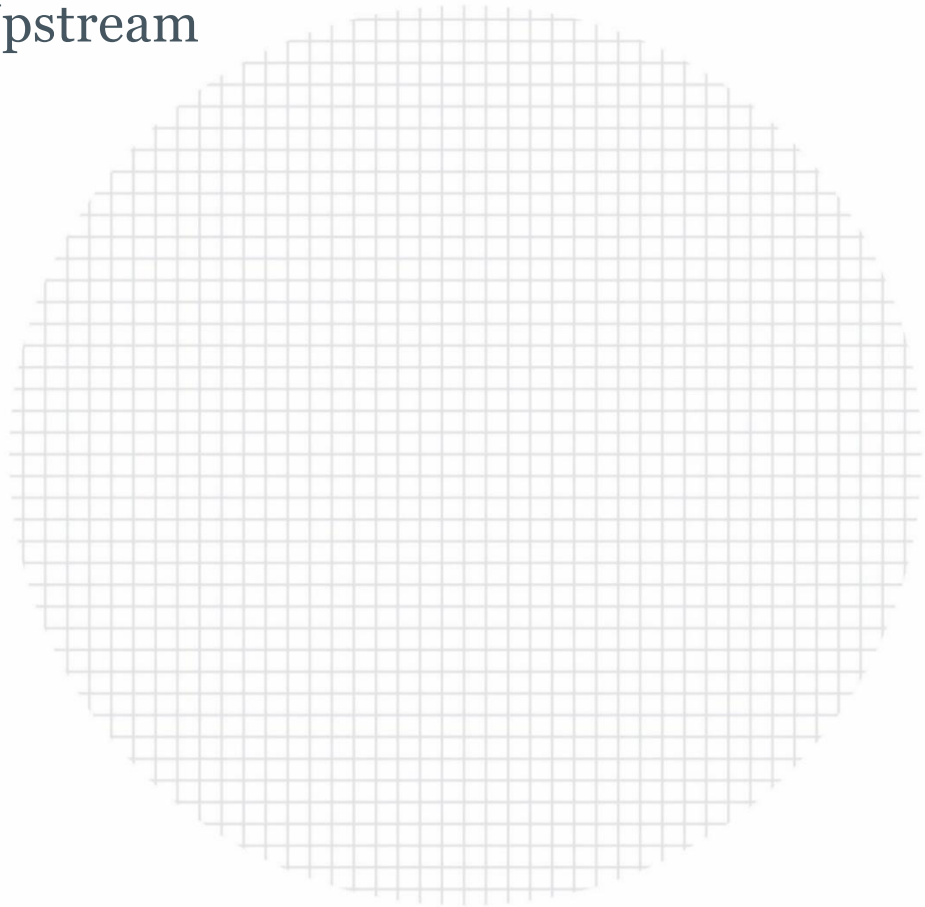
Institute for Healthcare Improvement

Framework, Changes, and Measures

Excerpt from IHI White Paper: Improving Behavioral Health Care in the Emergency Department and Upstream



Excerpted from: Schall M, Laderman M, Bamel D, Bolender T. *Improving Behavioral Health Care in the Emergency Department and Upstream*. IHI White Paper. Boston, Massachusetts: Institute for Healthcare Improvement; 2020. (Available on ihi.org)

The content in this document is excerpted from the IHI White Paper, *Improving Behavioral Health Care in the Emergency Department and Upstream*.[1] The white paper provides actionable guidance for hospital emergency departments and their community partners who are committed to creating a compassionate, seamless, and effective system of care that is respectful of and works with patients with mental health conditions and substance use disorders who present to the emergency department.

