Making Behavioral Health a Core Competency

Hospitals are training employees and using new tools to address a growing need

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More and more patients at U.S. hospitals are presenting with mental health diagnoses that complicate their medical care, including suicide ideation, substance use disorders or other causes of confusion. Acute care hospitals, many of which are already short on financial and human resources, are being forced to respond to the challenge of protecting these patients and providing them with a safe care environment.

Brad Playford, CEO of AvaSure, sat down with five healthcare leaders to discuss their common challenges and share how their organizations are innovating to protect some of their most vulnerable patients.

Brad Playford: What innovative tools or best practices does your health system currently utilize to assess and monitor patients for suicide and self-harm risk in the acute care environment? How have you learned from "never events" that may have occurred?

Joyce Young: One of our ministries is piloting a psychiatric resource team whose purpose is to be a phone call

away to provide a little additional information or a little more in-depth assessment. If a behavioral health patient is being treated in an acute care unit, the staff on the acute care unit may not be as competent in picking up on small cues that may indicate an escalating behavior or deterioration in mental status, or other signs. This team responds not only to issues that may lead to patient self-harm, but also issues that can lead to workplace violence against our colleagues.

Diane Washington: We've developed assessment algorithms that have helped open the lines of communication, but we also need to build a more general awareness of warning signs, which can vary by setting. Unlike the ED or psych, people who are not doing well in the acute inpatient setting or oncology unit may not say, "I don't want to do this anymore. I just want out." They may not vocalize that to anyone – they may just enact it. One of the things we have found is that patients are more likely to vocalize these issues to someone who is in less authority, like kitchen or cleaning staff. So, we're training all of our staff around their responsibility to communicate these issues forward.

Kyle John: At Mercy, we've started what we call Rover Rounding, a process that is enabled by a mobile tool that allows us to round on our patients in an acute setting every 15 minutes without having to run back to a computer to chart it. Our staff can do it with their phone, and the application reminds them, "this patient is due for a 15-minute check." Our floor staff have found that to be very helpful and effective. We also use some door sensors, but these are not very cost-effective. We're not yet using video monitoring, but we've discussed it, especially in environments like the medical psych unit where it's more appropriate because patients have medical devices like a CPAP or IV. They may not be at higher risk for suicide, but they have easier means, so it's an area where we've considered using cameras.

Lee Ann Odom: We have spent a lot of time focusing on the care environment, recognizing that the emergency room, as well as a lot of our acute care areas, are ill-suited to take care of mental health patients. I think part of that relates to how deep we go into patient assessment, and what stratification we use, and how we act on the findings of the assessment.

Tim Jones: In reference to never events, we're focused on training for staff and shared learning that goes out systemwide. We also have a team dedicated to reviewing our patient safety reporting data on a biweekly basis to identify near misses that we need to learn from and shore up, so that we can continue to improve and ensure we're providing the highest quality and safety.

BP: What challenges has your organization faced in monitoring at-risk patients in acute care settings? Do limited resources become a challenge when trying to monitor these patients outside of the psychiatry unit?

JY: We simply do not have enough staff to meet the growing need for safety companions or sitters for suicide risk, falls and other harm-events. When we have a patient presenting with potential for suicide ideation and they've been identified as high-risk, they are automatically assigned

a safety companion. These companions are not a sitter in the simplest terms – they're someone who has a little bit more training and understanding of mental health conditions and de-escalation. Patients with a low to moderate risk are assigned to a TeleSitter, which allows a highly skilled staff member to monitor multiple patients via video and speak with them directly. Recently we were asked some tough questions by a couple of Joint Commission surveyors who were skeptical on our use of video technology and patients at moderate or low risk versus high via the stratification from the Columbia scale. In the end, they accepted that this was very appropriate, and this particular ministry did not have any citations. We have to optimize technology. We simply must, because there simply are not enough people for the growing needs and demands that we're seeing in the acute space, as well as in the behavioral health space, specifically.

TJ: I would say that the biggest challenge is when you're on those units that don't have knowledge on how to work with patients in crisis. There's a knowledge gap in our acute care environments on how to manage and care for someone with an acute mental health need. It's important that we support training and education for our staff that are often called upon to help intervene and de-escalate. I think it's critical to the patient experience and in assuring safety and positive outcomes.

