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INSIDE

RELIAS MEDIA

Coordination Center Uses Real-time Data to Speed Collaborative Decision-making

A nurse navigator serves as the ED point person, streamlining communication and anticipating services required for incoming patients

It is a common and justifiable refrain of ED leaders faced with perpetual boarding problems: *It is not an ED problem, it is a hospital problem.* True enough, but how should one resolve such continuous logjams? A small but increasing number of institutions are buying into the concept of a centralized command center that includes representation of all hospital key capacity decision-makers and real-time data on incoming and outgoing patients.

The latest example of this approach is the Capacity Coordination Center (CCC) at Yale New Haven Hospital (YNHH) in New Haven, CT. "We have a very large inpatient service, a very busy, active ED ... and there has been increasingly more struggle as the volumes have increased and more patients are coming into the system," explains **Andrew Ulrich**, MD, operations director for the department of emergency medicine at YNHH. "About a year and a half ago, there was some talk in a number of different areas about the need do just this, bring all these resources and all these people together in one area."

Stakeholders in the ED have been big supporters of the approach and helped drive the move to establish the CCC, Ulrich observes. "We feel the greatest effects when the hospital is overcrowded and we are not working as efficiently as we can," he says. "It all filters back down to us because we essentially are the front door to the institution."

Address Unique Stresses, Demands

Officially launched in October 2017, the CCC was very much a work in progress early on, according to Ulrich. "We were trying to figure out how to do it, who needs to be part of it, and what systems and resources need to be in that room," he explains. "Several of us visited

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places around the country that have done this in a successful manner." One of the places that YNHH representatives visited multiple times was the sophisticated Capacity Command Center at Johns Hopkins Hospital in Baltimore. That center, developed in coordination with GE Healthcare Partners, opened in 2016. "One of the things they are very, very good at is the very timely use of data that is in front of the people in the room. That is one of the keys that our model is trying to bring forward," Ulrich says. However, he stresses that each health system that has opted for this approach has customized a solution to fit its own unique stresses and demands.

For example, YNHH encompasses two separate campuses and two adult EDs that are within one mile of each other. Together, these two EDs serve about 150,000 patients per year. "We have one major EMS provider that brings patients to us, so we were very interested in having improved communications with [EMS] because YNHH has two ports of entry," Ulrich notes.

Previously, the larger of the two EDs would serve a heavier load of patients while the smaller ED would tend to intake fewer patients than it could handle. "As the whole discussion about the CCC was starting to take seed and blossom, we were working with our own group to develop a nurse navigator role," Ulrich says.

Originally, the job of the nurse navigator was to work alongside the prehospital provider agency to direct ambulance traffic to the facility best prepared to receive specific patients, based on capacity as well as specific services available.

"The [EMS agency] was kind enough to put [the nurse navigator] there. We were right next to the dispatchers," explains **Thomas Saxa**, MSN, RN, patient services manager for the adult ED at YNHH and the person who supervises the nurse navigators. "We were able to balance our volume load by directing ambulances to one of our campuses or the other, whichever was best equipped to handle that patient with that particular complaint at the time."

In that role, the nurse navigator primarily was focused on public safety and public health, Saxa adds. "Why take a patient to a crowded ED when there is an ED a half-mile away that has open rooms and is ready to go?" he asks. "The role was really designed with the public in mind."

Centralize Decision-makers

However, with the opening of the CCC, which is housed on the fifth floor of Smilow Cancer Hospital, not far from YNHH's primary ED, the responsibilities of the nurse navigator have expanded. "We pushed real hard to bring that person up to the CCC, to sit [him or her] right next to the people assigning beds and to the people doing all the other types of activities that affect how we are able to handle patients in the ED," Ulrich explains.

Along with the nurse navigator, the point person for EMS also is housed in the CCC. "That relationship is critical, so we moved both over," Ulrich says. "The hospital did some necessary electronics and IT work to have the communications system that [the EMS provider] uses brought over as well so [EMS] can handle their responsibilities in our own hospital." The EMS representative sits next to the nurse

navigator in the CCC, but the navigator also has direct access to the person handling bed management, admitting, environmental services, patient transport, and other operational services. "Now, the navigator can not only direct ambulances, but we also have [him or her] working with bed management," Saxa explains. "We understand what beds are coming open, what is being cleaned, and what is in the pipeline so that we know how to shift our patient volume."