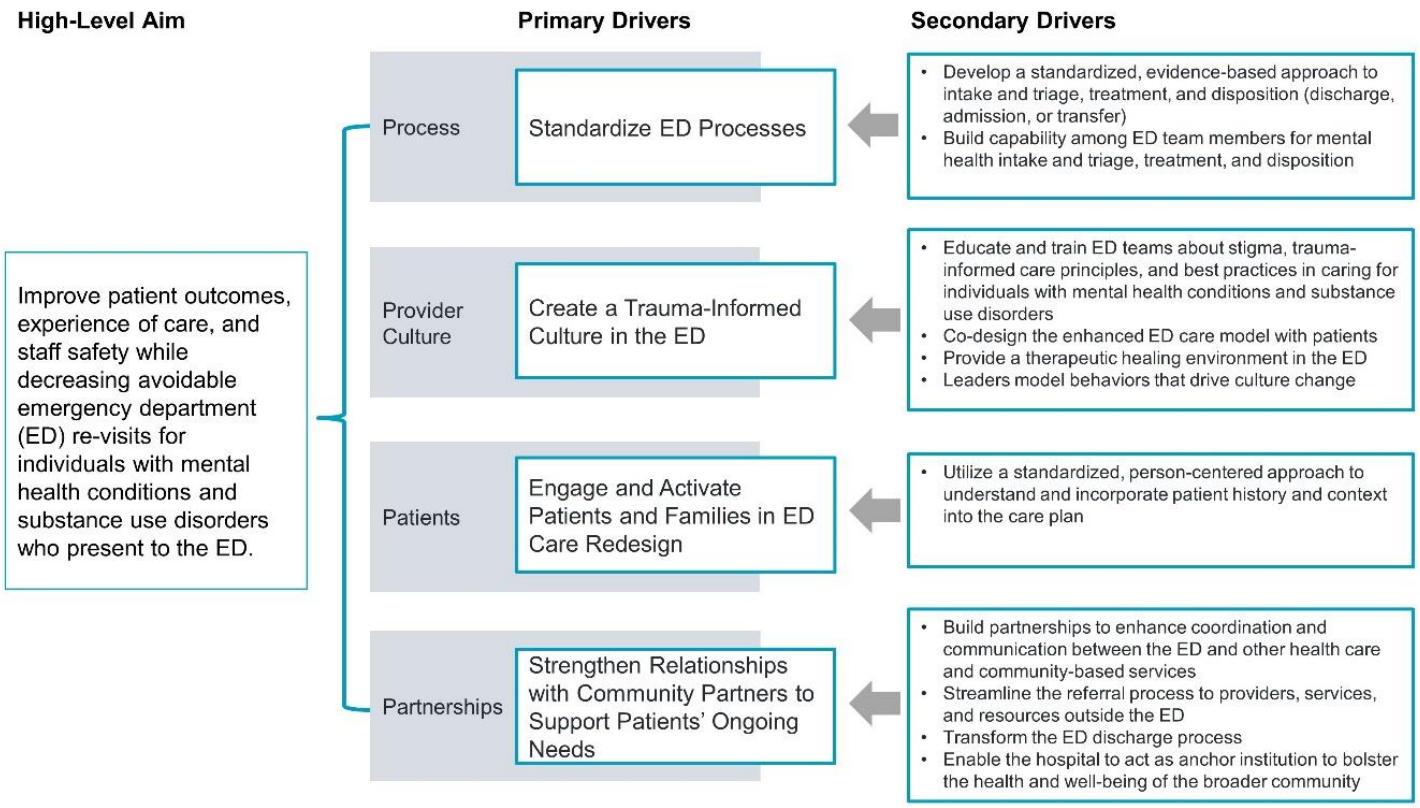
We recommend reading the complete white paper, which provides important additional information about the specific content extracted in abbreviated format in this document: a framework that comprises four key components; high-leverage changes and specific change ideas; and suggested measures.

Framework for a Better System of Care

The figure below presents a guiding framework for hospital emergency departments and their community partners to implement evidence- and experience-based changes to improve patient outcomes, experience of care, and staff safety while decreasing avoidable ED revisits for individuals with mental health conditions and substance use disorders who present to the emergency department.

While the four framework components are numbered, there is not a sequential order for testing or implementing the changes. Work in all four components, however, is needed to achieve the high-level aim.

