Improving the Experience for Pediatric and Adolescent Behavioral Health Patients Presenting in An Emergency Department

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Prepared with HLD X

Contents

1. Introduction / Background

According to the Agency for Healthcare Research and Quality (AHRQ) in 2010, 4% of Pediatric Emergency Department visits nationwide were for Mental or Behavioral Health related issues. Additionally our country has seen both a rise in the use of Emergency Departments for mental health reasons and in suicide rates amongst adolescents and young adults (Andrea Kablanian). Providing healthcare in Maine presents unique challenges, due to geographical and socio economic factors. However, through interviews of members of the Emergency Department and Mental Health Communities in Maine we have established a common belief that these national trends are relevant to Maine as well. A recent study in the Annals of Emergency Medicine, using data from New England, saw that patients with Mental Health related concerns waited up to 5 times longer in an ED to be admitted or transferred(Pearlmutter et al.).

The prevalence of Mental Health issues in Emergency Departments, particularly in adolescents and the time it takes to place them, presents a challenge in providing a positive patient experience. To investigate this problem we have created a multi disciplinary team of individuals in order to inspect the issues and propose potential solutions to the Emergency Departments serving adolescents in Maine. There are many qualified practitioners throughout the state working on solutions to provide access to outpatient care, to prevent unneeded Emergency visits, to decrease length of stay in Emergency Departments and to ensure an appropriate number of inpatient beds are available for psychiatric care. However according to well respected members of the behavioral health community, *"The most important aspect of a patient's experience is not only the quality of medical care but how they are treated by staff."(Stuart Buttlaire and Brown) Through this White Paper we will investigate ways to improve the patient experience of adolescents in Emergency Departments by considering existing aspects of care.*

2. Process

Through the guidance of the Daniel Hanley Center for Health Leadership, particularly HLD Class X, a group was formed to investigate the specific issues of patient experience for adolescents presenting to the emergency department for mental and behavioral health conditions. To get a sense of bedside clinician and community perception of the issues impacting experience the team assembled a list of providers to interview and a standard set of questions. Please see Appendix B for a list of those industry experts interviewed. Additionally an extensive research review was conducted to ensure that solutions proposed were grounded in either experience or research supported best practices.

3. Proposed Solution(s)

A. Patient Support In Room

A common thread throughout the interviews conducted, pointed to lack of resources and activities available for patients that are in crisis mode in an Emergency Department. Dr. James Wolak of the Maine Medical Center Emergency Department pointed to lack of staffing as a challenge for the patient population, and made a suggestion of increased availability of structured activities to improve their visit. Kim Spectre, the Regional ED Director for Pen Bay and Waldo Hospitals pointed out the children in the Emergency Department often have a good deal of time waiting with very little to do.

A potential solution to this is to provide support to the patient in room. A companion program would put a person in room with the patient to talk or provide structured activities. Pen Bay Medical Center has created a Bedside Safety Attendant Position to monitor patients. These attendants are existing hospital personnel that take on this role as additional to their typical role. They are not to touch the patient at any time, and can be requested at the discretion of the House Supervisor or Charge RN. We propose an extension of this with additional supplies such as playing cards or other safe items to provide distraction and structured activities with pediatric and adolescent patients in the Emergency Department.

The use of Sitters or Companions is a well established strategy and has demonstrated successes both clinically and financially in other areas such as reducing patient falls (Feil RN MSN and Wallace MPH). While there is a lack of scholarly articles on effectiveness, other health systems are using Patient Sitters and Patient Companies to aid other challenging patient populations. The Domestic Violence Healthcare Project in association with the Carolinas Healthcare System Emergency Department has created Domestic Violence Victim Companions to help those patients through the challenging times of receiving health care (“Domestic Violence Services”). Creating similar programs at Maine Hospitals and equipping either volunteers or paid hospital employees with structured, safe activities has the potential to resolve key factors that negatively impact Pediatric and Adolescent patients during a crisis visit.

B. Technology

The use of technology to support adolescent behavioral care intervention in the Emergency Department has been limited. The limiting factors generally include technology availability, safety and security of the patient, and common technology approaches for age specific patients.