This enables the navigator to anticipate services needed further upstream when determining which campus can better accommodate incoming patients with specific clinical needs. "For example, if there is abdominal pain in a young male that sounds like it could be appendicitis, the navigator now knows what operating room is open and where they can send that patient. For orthopedics cases, they know where these services are better equipped at certain times of the day to handle the patients coming in," Saxa observes. "If ICU beds are full and not expected to open for another 12 hours at one campus, but we have another campus with three ICU beds open, then a patient [requiring ICU care] is better served at the campus with the open ICU beds."

Another key to the nurse navigator role is that it is shared among experienced nurses who come from both campuses, Ulrich says. "The two hospitals merged four or five years ago. It has been a continued work in progress to sort of change the culture from the two separate EDs to one big ED with two points of entry," he says. "I think having the nurse navigator upstairs who is overseeing this for both sides has really been a big step in unifying our activities." Currently, the navigator is on staff in the CCC for 16 hours a day, from 7 a.m. until 11 p.m., but administrators anticipate that these hours will be expanded. "Originally when we did this, we weren't sure where [the role] would go and what the success would be, so we committed to 16 hours while the nurse navigator was still stationed [with EMS]," Saxa notes. "We didn't realize the value in it until we pulled the role into the CCC. Now, we are really starting to see it."

In the coming year, plans include a nurse navigator eventually working on site in the CCC around the clock. "We find that ambulance traffic is just better managed throughout rather than [ending the CCC presence] at 11 p.m., and then having more arbitrary destinations," Saxa says.

Streamline Communications

Essential to the CCC's operations is a rich source of operational data that are updated constantly in real time. The hospital worked with its electronic medical record (EMR) vendor to create electronic dashboards that display information pertaining to available beds at both campuses, the time it takes to clean a bed, transport time, and quality and patient safety indicators. Additionally, the dashboards reveal which patients are on their way to the hospital, which patients have been admitted, which patients are being discharged, and which ambulances are just heading out to respond to calls. "We are all on the same EMR. Everybody is accessing that same data and we are aware of things at the same time," Ulrich notes.

While everyone can access the data, the navigator can confer instantly with other operational decision-makers in the CCC. Also, the navigator regularly engages in phone conversations with the ED to discuss alternative scenarios regarding patient placement or to notify decision-makers in the ED about incoming patients with specific needs. Typically, the navigator will correspond with either the charge

EXECUTIVE SUMMARY

To handle increasing volumes better, Yale New Haven Hospital (YNHH) in New Haven, CT, has opted to centralize operational decision-making in a new Capacity Coordination Center (CCC). Here, a nurse navigator representing the health system's two busy adult EDs works with representatives from EMS, admitting, bed management, and other key operations to manage incoming and outgoing traffic optimally and to anticipate clinical services that may be needed further upstream.

- YNHH is the latest hospital to adopt the command center concept, a new approach that is catching on with hospitals that offer a diverse, complex array of clinical services and serve a high volume of patients.
- Essential to the YNHH model is a steady stream of real-time data that are available simultaneously to all key decision-makers through the system's electronic medical record.
- Hospital administrators note the CCC has changed the culture, eliminating a silo mentality that used to be prevalent in the different hospital departments, hindering efficiency.

nurse in one of the two EDs or the nurse expediter, a person who manages flow from the waiting room, Saxa explains.

"The nurse navigator upstairs is acting as a conduit and a communicator with the other parts of the hospital, [making] it easier for us to convey information about what is happening in the ED with the other services within the hospital," Ulrich says. "There is a better sharing of information to make decisions about who can go upstairs, who is the next person to get a bed, and things like that."

The communications aspect becomes increasingly important in health systems as large and multifaceted as YNHH.