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LAO: As an organization, we're struggling internally with the role of security in these events. At most hospitals, the typical response of a frontline worker is that, if a patient seems like they're about to hurt themselves or someone else, you call security. But security officers often have not been trained to the degree they should be in how to productively work with patients in crisis. So, now we have somebody in an acute mental health situation and somebody in a uniform, who may be armed. How does that make the patient feel? Could it add to the intensity of the situation? Instead of asking how we can better educate security, we've found ourselves questioning whether that's who should respond, as we don't want to contribute to the criminalization of mental health. It's still a big, open topic at our organization, but we really need to make it a clinical response, not a security response.

TJ: I like to compare it to a code blue or a stroke code. Security's not responding to that, so why should they respond for someone that's in a mental health crisis? This is a core competency for healthcare that we've neglected for so long, that we really need to reinvest in and understand. We've got a really great opportunity to ensure that our workforce can manage folks that are coming through our doors, regardless of what their condition is.

KJ: We joined the national Zero Suicide Initiative last fall. As a part of that, one of Mercy's hospitals has a grant-funded employee that meets with patients who are recognized as high risk for suicide to plan for their safety outside of the hospital post-discharge. We also have developed specialized education for our primary caregivers, which includes ER, urgent care, inpatient providers, OB/GYNs, and specialists, and we have also developed special training for our nurses, and basic training for all other employees. We want all of our staff to know what I would call the "CPR of mental health," so that they can go through a checklist and know exactly how to respond to a mental health crisis.

DW: When people are in a crisis, they're not thinking. Rather, they're reacting, and their reaction is not necessarily of a logical basis. We have to give staff the tools to be able to visualize what a suicidal patient

looks like, because they can't wait for obvious signals. A staff member could say, "It wasn't until I saw the woman raise her hand – she had all these marks from self-injurious behavior – that I started to take her seriously." We can't rely on those points. We need to just be able to say, "Okay, this person is in need of some care, so let's make sure we get that care to them." We need to roll that out to all staff in our patient safety training, and maybe do it on a quarterly basis instead of annually, because new research is coming out all the time.

BP: A Modern Healthcare Custom Media study conducted for AvaSure found that 72% of providers use one-to-one sitters for suicide prevention. Our study found that, in addressing the risk of falls, agitation, self-harm and any other issues, nearly 60% of providers are deploying one-to-one sitters for less than 5% of their census. How does your organization deploy sitters and what has been your perception of their value and effectiveness?

JY: I think there's mixed value and mixed effectiveness. Systemwide, I would say we probably are right around 5% of census. If you consider a census of 500, for example, that's a lot of sitters on any given day. Sometimes the most appropriate strategy is a safety companion or sitter, but sometimes, on the other hand, technology is the better option. In fact, in our Michigan hospitals right now, we're looking at a hub and spoke model where one hospital monitors its own patients in addition to patients at three other hospitals. As long as the procedures are solid and standardized, the monitoring can actually take place anywhere, so we're optimizing the way in which we deploy technology. People are finite, so we have to be stewards of our resources, both human and technology.

DW: I've been a psychiatrist for many years, and I see that we're still doing things in a very traditional way. We need to move on. We need to get up to speed with technology. I don't see a lot of value in human sitters, in terms of them being competent enough to be able to manage a patient that is suicidal. For many sitters, the skill level and level of interest is just not there, so you're just hiring people to babysit and not really do anything else.

LAO: I think we all have concerns about the quality of that interaction. I had the opportunity to talk with a patient who was in the hospital and was at a significant suicide risk. I must say, it was very awkward sitting in this young lady's room with a sitter sitting 10 feet from us the entire time. It was just a weird presence. The sitter was very attentive and very respectful, she was quiet and documenting and doing her thing, but it made me reflect on how that must feel as a patient. We really don't involve our patients and families in the decision-making that happens around what the intervention is or should be. So, I just offer that as something that I think we have not done a great job of in healthcare, and we may want to consider how we engage patients and families in that conversation.

KJ: We're talking about safety within the hospital, but the risk for folks with suicide ideation in the 30 days following a mental health admission is higher still. So, we've taken somebody out of a high-risk situation where we monitored them closely, and we send them home with no ability for good follow-up at another very high-risk time. It doesn't stop when the patient leaves the hospital. It may be the end of our unique responsibility, but those patients are still at risk and we're not doing nearly enough to monitor them. Considering whether we could use technology in that realm, I think, is exciting, and we do some of that at Mercy Virtual.