With the advancement of mobile technologies, it would be assumed that there are a large number of apps and approaches to assisting adolescents in the BH/ED setting to provide entertainment, mindfulness and treatment during the blocks of time of care. Unfortunately, most technology cannot be secured to the extent that it cannot cause harm to the patient, or be used

as a weapon in the care setting. Additionally, few EDs have space built out specifically for critical behavioral healthcare intervention, so many of the elements that would be needed to support behavioral care are not in place.

As EDs have begun to adapt to their role in managing BH adolescents in crisis, there has been the addition of some technology in limited scenarios. While a 2010 study of the Emergency Department Use in Maine(Kilbreth et al.) proposes that Emergency Departments split the ED into sections, one that serves patients with physical problems, and one that serves people with behavioral health problems, this recommendation has not been widely implemented.

Scenario 1: Mindfulness and Entertainment

While one of the goals in a behavioral crisis is to limit extraneous stimulation, there is increasing support for providing content supportive of the treatment process to BH patients that may be maintained in the ED for an enduring period. These approaches could include:

- Mood enhancing music playing in the care space at low volume
- Video capabilities with screened content to support the patient mood and limit boredom for adolescents
- Specialty lighting to remove harsh wavelengths of light and decrease stress in the environment

Scenario 2: Treatment

Many recommendations for treatment of behavioral health in the ED have been made. Some examples include:

- Patient should be remotely monitored using video surveillance with audio capacity. Monitoring location should meet patient privacy and clinical requirements.
- Installation of television for patients held over for extended periods of time. Television to be mounted behind protective glazing(Nibbelink).
- The use of Telehealth for psychiatric evaluation and intervention for ED's without psychiatrists, with staffing shortages, or in remote areas, and during weekends or low volume periods.(*OREGON RURAL HOSPITAL LISTENING TOUR: 2014*), (Abid MPH et al.)
- Improved behavioral health screening tools utilized in the ED that can be used to develop and sustain a behavioral health screening process(Pailler and Fein).

C. Family Education

Our interviews revealed that patients and families often do not know what to expect when a family member in crisis is admitted to the emergency department. They typically do not know what will happen to the individual who has been admitted; what the process will be for their stabilization, treatment, and discharge; who will be involved in their care and what their various roles are; and how long this process will take. Without this information, patients and

families are often confused and overwhelmed. They may feel disempowered in such an unfamiliar situation if they feel that they lack control over what happens to them.

For this reason, we recommend creating patient education materials to provide these families with the information they need to navigate this experience. These educational materials should cover the following topics:

- **What to expect** including what the process is and the possible timeline
- **Measures that may be taken to keep the patient safe** so that the family knows what to expect in terms of security precautions
- **Members of the care team** including the roles of each team member
- **What will happen next** including possible discharge options and community resources the family may rely on
- **Who to talk to with questions or concerns** so that families know how to ask unanswered questions

These topics will give families a better understanding of what will happen to them, which may help them to feel less fearful about such an unfamiliar situation.

The experience of having a child in crisis and in the emergency department for an extended period can also be extremely frightening. Patient education materials may also be used to acknowledge and address that emotional experience. For example, simply acknowledging that this can be a frightening situation for families may be provide comfort. Materials could also include a short, illustrative story or quote from a family or patient, thus showing the family that they are not alone, and that others have been through this same experience.

This patient education could be provided in a simple booklet or handout, or through an educational video, depending on the facility's resources. Any print materials should be simple and easy to understand, following best practices for health literacy (see https://health.gov/communication/literacy/quickguide/Quickguide.pdf).

Facilities may also wish to provide additional patient education materials at discharge. In particular, families would benefit from a list of community resources that they may access, such as support groups and counseling resources.

D. Environmental Design

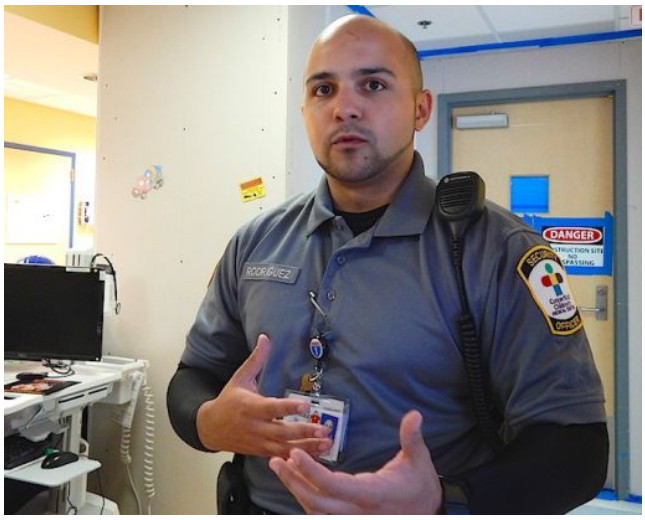
Emergency Department exam rooms contain expensive equipment and infrastructure which must be removed or protected when behavioral health patients are brought into the exam room. This takes a lot of time and wastes valuable resources which could otherwise be used treating patients.

