 median income for a household in the city was $34,947, and 16.0% of the population and 12.4% of families were below the poverty line. In 2008, Forbes magazine named Oklahoma City the most "recession proof city in America." The magazine reported that the city had falling unemployment, one of the strongest housing markets in the country, and solid growth in energy, agriculture, and manufacturing.

Part of SSM Health Care, St. Anthony was the first hospital established in Oklahoma and is the largest with 686 licensed beds. It serves as a regional referral facility with specialties in cardiology, oncology, surgery, and behavioral medicine. The behavioral medicine center is licensed for 272 beds and includes inpatient programs for adults, adolescents, and children, plus a wide range of outpatient and residential programs, addressing such issues as senior diagnostics, drug and alcohol abuse, adolescent conduct disorders, and mental retardation.

Program Overview
The stated aim of the Institute for Behavioral Healthcare Improvement (IBHI), which began in 2004 and built on the work of the Institute for Healthcare Improvement (IHI), is: "To dramatically improve behavioral health care outcomes by creating a high performing national learning organization that invites organizations out of their historical silos. IBHI seeks to encourage a movement that translates a passion for quality improvement into sustained action."

The IBHI Collaborative on Improving Care for Behavioral Health Clients in Emergency Departments, of which St. Anthony Hospital has been an active participant since it began, aims to reduce client suffering; improve knowledge for better care of persons with behavioral health

care needs in hospital emergency departments; improve hospital functioning and effectiveness as measured by reductions in overall time for care, time from arrival to assessment, and use and time in restraints, as well as improved patient and staff satisfaction and less congestion and conflict in EDs. The IBHI Collaborative also hopes to create collaborative efforts nationwide.

St. Anthony's experience began in August 2007, when the hospital's COO, who is also co-chair of the IBHI Collaborative project, approached the director of the ED and the manager of the mental health department about refining processes and improving efficiencies and throughput time for behavioral health patients in the ED.

Of the 49,000 patients who come through the ED every year, 11 percent have behavioral health issues and 1 in 3 admissions from the ED are to a mental health bed. The 7,000 patients that come to the mental health department each year mostly come through the ED. It made sense to bring these two departments together to find ways to benefit these patients. The ED staff has come to see behavioral health as a specialty within the department, like trauma, with different benchmark goals. The mental health department steered the process of change and was able to help ED staff offer the best and most efficient service to behavioral health patients.

The two departments developed a strong sense of teamwork through this effort. They brought in "mystery shoppers," who were actually mental health therapists from other sites pretending to be patients presenting at the ED with a variety of behavioral health issues. Reports from these "customers" opened the eyes of the departments' leadership about how inefficient the processes were and how little the ED staff understood mental illness. Interviews were also held with ED staff to add to the total picture of how mentally ill patients were being perceived.

Other departments were brought into the change process, including registration, labs, security, and transportation. External links were created with the sheriff's department and police that resulted in meetings where the police department has agreed to assist in training hospital staff on emergency de-escalation using the Crisis Intervention Training (CIT) concept. Twenty percent of the police force in Oklahoma City are trained in CIT. Of the 1,888 crisis intervention calls that police responded to in 2009 - including for mental health crisis, domestic violence, and suicide risk - 286 resulted in individuals being brought to St Anthony Hospital ED by police, of which 57 were brought in by ambulance service.

Tearing down silos was an essential early step, and an ongoing challenge. Both the mental health and the emergency departments share the same turf and the same goal - the most efficient, quick, and accurate treatment for their patients. The ED director has been proactive in asking the mental health department manager about what works, both are committed to change, and both are open to different ideas. Every January, they sit down together and develop a goal for the mental health population, and they constantly check in about how they're doing.

All six hospitals participating in the IBHI Collaborative on Improving Care for Behavioral Health Clients in Emergency Departments shared data on results of a 10-month improvement process plus an additional 6 months. A pre-work exercise assessed initial organizational

readiness, baseline data, and patient experience, and involved getting support from senior administration, forming a team from general and behavioral health to develop the change process, having a member of the team go through the process of becoming a patient in the ED, and interviewing two to four people who were recently provided behavioral health care in the ED. Results of these assessments in January 2008 drove the process of creating the "Model of Improvement," the "Rapid Tests of Change" process, and the "Change Package."

The following were among the recommendations from the Collaborative:

- *Training* (e.g., emergency de-escalation training for all; decreasing use of restraints through de-escalation, early use of anti-psychotics, time-out room, diversion activities, and a one-to-one psychiatric aide; continuing education of staff, including identifying high-risk clients and standardized use of medications)
- *Operational modifications in professional practice* (e.g., using newer psychotropic medications; psychiatrists taking responsibility for noon discharge; psychiatrists managing patient care vs. consultation model)

Program Impact

Of special interest when St. Anthony's first began its effort was the length of time patients were waiting in the ED before they could even have an initial assessment by a mental health professional - about three hours. By February 2008, they reduced that time to two hours. By December 2009, behavioral health patients in the ED were able to meet with a mental health professional in about 28 minutes.