Framework for Improving Emergency Department Care for Individuals with Mental Health Conditions and Substance Use Disorders



The section that follows organizes the high-leverage changes and associated specific change ideas by the four framework components (primary drivers and related secondary drivers).

1) Process: Standardize ED Processes

1A) Develop a standardized, evidence-based approach to intake and triage, treatment, and disposition (discharge, admission, or transfer)	
High-Leverage Changes	**Specific Change Ideas**
ED Intake and Triage of Patients with Mental Health Conditions and Substance Use Disorders	
Connect the patient with the appropriate mental health or substance use disorder consult as early as possible	• Conduct medical and psychiatric evaluation in parallel (e.g., use an evidence-based tool such as the SMART Medical Clearance Form to initiate clinically indicated tests in a timely manner)
Ensure individuals are seen in a comfortable, non-coercive, and non-threatening environment in the ED	• Establish a patient-provider relationship by using, for example, verbal de-escalation and sensory modulation techniques • Create dedicated beds and/or space inside or outside the ED based on acuity (e.g., observation unit, dedicated waiting area, hospital-based crisis stabilization unit or psychiatric emergency unit)
Assess ED patients for mental health conditions or substance use disorders, stratify patients by risk level and acuity, and develop pathways to needed level of care	• Develop a rapid triage assessment process (e.g., use the Australasian Triage Scale) • Use a brief screening tool to conduct an initial assessment of suicide risk and identify patients who require a full assessment; for full assessment, use a validated, standardized scale • Assess level of agitation using a validated, standardized tool (e.g., Behavioral Activity Rating Scale[2])
Gather relevant information from family or support person	• Build an information gathering step into the triage and assessment workflow, specifying how and when this will be done and by whom (may be one or more care team members)
ED Treatment of Patients with Mental Health Conditions and Substance Use Disorders	
Form a therapeutic alliance with the patient that is compassionate and respectful	• ED staff treat all patients, including those with mental health conditions and substance use disorders, with compassion and respect • Staff collaborate with patients on treatment decisions rather than ordering compliance with provider-only decisions • Engage patients and learn their story in their own words • Review patient history and any additional information provided by a family member or companion who accompanies the patient to the ED
Provide the appropriate level of care to manage symptoms and stabilize the patient	• Regularly re-evaluate the patient for changes in symptoms on disposition and also after stabilization; do not assume patient condition is static from the time of the formal assessment, and if the condition changes disposition options may be different as well • Educate ED staff on safety planning and lethal means restriction following patient discharge from the ED • Provide prescribed medication at ED discharge
Identify relevant clinical guidelines for major disease states (e.g., agitation, anxiety, psychosis)	• Use prompts to initiate treatment decisions
Provide active treatment with medications in the ED as soon as possible; provide brief interventions where appropriate	• Develop protocols for specific populations and conditions such as medication based on assessed level of agitation
ED Disposition of Patients with Mental Health Conditions and Substance Use Disorders	
Develop a standardized approach to ED discharge and follow-up for mental health and substance use disorder patients	• Schedule follow-up appointments before patients leave the ED • Include a flag in the patient record to identify high-risk patients, to ensure follow up with the patient after ED discharge and appropriate continuation of care and utilization of services and resources • Determine optimal care team member roles for care plan follow-up and outreach to both patients and the next provider or community-based services