"We are very complex, both in the ED as well as in the entire hospital with regard to patient movement because there are so many different clinical services upstairs and there are different beds assigned to different types of patients," Ulrich says. "Within the ED, when we are in our very busy crowd-surge models, which is what we are in very frequently now, we are moving patients within the ED."

For example, patients may be moved to one area for boarding to create care space in another area, Ulrich explains.

"Some of that involves handing off the care of patients to the hospitalist service, which then may take on the care of the patients while they are still down in the ED," he says. "It is all very complex because there are so many moving parts."

Change the Culture

The CCC already has been tested in some ways. For example, on Aug. 14, when a flood of overdoses racked New Haven, prompting a high volume of ambulance traffic to the two YNHH EDs until about noon on Aug. 16, the CCC was instrumental in effectively balancing the crush of patients between the two hospital sites.

"There was what could only be described as a mass overdose involving 60-plus patients in a short period of time," Saxa recalls. "I am not sure what the drug was, but [the patients] thought it would be K2, [a potent synthetic compound that produces a marijuana-like effect], but it was probably something else, and it caused some very bizarre reactions and overdose symptoms."

Since the navigator on duty that night was sitting next to the supervisor for EMS, who in turn was in direct communication with the ambulance crews, there was direct feedback from the scene of the overdoses as well as the two EDs.

"It really kept both [EDs] operating at maximum efficiency well into the night, whereas [under the old arrangement], that would have crippled one or both EDs for a good 12- to 24-hour period before we dug out," Saxa explains.

In that incident, most patients were able to be treated and discharged home, although some patients overdosed a second time and returned to the ED.

"Had there been higher severity or some patients requiring more prolonged care that required hospitalization, then certainly the CCC would have been very involved with how to get [patients] upstairs and where to get them upstairs," Ulrich notes. "Even so, the CCC was helpful because everybody knew right away together what was happening. We didn't have go out and tell people."

It will take some time for the full potential of the CCC to be realized, according to Ulrich.

"The early part of this is just getting people in the same room and learning how to share data together. We are really getting good at that," he shares.

"Transparency was a big part of this because [in the past], when we all got busy and everybody really got stressed, not knowing exactly what someone else was seeing, doing, and acting on sometimes inhibited our ability to be effective. Now, by putting everyone in the same room and having all these services sharing the same data, we know that everyone is working off the same information."

The CCC has produced a positive difference on some operational metrics, but the model is not yet mature enough to make definitive conclusions on effectiveness, Ulrich observes.

"We are now just starting to cross over from the data-sharing to the point where we can start to enact different activities and plans," he says.

For example, the CCC has put YNHH in a position to develop a very structured, tiered surge plan for when the system gets busier to the point when patients begin to board in the ED.

"That is one of the real benefits of the CCC, which is [being able to] develop further plans and further structure for how to change our day-to-day operations when things are not going as well as they should," Ulrich says. "As we start to do this more, I think we will be able to pull some very specific metrics around LOS, throughput, and boarding hours ... and to be able to say we are really making a difference. We are not there yet, but we are very close."

While there is much work left to do in developing the CCC concept, the approach already has helped YNHH rid itself of a silo mentality whereby each department made its

own decisions independently, Ulrich says.

"The culture itself is the first big change," he says. "We are light-years ahead of where we used to be because at least we have a shared resource and a shared approach, which is much more than we had a short period of time ago." ■

SOURCES

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A Growing Number of ED-based Physical Therapy Programs Taking Root

As patients flock to the ED with orthopedic injuries, vestibular problems, wounds, and gait difficulties, physical therapists are finding themselves increasingly involved in treatment. In fact, it has gotten to the point where a growing number of hospitals are establishing ED-based physical therapy programs, many of which are proving financially viable and greatly appreciated by medical staff.

Proponents of the practice caution that it takes time to build the kind of trusting relationships needed for physical therapists to thrive in an emergency setting. However, these proponents note established programs have shown that not only can such programs pay for themselves if given the time and commitment, they also can deliver cost-savings in some cases for both hospitals and patients.

