Summary:
Improving communication between teams, developing medical screening criteria, decreasing readmissions, decreasing ED boarding, and decreasing emergency department (ED) to bed times for psychiatric patients.

Hospital: The Christ Hospital
Location: Cincinnati, OH
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Category:
- B: Bed Placement
- C: Clinician Initial Evaluation & Throughput
- D: Disposition
- E: Exit From the ED

Key Words:
- Consults
- Continuity of Care
- Crowding
- Frequent Flyer
- Information Systems
- Patient Satisfaction

Hospital Metrics:
- Annual ED Volume: 50,000
- Hospital Beds: 500
- Ownership: Private, Not-For-Profit
- Trauma Level: 3
- Teaching Status: Yes

Tools Provided:
- Psych Bed Board
- ER Med Clearance
- Flow Chart

Clinical Areas Affected:
- Emergency Department
- Psychiatric Consult Department

Staff Involved:
- Administrators
- ED Staff
- Nurses
- Physicians
- Social Workers
Innovation
Goal of our innovation was to improve communication between teams, develop medical screening criteria, decrease readmission, decrease ED boarding, and decrease emergency department (ED) to bed times for psychiatric patients.

A lack of processes and communication between the ED and behavioral unit created a situation that prolonged wait time and increased readmissions for psychiatric patients. We did not have a standard medical screening exam for these patients.

The problems faced with increased volume in the ED as well socioeconomic changes in the recent past as a decrease in the available psychiatric beds in the state and the potential to prevent left without being seen prompted planning to improve processes between the teams.

Innovation Implementation
The implementation process was a leadership driven, multidisciplinary approach to improved processes between ED and Behavioral unit.

In 2011 the Emergency and the Behavioral Departments were moved to the same division. There was an expectation to improve processes for both teams to enhance quality, safety and satisfaction for the patients.

- Early 2011 medical screening criteria were developed to promptly identify health issues that may have a behavioral presentation. The behavioral intake would call ahead to the ED for patients being brought from ECF or the court. The Behavioral intake nurse would also maintain open communication with the ED flow coordinator re: bed availability.
- When beds are not available; the behavioral intake would initiate having the patient moved to another facility. The behavioral intake began seeing patients in the ED to decrease admission process time if the patient was going to be held in the ED as a result of beds not being available.
- An electronic record for behavioral intake was developed giving the ED physicians access to historical psychiatric data that previously was not available.

Timeline
Internal work began in 2011. From 2012-2013 we partnered with the Hamilton county Mental Health Board to identify behavioral patients with co-existing chronic medical issues that frequented the ED’s in the area as a result of decomposition medically as well as psychiatrically. Our teams work in collaboration to identify these individuals at the time of admission and initiate the established pathway within the community to prevent readmission. Each of the identified patients is partnered with an assertive multidisciplinary team employed by the county to align the patient with needed resources.

2013 a multidisciplinary team representing the ED and psychiatry has come together to identify others that would benefit from an ED Care plan/ contract to prevent readmission and abuse of ED systems. In 2013, we partnered with the Greater Cincinnati Health Council to develop a bed board that will provide a dashboard glance of available beds within the city wide area. This will assist with prompt placement and decreased ED times/boarding.

Results
- The innovation improved safety, quality and satisfaction for patients.
- Improved relationships between teams.
- From 1/13-6/13: 58% of all psychiatric admission from our ED were placed into beds in under 60 minutes after disposition.
Cost/Benefit Analysis
$400 fee for bed board partnership

Advice and Lessons Learned
- Provide opportunities to staff(s) to become familiar/ develop rapport.
- Need front end Physician by in re: medical screening.
- Leadership has to maintain the prioritization of the initiative in order for the staff to recognize as a standard.

Sustainability
The innovation will be sustained with ongoing communication with both ED/Behavioral Departments.

Tools to Download
- Psych Bed Board
- ER Med Clearance
- Flow Chart
## Current Inpatient Psych Board

### View Inpatient Psych Board Definitions

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### GCHC

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Summit Behavioral Health

University Hospital
Guidelines for Medical Clearance of Behavioral Health Patients in the Emergency Department

Standard Labs/Diagnostics:

- CBC
- CMP
- TSH
- UA
- Drug Screen (n/a for ECF patients)
- EKG

PRN Labs:

- Ethanol
- BETA HCG (women of child rearing age)
- Lithium
- Depakene
- Dilantin
- Carbamazepine

PRN Diagnostics (Psychiatrist will notify Intake)

- Chest X-ray
- MRI
- CT

Inappropriate BH Admissions/Acute medical needs outweigh Psychiatric needs (not all inclusive):

- COPD (Acute exacerbation)
- Patients requiring blood transfusions for acute blood loss
- Uncontrolled Diabetes (hyperosmolar and DKA)
- Unstable angina/cardiac arrhythmia
- Uncontrolled HTN (SBP>180 or<90, DBP >100 or <40)---unless patient’s baseline
- Hyponatremia (symptomatic)
- Acute Drug Overdose
- Acute D/T’s /acute drug withdrawal
- Acute Renal Failure
- Febrile (defer to Psychiatrist)
- Acute Blood Loss
- Acute infectious process (defer to Psychiatrist)

**Acceptable Common Lab Ranges for Admission:**

- Blood Alcohol <100 mg/dl
- Glucose <400 mg/dl
- Hgb >9 g/dl (unless chronic issues present)
- Sodium >130 mmol/L
- Potassium >3 mmol/L, <5.4 mmol/L
- Creatinine <2.5 mg/dl (unless chronic issues present)
- BUN <40 mg/dl (unless chronic issues present)

It is not acceptable to forego calling the psychiatrist prior to tests being completed or results being available. This will not be effective throughput. If issues arise after the patient is accepted; the psychiatrist should be contacted to re-evaluate appropriateness is concern is present.