For this reason, exam rooms especially designed for behavioral health patients. They are sparse and stripped down for patient and staff safety. These spaces often lack natural light or any kind of decoration other than a small television monitor to view hospital channels.

A moderately “Psych Safe” emergency department exam room. Prison grade sink, secure flip down covers to conceal power, data and medical gas outlets.

A moderately “Psych Safe” emergency department exam room. The patient monitor and bracket can be removed from the space if needed.


An emergency department exam room which can become “Psych Safe”



Because of the risk to themselves and staff, patients are often under constant watch by a security guard during their stay in the emergency department. These staff members can be an intimidating presence to children.

ED Exam Rooms can be adapted to be friendlier without sacrificing patient and staff safety. The use of color, lighting, accent graphics can be updated with little or no cost. Large screen displays, sound masking or sound enhancing can be incorporated with little cost and no additional space.

Small additions of space, like a nook for a daybed, may be planned with moderate cost.

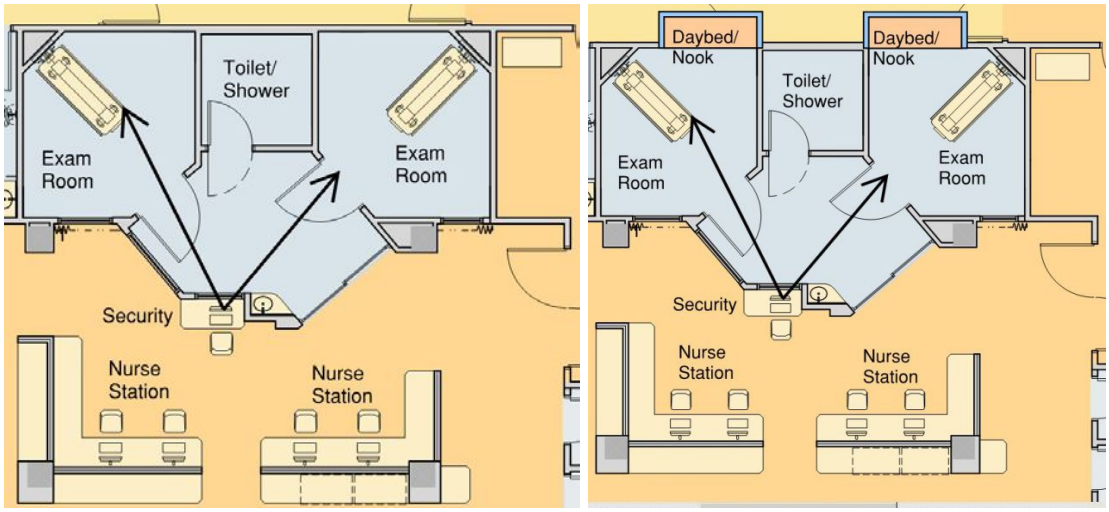
Brand new facilities should take these ideas into account and plan to locate rooms for behavioral health patients along an outside wall to allow for natural light.

Playful uses of color and materials add interest. Illuminated ceiling panels provide calming visual interest.

Artificial Sky has animated computer driven LED panels with show videos of nature, trees rivers and clouds move in real time. As reported by this example manufacturer, ceiling art (of various

types) is scientifically proven to; Lower Blood Pressure, Reduce Stress/Anxiety, Decrease Muscle Tension, Reduce Pain, and Re-Direct Negative Thought.

A new impatient room illustrates the effect natural and indirect light can have on a space. The Daybed near the window could be placed in an alcove as shown in the floor plan below.



Typical secure “Psych Safe” suite left, and a small addition of a nook or daybed.