Foster Collaboration

Some of the oldest ED-based physical therapy programs are in Arizona. For instance, Carondelet St. Joseph's Hospital in Tucson has stationed physical therapists in the ED since 1998. **Carleen Jogodka**, PT, DPT, has been tending to patients there for 15 years and has seen the program evolve. "It started off much more protocol-driven ... if someone came in with whiplash, a knee sprain, or vertigo, there was pretty much a protocol of what the therapist would do," Jogodka explains.

Now, the situation is more fluid. Physical therapists are involved with a much more diverse set of problems, including some trauma, Jogodka notes. "We have lots and lots of wounds, various types of vertigo ... and we are interacting a lot more with hospitalists in making determinations on placement," she says.

Typically, Jogodka will hear about a patient who could benefit from her services through face-to-face contact with emergency clinicians. "Usually,

EXECUTIVE SUMMARY

While a few ED-based physical therapy programs have existed for decades, the practice is gaining new converts as emergency clinicians increasingly turn to physical therapy for expertise with conditions ranging from vertigo and orthopedic issues to wounds, vestibular issues, and gait training. Long-standing programs have shown that leveraging physical therapy in emergency medicine can be a financially viable approach with the proper administrative support and guidance.

- When a physical therapy program was implemented at Carondelet St. Joseph's Hospital in Tucson, AZ, it was primarily protocol-driven. Experts there say the program is much more fluid today, with physical therapy integrated into a diverse set of medical problems.
- The emergency medicine trauma center at Indiana University Health Methodist Hospital in Indianapolis began using physical therapy in 2002 and now maintains physical therapy coverage seven days a week.
- To work in an ED-based program, physical therapists should be well-versed in orthopedics, wound care, vestibular therapy, and balance dysfunction, according to experts. Also, physical therapists are taking an increased role in assisting with geriatric disposition issues that present to the ED, making a knowledge of community services important as well.
- To be successful, experts advise hospital administrators interested in establishing a physical therapy program in their ED to enlist the assistance of both emergency medicine and physical therapy champions and give the program time to get established before looking at specific revenue targets.

a physician will just come over to my desk and give me a report on what is happening with the patient," she says. "Otherwise, bedside nurses are recognizing when there is an issue with a patient; they may be concerned about the patient's mobility, a wound, or any of the things they have now learned are within our scope of practice."

Even the paramedics who work as techs in the ED will alert Jogodka when they recognize cases in which physical therapy services could be of benefit, she says. However, with the constant churn of new staff coming into the department, Jogodka has to train residents continually about the services that physical therapists provide, although she often has help in this task.

"There are usually other staff who will also inform new providers coming through on what it is that we do, but we do absolutely still need to be proactive," she says. "A physical therapist does not necessarily have to be overly aggressive, but rather collaborative and approachable."

Frequently, Jogodka is involved with patients in the ED who present with low back pain. Jogodka recalls one recent case in which her involvement made a big difference in the patient's care and disposition. A woman was experiencing such severe symptoms that her family was unable to get her out of bed and into a car. An ambulance brought the patient to the ED, Jogodka explains. "The pain was so severe that she was put on a Foley catheter because she was unable to lift her bottom up to get on a bed pan," she says.

The staff and the attending physician on duty at that early-morning hour arranged for an MRI, revealing a large, herniated disc in the woman's back. She was scheduled for surgery the following afternoon. However, when Jogodka arrived to work a few hours after the woman arrived, she inquired about the case, finding that there were no red flags or any neurologic deficits involved — nothing that would suggest that Jogodka should not be involved.

The work consisted of certain exercises with an initial focus on bed mobility and some relaxation techniques. Jogodka recalls that she also may have used some electrical stimulation to distract the nerves. "The woman got to the point where she was able to walk, and she eventually walked out of the hospital ... that afternoon with a scheduled follow-up appointment. The surgery was cancelled, and all the parties were pretty happy," Jogodka says.

Emergency providers also frequently turn to Jogodka when they see patients with suspected vertigo, which can be quite frightening to patients. "This involves not just treating the vertigo, but also the really hyper aphasia that the vertigo is coming with, and lots of anxiety," Jogodka says. "I have had patients who were flown in by helicopter because they had vertigo."

