Challenges versus Solutions to Psychiatric Patients in the ED

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Evidenced-Based Practice

Quality Improvement

Background

Patients with psychiatric complaints are 7-10% (12 million) of annual ED visits nationally. Reduced availability of inpatient beds for treatment and an increase in under insured patients has rose over the last decade. Of the reported psychiatric ED visits 41% required inpatient hospital stays. This has led to many ED's holding psychiatric patients in the ED for hours and days, until a final disposition is established. Likelihood of holding a psychiatric vs. non psychiatric patients in the ED was almost 5 times greater. Leading to poor patient outcomes, decreased patient satisfaction, increased morbidity and mortality, delays in care, increased elopement, and overcrowding in the ED. The Supreme Court in the State of Washington ruled in 2014 that boarding psychiatric patients in hospital EDs is unlawful.

Participants/Subjects:

Of the annual 96,000 ED visits 10 to 12 percent focus on behavioral health complaints. Greater than 90% of the behavioral health population are on legal holds, requiring care with a multidisciplinary collaborative approach. This project included stakeholders from ED leadership, ED physicians, Behavioral Health leadership, psychiatrists, social services, alert team members, ED clinical ladder nurses, ED technicians, hospital security and community partners.

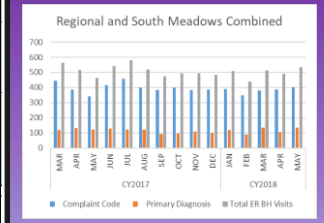
Purpose/Design

The purpose of the project was to evaluate alternative methods to care for behavioral health patients who present to the emergency department. As a quality improvement project, the focus was length of stay and management of high utilizers in the ED. Community partnerships were formed to better provide wrap around services and discharge planning for overall care of behavioral health patient in the emergency department setting. Specific bench mark metrics were: average length of stay (LOS), time from physician complete to discharge, LOS improvements < 11hrs, LOS improvements < 24hrs, and high utilizers better managed.

TARGET SHEET

Metric (units of measurement)	Baseline	Target	Report Out 1	Report Out 2	Report Out 3	1 Year Average 03/17-02/18	%Change
Time							
Lead Time – Average Length of Stay (LOS)	16.5 hours	6 hours	13.5 hours	14.6 hours	15.7 hours	16.2 hours	2%
Cycle Time - Time from Physician Complete to Discharge	12.4 hours	4 hours	10.1 hours	10.7 hours	11.5 hours	12.1 hours	2%
Quality							
LOS improvements (<11 hours)	73%	90%	80%	74%	73%	74%	1%
LOS improvements (<24 hours)	82%	100%	87%	85%	84%	84%	2%
High Utilizers are better Managed (1 month of ED Visits, annualized)	189	104	84	180	48	108	43%

Data Collection Methodology:
1. Average length of stay (LOS) for all patients with a Behavioral Health primary diagnosis.
2. Time is measured as the average amount of time generated between the time stamps in Epic for the patient ready for transfer to the time stamp of discharged.
3. % of patients that fell below 11 hours LOS. Monthly basis we will run the LOS for patients with a primary diagnosis behavioral health ICD-10 codes between F01-F99
4. % of patients that fell below 24 hours LOS. Monthly basis we will run the LOS for patients with a primary diagnosis behavioral health ICD-10 codes between F01-F99
5. Utilizing detail report from 2 above we determined the top 10 ED utilizers. Based on specific MRNs we will monitor their total ED use in the coming months on an annualized basis. The baseline is the 12 month total for the 10 MRNs.



Key Elements of Solution Process

Lessons Learned

- Involve community partners early in process
- Cannot base process on one partner/person
- Problem bigger than we can solve internally
- Needs community wide solution

Additional Impacts

- ✓ Changed conversation in community
- ✓ Built and strengthened community partnerships
- ✓ Replaced SAD score with evidence-based practice Columbia Scale
- ✓ Opened 4 observation beds on medical floor for patients awaiting transfer
- ✓ Collaboration with law enforcement to implement safe handoffs – community wide process

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