E. Additional Therapeutic Resources

Over the past ten years, there has been a significant increase in adolescent admissions to the Emergency Department requiring behavioral health intervention(Owens, Mutter, and Stocks). These young adults are being admitted to the ED often by family unable to manage the

adolescent's anxiety, depression, substance abuse, and/or behavior problems. These adolescents are meeting hospital admissions criteria to include one of the following : medication adjustment or medical observation due to the inability to stabilize mood. Additional hospital E.D admissions criteria may include the patient's behavior places him/herself at risk to him/herself or others, or exhibits destructive behavior to the community(Owens, Mutter, and Stocks)(Sheppard Pratt at). Even the most updated ED units have been marginally prepared to therapeutically support this patient population. Currently the ED environment is designed to address the needs of the medically ill and is not configured to address the patient needs of those experiencing acute behavioral health events.

Due to the insufficient behavioral health treatment settings available in the State of Maine, the ED hospital patient stay may vary from 12 hours to 14 days(Sheppard Pratt at). In sum, these patients are admitted to a hospital setting that is marginally able to address their clinical needs. Patients report boredom, restlessness, hopelessness, and physical decline due to this inactivity. The patient who is boarding in the ED is at risk for deterioration due to the delay in appropriate mental health treatment.

Currently the medical model serves as a template for this care. These young patients are examined and assessed by the ED medical team. Emergent medical care, a mental health screening, and a team based clinical assessment are completed to determine the appropriate mental health disposition(Owens, Mutter, and Stocks). In most emergency rooms, the ED team will include: an ED physician, a psychiatrist, clinical nurse, social worker, and a hospital-based security team.(Sheppard Pratt at)(Dudley et al.)

The ED physician will determine medical clearance .The psychiatrist will complete a mental health evaluation and determine if the patient requires a hospital admission or is able to return to his/her prior living situation. Nursing personnel will provide the continuation of the medical care and a social worker will work with the patient and families on the appropriate disposition. (Owens, Mutter, and Stocks)(Dudley et al.)(Travares AD and Cortez EA)

As with any problematic programming there lies an opportunity for redesign. With the delay of a mental health facility placement, there is an increased need for the acute hospital ED to design a clinical pathway to better meet the BH patient needs. Currently there are additional hospital personnel who could greatly enhance the current ED treatment model. These professionals include may include: a physical therapist, occupational therapist, a child-life specialist and the hospital –based chaplain. A certified music therapist and a certified art therapist would also be a valuable addition to promote a comprehensive treatment environment("Professional Chaplaincy: Its Role and Importance in Healthcare")(Gold et al.; Riley)(ToolKit)(ToolKit; Kohn, Hitch, and Stagnitti).

The physical therapist is an on-staff resource that is commonly overlooked and a service that is covered under most insurance coverage plans. The physical therapist is able to complete a physical therapy evaluation and establish an individualized wellness program with a focus on

fitness. It has been well documented in the literature that exercise is as an effective adjunctive treatment for depression and serves as a treatment to reduce anxiety. This programming could be implemented while the patient is awaiting placement.

As part of the care team, the occupational therapist is another hospital resource that could improve the therapeutic milieu. The occupational therapist completes a patient evaluation and assesses the patient's ability to engage in activities of daily living. Relaxation techniques, time management skills and avocational activities would be explored to increase the patient's coping skills. The overall occupational therapy therapeutic goal is to maximize the patient's level of physical and psychosocial functioning(ToolKit; Kohn, Hitch, and Stagnitti).

During this medical episode, the young adult is absent from his/her academic setting fro an extended period of time.A school tutor may serve as linkage between the school and patient; i.e. obtaining school based lessons plans and academic work.

A certified child -life specialist is also an important team member to address the psychosocials needs of a child who is hospitalized . (Comittee on Hospital,Child Life Council.) This professional has an important role in providing emotional support to a young adult being admitted to the ED. This individual may provide comfort and safety for an adolescent lacking family presence and support. Through a specifically designed play therapy or expressive therapy program.

All Joint Commission accredited hospitals provide chaplaincy services to address the spiritual needs of the patient ("Professional Chaplaincy: Its Role and Importance in Healthcare"). The hospital-based chaplain also has a role in this ED programming. They can provide an empathetic ear for those patients in stress, and may serve as a patient advocate. Such service may provide comfort and support to both the patient and family during this stressful period.