In one case, a woman had attempted suicide because she assumed her symptoms from vertigo were actually a brain tumor. A family member who experienced similar symptoms had been diagnosed with a brain tumor.

"Even when physicians think a diagnosis is probably not positional vertigo, they want to be able to get my input on it," Jogodka says. "They want to be able to present to the hospital that physical therapy has already seen the patient, and they do not think this is positional vertigo." The physicians will seek to admit the patient for a different suspected diagnosis, confident that vertigo is not the problem.

The emergency medicine trauma center (EMTC) at Indiana University (IU) Health Methodist Hospital in Indianapolis began using physical therapists in 2002 based on the earlier experience of programs in Arizona like the one at St. Joseph's Hospital in Tucson. Here, physical therapists are used frequently in cases involving acute orthopedic issues or injuries, gait or balance problems, and vestibular issues, explains **Kevin Flint**, PT, MBA, a physical therapist in the EMTC at IU Health Methodist Hospital.

"Physical therapists are frequently called to assess and treat varying types of wounds, including burns and traumatic wounds," he says. "They evaluate most levels of patient acuity and a far-ranging list of diagnoses." Flint adds that physical therapists work with other clinicians to plan disposition needs and address safety concerns in the geriatric population.

"Upon arrival to the ED, patients are typically triaged to different areas of the ED based on acuity. Then, physical therapy is consulted during the work-up/evaluation portion of their visit," Flint explains. He adds that staff physicians, residents, medical students, and advanced practice providers all consult with physical therapy services on occasion. "We receive verbal consult orders that are then written into the electronic medical record [EMR]," he says.

The primary benefit that physical therapists bring to the emergency setting is the ability to offer more comprehensive management of patients, according to **Michael Brickens**, PT, another physical therapist at IU Health Methodist Hospital. "Whether [patients] are critical/acute or non-life-threatening, physical therapists bring a unique skill set and expertise that complements the medical evaluation," he says.

Brickens explains that the average daily census in the ED is more than 280 patients, so dealing with surges is routine. He notes that physical therapists can help assess orthopedic cases, vertiginous conditions, and chronic and acute wounds. Further, physical therapists work closely with physicians, case managers, and social workers to create safe and appropriate care plans for elderly and underinsured patients. "Specific to mass casualty events, physical therapists have been utilized to assist with musculoskeletal conditions, splinting fractures, and they addressed traumatic wounds and burns," Brickens adds.

Brickens notes that the ED is staffed with physical therapy coverage from 9 a.m. until 9 p.m. Monday through Friday and from 8 a.m. to 2 p.m. on weekends. "Most major holidays are staffed except Thanksgiving, Christmas, and New Year's Day," he says. "We have tried varying hours, but these seem to capture the greatest patient volume and needs of the ED."

Hospital administrators interested in starting a physical therapy program in their ED should look for physical therapy candidates who offer a strong background in orthopedics, Flint advises. Also, candidates should be well-versed in wound care, vestibular physical therapy, and balance dysfunction, he says.

"Over the past five years, as healthcare has changed, physical therapy has taken an increased role in assisting with geriatric disposition issues that present to the ED," Flint adds. "A knowledge of services available in the community and levels of care ... has become vital to assisting case management with discharge needs."

Flint cautions that some newer physical therapy graduates might experience difficulty with the pace and differential diagnosis aspect of working in the ED. "A strong physical therapy candidate should show a high degree of flexibility and ability to triage their daily caseload," he says. "There is not a set schedule. [Physical therapists] will frequently be called upon to juggle several patients or issues at once."

Administrators from other hospitals and EDs often visit IU Health Methodist Hospital to review the ED-based physical therapy program with an eye toward possibly starting a similar program in their own facilities. Frequently, their number one concern is reimbursement, Flint notes.

"Through the years, we have done reimbursement audits to ensure that having physical therapy in the ED is viable," he says. "Reimbursement tends to follow outpatient physical therapy guidelines and requirements, and is separate from the ED reimbursement structure."