1B) Build capability among ED team members for mental health intake and triage, treatment, and disposition	
High-Leverage Changes	**Specific Change Ideas**
Create an ED behavioral health intervention team, including a hospital-based mental health provider (e.g., psychiatrist, psychologist, or licensed clinical social worker [LCSW]; community mental health worker; peer support specialists; patient navigator)* *Note: These are suggested team members, representing roles and resources that may be filled in different ways depending on the specific context of a hospital ED (e.g., by partnering with community agencies to provide peer support specialists, or using telehealth to connect patients in the ED with psychiatrists for a consultation).	• Maximize the training and expertise of all staff • Increase the availability of psychiatric consults in the ED, including psychiatric nurse practitioner shifts, to free up psychiatrists • Provide virtual access to mental health services for triage, consultation, and treatment via dedicated phone access or utilizing telepsychiatry consults/evaluations and virtual mental health providers (e.g., psychiatrists, LCSWs, psychologists) and teams as needed; these can be consultations between clinicians or direct connections between a virtual clinician and patient • Engage the ED behavioral health intervention team in interdisciplinary rounds
Optimize onsite staff expertise and training in caring for patients with mental health conditions and substance use disorders	• Develop "go-to expertise" within the ED (e.g., nurses and LCSWs with special training) to support ED staff who do not have psychiatric expertise • Utilize peer support specialists in the ED (e.g., National Alliance on Mental Illness [NAMI] representatives in the ED)
Make mental health and addiction medicine resources easily accessible to ED staff	• Identify ways to engage local organizations (e.g., NAMI) and peer support specialists to support high-risk patients

2) Provider Culture: Create a Trauma-Informed Culture in the ED

2A) Educate and train ED teams about stigma, trauma-informed care principles, and best practices in caring for individuals with mental health conditions and substance use disorders	
High-Leverage Changes	**Specific Change Ideas**
Train and educate all relevant ED staff in key issues to improve care for individuals with mental health conditions and substance use disorders, including: • Implicit bias toward individuals with mental health needs, "drug-seeking" behavior, homelessness, and other issues • Inequities related to race, age, gender, insurance coverage, or other populations (identified using quantitative and qualitative data) • Diagnosis-based, evidence-based, standardized care models for psychiatric patients (e.g., dialectical behavior therapy) • How to provide trauma-informed care; de-escalation; care for agitated patients	• Provide ongoing support for ED staff to reinforce training • Train staff "go-to experts" (such as psychiatric-trained ED nurses) who specialize in working with patients with mental health needs • Collaborate with hospital security personnel on safety and trauma-informed care trainings
2B) Co-design the enhanced ED care model with patients	
High-Leverage Changes	**Specific Change Ideas**
Identify what does and does not work in the current care approach by talking with and listening to patients with mental health conditions and substance use disorders	• Conduct an observational exercise in which a dedicated ED care team member follows the care process (note that patient permission is needed for any direct clinical interaction) or by "simulating" ED staff interaction with a patient • Interview patients and staff about their ED care experience and incorporate that qualitative data into the care process redesign • Ensure the viewpoint of different patient populations is represented (e.g., race, age, gender, insurance status)
Engage mental health and substance use disorder patients in designing and testing new ED processes to improve trauma-informed care	• Partner with NAMI to identify patients and/or families to participate in planning and testing new processes • Utilize existing patient advocacy groups

2C) Provide a therapeutic healing environment in the ED	
High-Leverage Changes	**Specific Change Ideas**
Ensure individuals with mental health conditions and substance use disorders are seen in a comfortable, non-coercive, and non-threatening environment in the ED	• Establish a patient-provider relationship by using, for example, verbal de-escalation and sensory modulation techniques • Create dedicated beds and/or space inside or outside the ED based on acuity (e.g., observation unit, dedicated waiting area, behavioral health urgent care)
2D) Leaders model behaviors that drive culture change	
High-Leverage Changes	**Specific Change Ideas**
Ensure productive dialogue and decision making within the ED team to foster engagement and alignment with creating a trauma-informed culture in the ED	• Leaders reframe mental health and substance use disorder needs as analogous to a medical condition, to help shift cultural attitudes • Leaders conduct weekly ED walk-arounds to reinforce the rationale and importance of a trauma-informed culture to better address mental health and substance use disorder issues • Senior sponsor of the ED improvement team regularly attends team meetings and holds monthly review meetings to assess progress and barriers
Build the health system's and ED's values on creating a team-based and patient-centered culture into processes for ED staff hiring and training	• Include trauma-informed care training in ED new hire orientation

