Strategy to reduce ED boarding of patients with behavioral health diagnoses

BETH ISRAEL DEACONESS HOSPITAL–MILTON

Beth Israel Deaconess Hospital–Milton 100-bed acute-care community hospital that serves Milton, Randolph, Quincy, Braintree, Canton, Dorchester, Mattapan, Hyde Park and other surrounding communities. The emergency department (ED) at BID–Milton serves 25,000 patients each year.

Challenge

The emergency department leadership at BID–Milton knew they faced challenges managing behavioral health (BH) patients in the ED, but their "burning platform" moment, according to chief medical officer, Dr. Ashley Yeats, was a serious injury sustained by one of the nursing staff from an escalated behavioral health patient. This incident, along with data showing that 95 percent of their ED boarding was attributable to BH patients, helped galvanize the BID–Milton ED to redesign their approach to patients with behavioral health needs. They applied for and received a $2 million CHART grant from the Health Policy Commission in 2015 and were on their way to redesigning their ED practices to better support BH patients.

Action

While many of the factors that lead to boarding of behavioral health patients are outside the control of the emergency department – insurance barriers, limited inpatient beds, and closure of other facilities, to name a few – the BID–Milton team committed to doing what they could within their own walls to shorten their BH patients' boarding time. At the outset, the team set an ambitious primary goal of reducing ED length-of-stay of long-stay (>8 hours) boarders for ED behavioral health patients by 40 percent.

The ED decided to invest in the creation of an ED Behavioral Health Care Integration (CI) Program, which included a Director of Care Integration, two co-located BH clinicians from the affiliated BH Emergency Services Provider (South Shore Mental Health), a part-time music therapist and chaplain, ED physician, RN, and security officer champions, a pharmacist, a certified peer specialist, and administrative and analytic support.

What is CHART?

The project described in this case study was supported by a Community Hospital Acceleration, Revitalization and Transformation (CHART) Investment from the Commonwealth of Massachusetts Health Policy Commission (HPC). The CHART program made innovative investments in the Commonwealth's community hospitals with the goal of establishing a foundation for sustainable care delivery. CHART funds enabled the hospitals to develop new care models designed to help patients avoid costly acute care settings like the emergency department by assessing local needs, modifying services, and expanding relationships with medical, social, and behavioral health community organizations.

The team focused on interventions that helped to address the patient's immediate needs and reduce the risk of symptom escalation in the ED:

- Therapeutic interventions such as the use of a music therapist, faith counseling, and familial counseling to help the patient feel more relaxed and cared for.
- Medication monitoring by a pharmacist on the team who performs medication reconciliation and monitors the patients' medications at the same level as they would for inpatients to ensure that BH patients were on the proper medications and dosages.

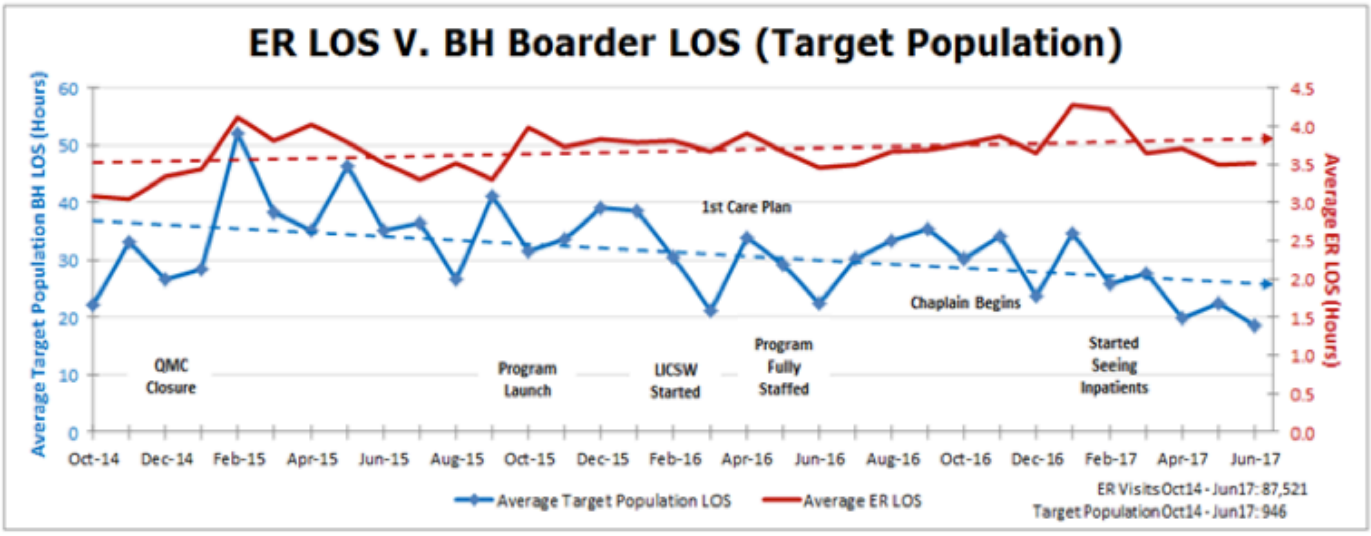
- More timely evaluation of BH patients by embedded mental health clinicians in the ED. Previously, the ED staff would have had to page someone to come in to evaluate their behavioral health patients, adding time to the patient's stay. After getting buy-in from the ED staff to incorporate these BH clinicians into the ED, they were able to eliminate the delays caused by not having BH staff on-site and early intervention services in the ED.
- Team communication, including regular meetings and huddles of the ED staff and the CI team, ensured patient and staff safety and facilitated expedient disposition to appropriate clinical services.
- Care coordination to ensure that patients get the care they need when they leave the ED. A "warm handoff" to all receiving providers and 48-hour follow up by a community behavioral health navigator and peer worker is standard of care upon discharge. Return ED care plans coupled with Behavioral Health Navigator outreach expedited future treatment and decreased high utilizer revisit rate.

Providing appropriate patient centered care is time and resource intensive – requiring collection of collateral information, sorting out medications, contacting primary care physicians, engaging pharmacists, and developing individualized care plans.

Outcomes

Overall, the team was successful in reducing the length of stay for behavioral health patients in the ED by 45 percent from a peak in February 2015 following the closure of Quincy Medical Center. The average length of stay for these patients dropped from 40 hours prior to the project to 22 hours by the end of the grant period. While the hospital has discontinued the time-intensive collection of data, they continue to see positive results. The hospital has maintained support for a consult liaison psychiatrist and an embedded licensed mental health clinician from South Shore Mental Health (now Aspire Health) and has added another social worker. They have also maintained the music therapist and chaplaincy engagement, because this added support has had a positive impact on ED operations.

Exhibit A: ER LOS V. BH Boarder LOS (Target Population)



Based on Equation of Line, Trend Over Time

	Oct-14	Jun-17	% Change
ER LOS	3.52	3.82	9%
BH Boarder LOS	36.99	25.89	-30%

501 Boylston Street, 5th Floor, Boston, MA 02116
BetsyLehmanCenterMA.gov
617-701-8271 • info@BetsyLehmanCenterMA.gov