Hospital decision-makers should not just look at the costs associated with maintaining a program, but also the potential cost savings, Flint stresses.

"A physical therapy consult can appear to be utilizing an additional resource, but many times we find that we can avoid an unnecessary admission and assist in appropriate referrals," he explains. "Physical therapy consults done in the EMTC can often facilitate and expedite the outpatient physical therapy revenue stream."

To sustain a program properly, it is important for physical therapists and the ED medical staff to develop relationships, Flint says.

"Staff [members] need to trust in the physical therapist's expertise. Once this occurs, volume can increase exponentially," he offers. "Physicians and nursing leadership can be [a physical therapist's] best advocates once [he or she] demonstrates expertise and patient-centered care."

While an ED-based physical therapy program can be viable in many different types of facilities, it is important to scale the program appropriately.

"Our ED sees nearly 100,000 patient visits per year and sustains 2.5 fulltime physical therapists, providing seven-days-per-week coverage," Flint says. "Smaller EDs would not adopt this staffing model, but one with 25,000 to 30,000 annual visits could have a successful part-time program."

Michael Lebec, PT, PhD, a professor in the department of physical therapy and athletic training

at Northern Arizona University, has completed numerous research papers on ED-based physical therapy programs and often consults with hospitals that are interested in starting a program.

"I am in contact with a lot of people who do this, and I keep track of who is doing this and to what extent," he explains. "I would estimate that there are well over 100 [ED-based physical therapy] programs across the U.S. that are doing this in some format."

Whether a program is successful boils down to the mindset of the providers who work in that setting, and whether hospital administrators are open-minded about the concept, Lebec says. "There are sufficient numbers to pay for the cost of the program as well as generate revenue if you capture sufficient referrals," he explains. "It's like anything else, though. It is going to take a little while for providers to wrap their brains around this and to trust the physical therapists."

Lebec advises hospitals interested in starting such a program to identify both an emergency physician champion and physical therapy champion to lead the effort, and give it some time.

"Don't expect big numbers in the first few months of the program. Try to forge relationships between the physical therapists and the providers. Make a concerted effort to educate providers on the types of services and patients that physical therapists can help to manage," he says. "If that is done up front, then you can have much more success." ■

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Psychological Evaluation Unit Provides Specialized Expertise, Calmer Atmosphere for Behavioral Health Patients

Like most EDs across the country, Elliot Hospital in Manchester, NH, receives a steady stream of patients who present with behavioral health concerns.

"The census of our ED is about 60,000 patients [per year]," observes **Matthew Dayno**, MD, FACEP, associate director of emergency medicine at Elliot Hospital. "We are a level II trauma center. It is a busy ED in more of a central, urban environment that has a significant volume of behavioral health patients."

However, even with some psychiatric resources on site, behavioral health patients tend to wait three times longer for a disposition than patients with traditional medical needs, a problem that contributes to crowding, boarding, and other ills. Further, administrators note that the atmosphere of a busy ED is hardly conducive to emotional healing.

"You go to the ED because you are anxious or depressed, and the environment is chaotic," notes **Heidi St. Hilaire**, MSN, CNL, BSN, RN-BC, clinical nurse manager of adult behavioral health at Elliot Hospital. "People are coming and going with testing and emergencies."

To address such concerns, the hospital has just opened what it calls a psychiatric evaluation unit within the confines of the ED, a 1,780 square-foot space that is designed specifically to meet the needs of patients who are psychologically distressed.

The new $1.5 million space contains a vestibule where staff can screen patients and visitors before they come into a safe area. There are six beds to accommodate patients, and the unit is equipped with a bathroom and shower.

"We find that patients in New Hampshire are staying longer in the ED, so we need to take care of their hygiene needs," St. Hilaire says. "We also have a separate interview/family room where we can talk privately with family or do meetings with family and the patients. The family room is also a place that we will use for basic group sessions."

The walls in the rooms of the unit are covered with a metal coating that makes them softer or squishier than traditional walls, although not in a way that is obvious or stigmatizing, St. Hilaire stresses. "If someone gets angry or punches the wall, it won't

hurt their hand as much," she says. "These walls are more durable, and we won't have to repair them as often."