3) Patients: Engage and Activate Patients and Families in ED Care Redesign

3A) Utilize a standardized, person-centered approach to understand and incorporate patient history and context into the care plan	
High-Leverage Changes	**Specific Change Ideas**
Map the ED care process from the patient's perspective to understand areas for improvement	• Identify and revise non-evidence-based ED protocols and procedures that adversely affect patient dignity • Collect and act on patient and family feedback on ED experience of care via text survey or electronic form • Engage families and caregivers in the design of ED discharge instructions, care planning, and transition to the next care setting
Train and support ED staff to incorporate patient and family engagement into care processes	• Develop a standardized process to engage families, as desired by the patient, throughout the ED stay, from intake and assessment to initial treatment to disposition (discharge, admission, or transfer)
Provide peer support opportunities both during and after ED visits	• Develop partnerships with the local NAMI chapter to connect patients and families with peer support and ongoing resources

4) Partnerships: Strengthen Relationships with Community Partners to Support Patients' Ongoing Needs

4A) Build partnerships to enhance coordination and communication between the ED and other health care and community-based services	
High-Leverage Changes	**Specific Change Ideas**
Identify and make direct and ongoing connections with care providers (inpatient and outpatient) and relevant community-based social services that will continue to support mental health and substance use disorder patients following ED discharge	• Collect information from patient intake forms about where patients get support, other than the ED • Collaborate with community crisis response teams and crisis counselors, among other community mental health and substance use disorder care providers, to provide community-based care management • Identify existing partnerships between other hospital departments and community-based organizations • Invite community partners into the ED for care conferences • Organize ED staff visits to community providers to broaden awareness of community-based services and resources • Engage community partners throughout the patient journey: intake and triage, treatment, and discharge (i.e., clearly delineate the roles of each integrated care team member)
Build relationships with community-based organizations, agencies, and providers that refer mental health and substance use disorder patients to the ED	• Conduct an analysis of the community-based agencies and providers that most frequently refer patients to the ED • Partner to coordinate care across the patient journey, including thriving health and wellness to pre-crisis and crisis
4B) Streamline the referral process to providers, services, and resources outside the ED for mental health and substance use disorder patients	
High-Leverage Changes	**Specific Change Ideas**
Co-create a simple referral process with key referring partners	• Develop a one-page referral sheet with key partners for ED staff; consider ways to share referrals electronically • Employ a licensed mental health counselor or social worker in the ED to make referrals to community-based organizations and providers, and to follow up with the patient to improve resource utilization and decrease ED revisits • Collaborate with urgent care centers and mental health crisis clinics to obtain immediate care for low- and medium-acuity patients and provide a bridge to follow-up care • Create secure notifications such as encrypted emails or phone calls (e.g., from case manager or social worker) to other care settings (e.g., ED, hospital, primary care provider, outpatient behavioral health)
Identify existing or develop new patient data and/or information sharing agreements with key referring partners	• Develop a secure data feed to track patients across settings within the health system • Enable secure access to patient medical records across care settings (e.g., ED, hospital, primary care, outpatient)
4C) Transform the ED discharge process for mental health and substance use disorder patients	
High-Leverage Changes	**Specific Change Ideas**
Ensure patients and families understand and are engaged in developing the ED discharge plan of care	• Engage the patient and family, with the patient's consent, in establishing the care plan and in designing the ED discharge process • At discharge, ask the patient and/or family if symptoms were addressed satisfactorily in the ED and if they are equipped to follow through with the care plan following ED discharge • Explore together the ways that family members can support ongoing connection to community providers
Provide active patient follow-up following ED discharge	• Follow up with patients via phone calls (sometimes called "caring contacts"); consider focusing on high-risk patients if staff resources are limited