Other significant data points for St. Anthony Hospital included:

- Throughput time, the time it takes for a mentally ill patient in the ED to receive medical triage, which the hospital decreased from 44 minutes to 16 minutes.
- Time from point of entry in the ED to being admitted to a room, which went from two hours to less than one hour.
- Total time in the ED, which went from 254 minutes to 187 minutes.

In the past, patients presenting at the ED with behavioral health issues might be juggled among multiple buildings on campus for assessment, medical triage, labs, lab results interpretation, and waiting for each step to be completed - the process generally took four to six hours before the patient in crisis could be admitted. The ED was backlogged as a result, and these patients, their families, and often the practitioners delivering treatment were frustrated at the slow pace of the system.

Now, with a mental health practitioner in the ED at all times, the patient registers and is seen quickly and assessed for risk. Keeping patients safe is top priority. Following a sequential procedure is less important. Whoever is available first does their part of the process: labs, medical evaluation, etc. Security staff watches patients if necessary. When safety is an issue,

dealing with insurance pre-authorization or other coverage concerns is lower on the to-do list. In crisis situations, getting the patient through the process and into a bed takes precedence.

To further address the high volume in the ED, St. Anthony opened a second triage area, with a nurse practitioner and physician assistants doing a medical screening before the patient enters the triage system. As a result, approximately 150 patients a month don't go through triage; they are treated without needing beds. The pace is now even faster than the clinic.

The hospital has also elected to move chemical dependence (CD) discharges up to noon, rather than in the late afternoon or evening, and to not admit these patients after 5 p.m. Because these are voluntary admissions, certain actions are required, including authorization from insurance and interpretation of lab results, so restricting them to daytime hours when ED crowds are lighter and more staff are available eases the ED crowd at night.

One change has facilitated a better working relationship with the sheriff's office and the police department. In Oklahoma, when an emergency order of detention is issued for a patient, police transport is mandated. Sometimes the police officer must wait with the patient for several hours - the officer can't leave until the patient is admitted. The hospital started prioritizing police-transport cases to release the officer more quickly. Now, the hospital and the police are more responsive to each other's needs and have agreed to participate in cross training in how to most efficiently access mental health services in crisis situations.

The next step for St. Anthony's ED involves working with the lab department to allow quick registration, while checking for comorbidities and chemical dependence. By doing standard labs before the patient enters the ED, the ED physician will have the patient's lab results before doing a medical assessment. In this way, the hospital hopes to shave off another 45 minutes of time in the ED. The shorter the throughput time, the higher the satisfaction ratings from both patients and staff.

Funding

Since the modifications were generally process changes and program redesign, most changes were cost neutral. When costs are involved, they are handled through internal budgets, which is another argument for the importance of teamwork and the need for universal buy-in. If silos can be effectively torn down, all involved departments can see the effort as a joint venture - and be willing to finance it together.

Obstacles and Challenges

- Opening up dialogue among involved departments is not always so easy. The ED director and the mental health manager admit that they represented their silos at first and didn't consider the total effect on other areas. How do you become more in synch? They suggest looking at the issue from all angles to see what can be done better. Training and orientation are key.

- Collecting useful baseline data is essential. Prior to this initiative, inadequate data had been collected about the amount of time it took for a behavioral health patient coming through the ED to see a mental health professional. The hospital had to reestablish baseline data for 30 days in order to be able to track improvement.
- Transportation is still an obstacle. One of St. Anthony's mental health facilities is six miles from the ED. In the past, the sheriff's department or an ambulance would provide transport - the patient's wait was often hours. Now the hospital provides transport internally 24/7 for medically stable patients and nonviolent patients.
- Implementing efficient agitation protocols continues to be a challenge.
- Motivating some staff to be more invested in reducing throughput times has been an ongoing issue. The hospital plans to try pay for performance - basing raises in the entire mental health department on achieving targeted decreases in throughput times.

Success Factors

The relationship with hospital administration has been the most significant success factor in making these improvements. Both the COO and the vice president for quality and risk management have backgrounds in mental health and are very invested in meeting the goals as set by the ED director and the mental health manager. Administration is "progressive, sharp, and demanding," yet does not try to micromanage. Excellence is expected.

Other factors contributing to the effort's success include breaking down silos by engendering cooperation and the desire to effect change; an "open door" policy that supports brainstorming and listening to each other's ideas; ongoing education and training; and program redesign.

Lessons Learned and Advice to Others

The following advice comes from St. Anthony Hospital's experience with improving ED care for patients with behavioral health issues:

- Don't give up on collecting accurate information and data.
- Use "mystery shoppers" to gain a full understanding of the patient's experience.
- Facilitate open dialogue with administration and cooperation between departments. Hold meetings months in advance of making a process change, so that staff across the hospital can develop common goals and shared interests.
- Change one step at a time.

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