Further, St. Hilaire stresses that designers took care to ensure the inclusion of windows in the unit. "There is a large window in the family room. Four of the bedrooms have windows," she says, noting that natural light can help improve patients' emotional health.

With the new unit, psychologically distressed patients can be brought to an area that is quieter and calmer, St. Hilaire notes.

"We can control what is happening in the common areas, and it is safe," she says. "It is highly monitored with video cameras and security."

Finding the square footage to accommodate the new unit in the midst of a busy ED was difficult, Dayno acknowledges.

"We actually had to move administrative offices for nursing leadership out of the ED to a different area just outside the department," he says. "We were restricted by square footage in terms of how the project was going to proceed. We had to make sure we were blending our objectives in terms of what we were trying to do."

For instance, at the same time the ED was setting up the unit, the department was starting a physician-in-triage model for the general ED population. Administrators had to look at design and flow and ensure the unit processes would fit into the larger plan.

"It is much more of a team approach in terms of the process with emergency medicine, behavioral health, psychiatry, and then our community resources," Dayno says.

Find Clinicians With Right Skills

To be sure, the new unit is not just about space. The hospital has added specialized nursing staff so that nursing ratios in the ED have improved. The care provided in the new unit is attuned more specifically to behavioral health patients who are waiting longer in terms of their disposition, Dayno explains.

"This is very important not only to the ED patients in that area, but also specifically to the entire environment of the department. We are trying to take care of those patients ... and they may be there for multiple days," he says.

In fact, finding personnel with the right behavioral health expertise was one of the biggest challenges involved in opening the new unit.

EXECUTIVE SUMMARY

Elliot Hospital in Manchester, NH, has unveiled a new $1.5 million psychiatric evaluation unit within the confines of its ED to boost resources and access to care for patients in psychological distress. The center is designed to offer an atmosphere more conducive to emotional healing. Administrators note that the added resources also should help ease crowding and boarding at the level II trauma facility.

- The 1,780 square-foot facility includes a vestibule where staff can screen patients and visitors, six beds, a bathroom and shower to address the hygiene needs of patients who are experiencing long lengths of stay, and a separate interview/family room.
- The unit is equipped with windows and plenty of natural light to create an area that is calmer and quieter than a traditional ED environment. The unit is heavily monitored with video and security 24/7.
- Staff with behavioral health expertise take care of patients who are referred into the unit following triage and a medical screening exam in the main part of the ED.

"Workforce is always an issue, and human resources had to do a lot of recruiting to find those specialized nurses," St. Hilaire reports. However, she adds that there was no pushback from a financial standpoint, and that ED staff members have been very supportive of the initiative.

All patients still go through the standard triage process. They will receive a medical screening exam and visit with an emergency provider in the main ED. There is no set formula for which patients will be directed to the new unit for care, St. Hilaire explains.

"It is really day-to-day triage in terms of who we put in that area," she says. "We tend to choose the patients who are higher acuity or have the likelihood to be violent because we want to put them in the safe area."

Further, patients can be moved in and out of the unit based on their own needs as well as the needs of the ED. For example, St. Hilaire notes that if the patients who are currently in the unit are calm and doing well, they may be moved back to the main ED to accommodate other patients who come into the ED in an agitated state.

"The unit has specialized behavioral health nurses who are attuned to managing agitation and de-escalating patients," she says. "We also have counselors, we have psychiatrists, and we have security there 24/7."

Other factors can figure into placement decisions as well, Dayno observes.

"There may be patients who present with acute depression, but they may also have a self-induced medical overdose," he says. "At that point during the triage process, we are treating the acute medical need with regard to the overdose. When [patients] are stabilized, they may be moved into the behavioral health area."

Typically, placement decisions are determined during a discussion between the charge nurse on the medical side of the ED and the charge nurse on the behavioral health side, St. Hilaire says.

While the new unit has not been designed for patients with substance use disorders, there may be patients assigned to the unit who are dual diagnosed.

"We may take a patient who has bipolar disorder and is also using substances," St. Hilaire offers.