4D) Enable the hospital to act as anchor institution to bolster the health and well-being of the broader community	
High-Leverage Changes	**Specific Change Ideas**
Identify the ED's current role in the overall community mental health and substance use disorder care system	• Learn about and participate in any existing roundtables, coalitions, or recurrent public health gatherings in the community to build partnerships and strengthen care coordination
Participate in community coalitions committed to improved community health	• Support the development and sustainability of community coalitions (e.g., work together to establish a monthly meeting place and time) • Hold cross-organizational case conferences, in compliance with HIPPA limitations, to offer all partners a way to problem-solve together, coordinate care effectively, and learn about each other's roles • Develop a shared release of patient information document that can be tailored to allow sharing across some or all linked agencies for a specified duration of time

Suggested Measures

For the four framework components depicted in the figure and described in detail in the white paper, suggested measures to gauge improvement are described in this section. While the tables that follow provide a useful summary of the consolidated measures, the context of each measure is extremely important — as are other considerations related to measurement for improvement, quantitative and qualitative measures, data collection, and stratification of data by equity factors. Thus, organizations are strongly encouraged to read the complete IHI White Paper.[1]

1) Process: Standardize ED Processes

Measure	Numerator	Denominator	Exclusions	Context to Consider
Percentage admitted to inpatient	Total number of patients with mental health/substance use disorder (MH/SUD) issues admitted to inpatient	Total number of patients with MH/SUD issues who present to the ED	None	This metric is important in measuring overall ED culture change, from a widespread assumption that most patients with serious behavioral health issues must be admitted to inpatient (with the ED as simply as pass-through) to the change in belief and culture that treatment can begin in the ED itself. As more treatment happens within the ED itself, a facility should see the percentage admitted to inpatient decrease.
ED revisits within 7 days	Total number of patients who revisited the ED within 7 days with MH/SUD issues after ED discharge for MH/SUD diagnosis	N/A	None	This metric addresses the issue of return visits to the ED that many facilities struggle with. As a facility improves and standardizes ED processes (to include treatment within the ED, referral to community providers at discharge, involving families in the care plan, etc.), the number of ED revisits within 7 days should decrease. While a facility can choose any length of time to measure revisits (e.g., within 3 days, 14 days, 30 days), 7 days is a long enough timeframe to capture return visits for MH/SUD issues, while short enough to acknowledge that an ED revisit may be for a different issue.
ED length of stay (LOS)	Total time in minutes from initial presentation to the ED to departure from the ED for patients with MH/SUD diagnosis	N/A	None	Length of stay is useful to measure standardization of ED processes, as both the median and variance for total LOS should decrease as processes become more standardized. For facilities that follow a general flow of medical stabilization, followed by mental health evaluation, segmenting LOS data (as described below) is a useful way to determine where changes can be most impactful.

Measure	Numerator	Denominator	Exclusions	Context to Consider
ED length of stay by segment	LOS 1: Total time from initial presentation to the ED until medical stabilizing process is complete and patient is waiting for mental health evaluation or disposition LOS 2: Total time from when patient is ready/waiting in the ED for mental health evaluation until mental health evaluation or disposition plan has been completed LOS 3: Total time from completion of mental health evaluation/ disposition plan to departure from the ED	N/A	None	As a balancing measure, looking at data for the various segments helps ensure that an improvement for one segment does not lengthen LOS for another segment. (Note: Some facilities may be running LOS 1 and LOS 2 in parallel, so this segmentation is not as relevant.)
ED boarding time	Total time in minutes when disposition decision has been made to the time of transfer, admission, or discharge	N/A	Patients placed in observation status in emergency settings (as they are in active treatment)	Boarding refers to patients receiving no treatment and who are just waiting for admission or transfer outside of the ED setting.
Qualitative Measure: Learning Community teams discovered the importance of stories and qualitative measures in building will and momentum, especially in the early phases of the work when there are competing priorities and it's too early yet to demonstrate improvements with quantitative measures. We encourage facilities to interview and collect patient and staff stories for all four components of the framework.				
Promising Results from Learning Community Teams: Learning Community teams noted two measures, in particular, for tracking improvements in the first framework component: • Length of stay (LOS) is one of the most important measures, with the ability to drill down further into the three LOS segments to discover the greatest opportunities for improvement. One facility reduced LOS by 4 hours, both shifting down the median as well as reducing variance in the measure. • ED revisits within 7 days is one of the most useful measures, and easy to measure and track. One team saw decreases in ED revisits through their work in community partnerships, while another team decreased variance in this measure as a result of testing specific changes (e.g., psychiatric patient discharge with 7-day medication, a clinical pathway for the psychotic disorder patient population, and warm handoffs from the ED to a community partner).				