Finally, additional professionals that may be added to the care team are a licensed certified music therapist and art therapist. Art therapy is a treatment modality that allows the patient to express themselves non-verbally(Riley). The artwork serves as a vehicle to allow negative or unhealthy expressions to be released in an appropriate way thereby allowing an outlet for emotion regulation. Music therapy including both music and voice is a treatment approach to address the unmet physical, emotional, cognitive, and social needs of the patient. The music therapist completes a patient evaluation and develops an individualized patient plan(Riley; Gold et al.). The overall treatment focus is to reduce anxiety and depression and to increase patient engagement. These services are not reimbursable in an acute hospital setting so creative approaches for funding would be required such as grants or monies raised by the philanthropy department(Riley)(Gold et al.; Kohn, Hitch, and Stagnitti).

In summary, there are professional resources that could be included in the existing ED adolescent behavioral health care model to improve patient care for those with extended ED stays. These additional personnel resources are able to provide therapeutic resources to reduce

patient anxiety, boredom, prevent physical deterioration, and increase the patient's active participation in his/her treatment plan towards wellness.

F. Guest Book, Mindful Drawing

One of our suggestions in terms of personnel is use of Art Therapy, but we recognize that this may not be an option in many Emergency Departments in Maine. There was also a consistent thread of one of the problems with Adolescent and pediatric patients in the ED is boredom and loneliness. Studies have demonstrated that mindful drawing and coloring is an effective way to relieve anxiety in pediatric patients(Carsley, Heath, and Fajnerova). To alleviate boredom and loneliness a budget friendly manner we propose creating a folder for patients to be given with mindful drawing materials and a guestbook.

There are many different mindful drawing materials available to for purchase such as the "Color Me Mindful" line of books. Giving patients these books and a safe set of felt tip pens will provide distraction and reduce anxiety.

By creating a guestbook, patients can use those same markers to write anything that they are inspired to, anonymously (see a suggested example in Appendix). This could be poetry, stories or letters, drawings, or pages from the mindful coloring material. This would then be collected by a designated member of the care team, reviewed for content and then included in a folder to give future patients. This would allow new patients to review prior patients art and writing, understand that others have been in the same place as them and create art to pass on to future patients.

We recommend designating one person to curate this material over time and keep materials up to date and in good shape.

G. Creation of Advocacy Program

Although these patients typically are assisted by a crisis team, our interviews revealed that these teams are typically focused on discharge treatment. Families may benefit from having a trained advocate as part of their care team. The use of patient advocates is supported by the American College of Emergency Physicians as a strategy to address patient comfort, satisfaction, education, and safety(American College of Emergency Physicians (ACEP)). This advocate may talk to families about their concerns, provide emotional support, help communicate the family's needs and concerns to hospital staff, and help the family connect with community resources and referrals.

We recommend facilities explore ways to connect families with advocates while they are in the emergency department; for example, by connecting with community organizations who may be able to provide trained volunteers or paid advocates. Hospitals may also explore opportunities to train existing hospital staff to provide these services; for example, by offering staff additional hours if they wish to engage in this work.