However, if the diagnosis is primarily a substance use disorder, the patient will go into the general ED and receive his or her evaluation. If the medical provider determines the patient requires detoxification, the patient may be admitted to the ICU, St. Hilaire says.

"The decision point with substance use is often with the provider as far as what the patient needs," she says. "In the psychological evaluation unit, the patients are already pretty much medically cleared. When they require detox, it needs to be [cases] where it is mild to moderate, where the patients are just getting oral medications, or there is IV hydration."

Integrate Resources

The types of diagnoses that St. Hilaire anticipates treating in the new unit include depression, bipolar disorder, schizophrenia, anxiety disorder, and personality disorder.

"We work very closely with the local mental health center. In fact, some of the clinicians from the center's assertive community treatment teams are credentialed to come and see their own patients in our ED. We do get some significant, persistently mentally ill patients that are being managed in the community," she says.

In addition, crisis counselors from the community mental health agency are embedded in the ED. These individuals help arrange for strong outpatient treatment when behavioral health patients do not require inpatient care.

"Having access to [these counselors] and getting them plugged in to the ED ... helps the emergency physician feel comfortable that a discharge plan is going to stand up," Dayno explains.

Administrators will be looking at quality metrics to measure the new unit's performance.

"We are hoping we will have improved patient satisfaction for our population. We also want to decrease the use of restraints and to decrease assaults," St. Hilaire says. "We want to prevent [escalation] before it even gets to the point that we are having to use restraints or [respond to] assaults."

COMING IN FUTURE MONTHS

- Frontline providers face continuing challenges after Hurricane Florence
- ED-based interventions for out-of-control blood pressure
- Guidance in the case of mild traumatic brain injury in pediatric populations
- A new effort to confront diagnostic errors

The ED also would like to reduce the length of stay (LOS) of behavioral health patients, but that will be challenging, St. Hilaire acknowledges.

"What we know is that a medical patient goes through the ED in three to five hours, and it takes a behavioral health patient 14 to 17 hours," she says. "We have had patients get stuck in the ED while they are waiting for a bed in our state hospital. Those patients can stay with us for three days to three weeks. When we talk about LOS, we are looking at decreasing the weeks or the days versus the hours."

While more than two dozen inpatient beds are available for psychiatric patients at Elliot Hospital, many patients are waiting for admission to other inpatient psychiatric facilities. However, with the specialized care provided in the new unit, there is the potential to improve the treatment and outcomes for behavioral health patients. For example, St. Hilaire notes that the status of an involuntary patient who comes into the unit can improve during the ED stay.

"We will be giving the patient medications and treating him for a few days," she explains. "Sometimes, the acuity changes, and we can send him to a voluntary facility. Sometimes, [such patients] get better, and we can discharge them to the community." ■

SOURCES

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CME/CE QUESTIONS

1. **As the discussion about a capacity command center was starting to take seed and blossom at Yale New Haven Hospital, ED administrators were working within their own group to develop what new role?**

   a. Patient service manager
   b. Patient experience director
   c. Physician relations manager
   d. Nurse navigator

2. **While much work remains in developing the command center concept at Yale New Haven Hospital, the facility's operations director contends the approach already has:**

   a. improved patient satisfaction.
   b. changed the culture.
   c. boosted nurse retention.
   d. None of the above

3. **Over the past five years, as healthcare has changed, physical therapists have taken an increased role in:**

   a. assisting with geriatric disposition issues in the ED.
   b. triaging patients in the ED.
   c. supervising emergency care teams.
   d. dealing with ED reimbursement issues.

4. **While a typical medical patient goes through the ED in three to five hours, how long does it take for a behavioral health patient?**

   a. Five to eight hours
   b. 10 to 12 hours
   c. 14 to 17 hours
   d. 24 to 48 hours

CME/CE OBJECTIVES

After completing this activity, participants will be able to:

1. Apply new information about various approaches to ED management;
2. Discuss how developments in the regulatory arena apply to the ED setting; and
3. Implement managerial procedures suggested by your peers in the publication.

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