2) Provider Culture: Create a Trauma-Informed Culture in the ED

Creating a trauma-informed culture is important for all patients in the ED. Focusing solely on patients with mental health (MH) conditions and substance use disorders (SUD) can exacerbate stigma by treating them differently and reinforcing the misperception that they are potentially more injurious to staff than other patient populations. For this reason, teams should use the suggested measures for all ED patients and not only MH/SUD patients.

Measure	Numerator	Denominator	Exclusions	Context to Consider
Average daily duration (in minutes) of ED patients in restraints	Total number of minutes restraints used in ED for all patients	Total number of all patients in ED where restraints used	None	This metric is critical to measure improvement in creating a trauma-informed culture. As staff confidence in their de-escalation abilities increases (see metric below), average daily duration of restraints should also decrease. By testing the changes described in the white paper, staff should begin to feel more confident in other methods before going to restraints (the use of which has been shown to increase staff assaults, as two-thirds of staff assaults happen during hands-on interventions in attempts to restrain patients).[3]
Total number of ED patients restrained	Total number of all ED patients where restraints used	N/A	None	As a complementary metric to daily duration of restraints, facilities may also want to measure number of patients restrained over time. As the denominator of the above measure, this is already being collected and facilities may want to analyze trends in this individually as well.
Percentage of agitated patient codes in the ED that result in the use of restraints	Total number of agitated patient codes in the ED per day that result in the use of restraints	Total number of agitated patient codes in the ED per day	None	When ED staff are alerted of an agitated patient through the designated "code," this alert often automatically results in use of restraints. Staff behavior during such an alert is a good indicator of how well-rooted a trauma-informed culture has become.
Average rating of ED staff confidence in managing disruptive behaviors using de-escalation skills and procedures (using a staff survey with a 1-to-5 rating scale)	Total number of ED staff who rate 4 or 5	Total number of ED staff survey responses	None	This measure can serve as a proactive measure of staff safety. As facilities test more of the changes described in the white paper, staff confidence is expected to improve.
Total number of patient-to-staff assaults in the ED (assaults defined as a physical or verbal attack)	Total number of staff assaults in the ED	N/A	None	This is already a standard metric collected in most EDs. Of note, as an ED tests and implements specific interventions, the number of patient-to-staff assaults is expected to decrease. It is also important to track these measures in facilities where staff fear that decreasing the use of restraints will increase the rate of patient-to-staff assaults. In fact, the converse is overwhelmingly true: as the use of restraints decreases, the number of patient-to-staff assaults also decreases.[4] Note: This is a particularly good measure to analyze data by equity factor (e.g., race, gender, income, or other segment most relevant to your facility).
Qualitative Measure: Stories from frontline ED staff (e.g., after trauma-informed care training), hospital leaders, and patients themselves are powerful. The National Alliance on Mental Illness (NAMI) is a good resource for patient-centered stories and qualitative measures of improvement.				
Promising Results from Learning Community Teams: Two Learning Community facilities had early results in decreasing patient-to-staff assaults by testing changes related to trauma-informed care training and staff learning to interact with patients in a different way.				

3) Patients: Engage and Activate Patients and Families in ED Care Redesign

Learning Community ED teams tested different methods of collecting patient feedback: in person as part of the ED discharge process, as a follow-up phone call to patients after discharge, and using a patient survey. Each facility will need to test the particular feedback method and timing within an overall process that works best in their context; it is recommended to start with small tests of change (e.g., test the change with *one* staff member during *one* shift with *one* patient) and then refine the change based on learning before expanding the test.