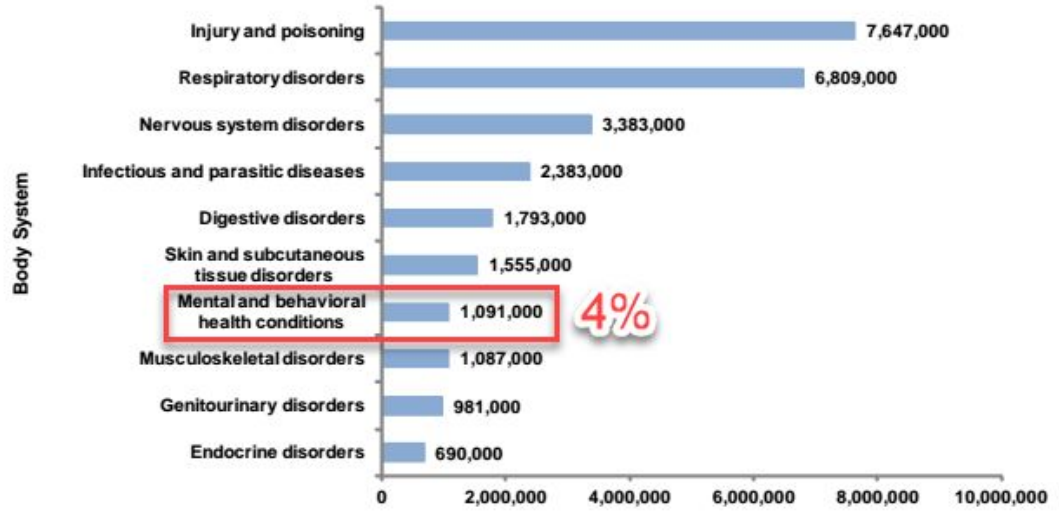
6. Results / Conclusion

This whitepaper is a selection of proposed solutions to a persistent and significant issue in our state. It was assembled by various members of the healthcare community and informed by interviews with clinicians that are engaged in providing direct care to patients and leadership to departments. We recognize that the use of ED for Behavioral Health concerns for adolescents will not be eradicated in the near future. The stay in the Emergency Department can be traumatic to patients and families. We have outlined various strategies with supporting evidence to assist facilities in providing the best patient experience possible during challenging circumstances. It is not assumed that any single facility or organization will be able to implement all of the proposed solutions, rather we are looking to outline multiple ways to improve patient experience that facilities can adopt according to their budgets and needs. Any initiative resulting in the improvement to the experience of a vulnerable population in a crisis scenario is a valuable endeavor.

Appendices

Appendix A – Common Pediatric ED Visits

Figure 3. Most common reasons for all pediatric ED visits by body system, 2010



Note: Based on all-listed diagnoses. Categories are not mutually exclusive.

Source: Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project (HCUP), Nationwide Emergency Department Sample (NEDS), 2010

Appendix B - Interview List

Name	Title
Kim Spectre	Regional ED Director, Coastal Care Alliance
Dr James Wolak	Physician, Maine Medical Center
Lisa A. O'Connor RN, BSN, CEN	Emergency Department Director, St Joseph's Healthcare
Charles Pattavina MD, FACEP	Medical Director and Chief of Emergency Medicine, St Joseph's Healthcare
Mindy Merrill-McGuire, LCSW	Mobile Crisis Coordinator Community Health and Counseling Services
Leslie Skillin	TIP Program Manager
Lori Rumery, NP	Maine Behavioral Healthcare

Appendix C - Guest Book

Please use the space below to share any feelings or advice that you have. This will be shared with other people of a similar age in our Emergency Department.

Appendix D - Authors

Jon Boyd, AIA, LEED AP is an Associate with e4h Architecture and a Maine licensed architect specializing in healthcare design. Jon serves as project architect on a number of healthcare projects throughout New England. He has 20 years of experience in planning and design. Jon is committed to Lean practices, sustainability, and energy efficient design. He works with clients on innovative ways to meet their sustainability goals.

Emily Brostek, MPH, CHES is Executive Director of Consumers for Affordable Health Care, an Augusta-based nonprofit committed to the right to quality, affordable healthcare for everyone in Maine. In this role, she directs, manages, and oversees the general operations of the organization, as well as CAHC's advocacy priorities.

Geoffrey W Fallon MBA is the IS Director of Patient Care Systems for MaineHealth. In that role he oversees the implementation and operations of the Epic EHR in Inpatient Clinical Settings. Geoff has been in Healthcare IT for 15 years previously working for Boston Medical Center and MEDITECH.

Scott Larsen is the Chief Technology officer for Mingle Analytics, Inc., a healthcare outcome-based analytics company. He oversees the technology teams that support more than 30,000 providers nationwide on reviewing outcome based data in order to improve their patient care practices.

Janice Siegle BSOT, OTR/L , M.Ed is the Director of the Rehabilitation Medicine Division at Maine Medical Center and is a licensed occupational therapist. In her role she serves as the clinical operational administrator for physical, occupational and speech language pathology programming at MMC,a 600 bed Level 1 Trauma Center. She has more than 20 years of healthcare management experience.

Troy Trejo is a Senior Consultant with Stroudwater Associates, a national healthcare advisory firm headquartered in Portland, Maine. Troy leads performance improvement projects and provides interim management services for health systems across the country. Prior to joining Stroudwater, Troy worked as a consultant and in health system finance.

Janet MacLeod is an experience professional preparing Health Systems for and leading them through cultural change. She has worked with various institutions on implementations of Electronic Health Record systems and Managed training and roll out.

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