Measure	Numerator	Denominator	Exclusions	Context to Consider
MH/SUD patient experience of ED care (using a 1-to-5 scale, survey responses rating the degree to which ED staff treated MH/SUD patient with respect, listened to the patient, and communicated effectively)	Average of all patient survey response ratings using a 5-point scale	N/A	None	This metric captures key elements from the patient-focused perspective. Facilities may find it useful to refer to the National Alliance on Mental Illness patient surveys. An additional component to this survey that measures effectiveness may also be to ask the patient: To what extent did we address the issue you came with today?
Percentage of families of MH/SUD patients who participate in and receive the post-ED-discharge care plan	Total number of families of MH/SUD patients who participate in and receive the care plan	Total number of MH/SUD patients who present to the ED, who desire family involvement	Patients who do not desire family involvement	This metric is useful for facilities testing family engagement as part of the changes being implemented. While this may be more challenging to measure (and likely is not a metric a facility is already measuring), it is useful in helping improve impact and effectiveness of treatment, and can also potentially result in fewer patients returning unnecessarily to the ED.
Qualitative Measure: Stories from patients and families (both positive and negative) can inform the extent to which they feel confident and/or informed as they transition from the ED. This feedback helps ED teams determine whether or not care processes and communication mechanisms are effective, and identifies patient and family needs that are not being addressed.				
Promising Results from Learning Community Teams: At the beginning of the Learning Community, few ED teams were collecting patient and family feedback for patients with mental health conditions and substance use disorders. By the end of the 18-month initiative a majority of teams tested some form of patient feedback, although systematically collecting and reporting this data was challenging for many. One of the more successful tests for obtaining patient experience feedback from discharged ED patients was a follow-up call made by a dedicated care coordinator.				

4) Partnerships: Strengthen Relationships with Community Partners to Support Patients' Ongoing Needs

Measurement data for this framework component are more challenging to capture, particularly if ED teams rely on external partners to report the raw data back to them.

Measure	Numerator	Denominator	Exclusions	Context to Consider
Total number of patients with a scheduled follow-up appointment at a community provider	Total of patients referred to community-based provider for follow-up appointment, as defined by the facility calling the community provider and scheduling the appointment, confirming day/time with the patient	N/A	None	This metric captures what is most in ED staff's scope of control regarding partnerships: referring a patient to a community-based provider for follow-up once discharged from the ED. While this metric in itself does not capture whether the loop closed and linkage happened (e.g., patient ultimately visited and completed the appointment with the community-based provider), it does measure the important first step in the community linkage process. This measure also relates to the measure for ED revisits within 7 days, as greater linkages to community providers should reduce unnecessary returns to the ED as patients become aware of other options that might better meet their needs.
Percentage of referrals completed	Total number of patients who successfully complete first appointment with community-based provider after ED discharge	Total number of patients referred to a community-based provider	None	While more of an "ambitious" metric (in terms of feasibility), this measure helps show the effectiveness of partnerships with community-based providers (i.e., the extent to which patients are indeed going to community-based providers they were referred to at ED discharge). Although this is a more challenging measure because data is collected and reported by external partners, the process of approaching this metric in partnership with a community provider strengthens the partnership itself. As an intermediate measure, simply looking at the numerator itself (number of patients vs. percentage) can help build will and momentum for change.
Qualitative Measures: Stories of impact from community partners and patients are strong qualitative measures. In particular, understanding a patient's journey between the ED and community providers (the full ED and upstream journey) is a powerful tool for patient-centered improvement.				
Promising Results from Learning Community Teams: One Learning Community team began tracking the number of referrals made and completed, anticipating that an increase in completed referrals would result in decreased ED revisits for these patients.				

References

[1] Schall M, Laderman M, Bamel D, Bolender T. *Improving Behavioral Health Care in the Emergency Department and Upstream*. IHI White Paper. Boston: Institute for Healthcare Improvement; 2020. http://www.ihi.org/resources/Pages/IHIWhitePapers/Improving-Behavioral-Health-Care-in-the-Emergency-Department-and-Upstream.aspx

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