Emergency Department & Upstream Playbook

A Blueprint for Implementing the Institute for Healthcare Improvement's Change Package

Providence | WELL BEING TRUST

Table of Contents

3	Executive Summary Purpose Guiding Principles Assumptions
4	ED & Upstream Scale & Spread
4	ED & Upstream Learning Community
7	Work at Providence Scale and Spread
8	Implementation Process
18	Process Tools/Strategy Table
21	Change Management
23	Recommendations & Insights
29	References
30	Appendix

Executive Summary

Purpose

The Emergency Department & Upstream Playbook (ED & UP Playbook) was designed to serve as a blueprint for implementing the Institute for Healthcare Improvement (IHI) Integrating Behavioral Health in the Emergency Department & Upstream (ED & UP) Change Package throughout the Providence family of organizations and within other hospital systems interested in this critical improvement work. The ED & UP Playbook incorporates best practices and recommendations from the IHI ED & UP Learning Community, the ED & UP Getting Started Guide, and lessons learned from working with various ministries across Providence.

The playbook has two goals:

1. Describe a standard and repeatable process to implement the ED & UP Change Package across Providence and beyond.
2. Provide resources and support to help increase implementation efficiency."

Guiding Principles

- This work is informed and guided by the IHI ED & UP Learning Community.
- While objective and goals are aligned throughout the Providence family of organizations or other organizations/health systems, it is recognized that each ministry* or hospital has its own unique mission and culture.
- While a systematic approach to the implementation process is recommended, each ministry will adapt and adjust to meet the specific needs of their patients and staff.

Assumptions

- Each participating ministry is interested in a pathway to deliver reliable, evidence-based and compassionate care.
- The leadership of each ministry prioritized and/or committed to embarking on this work.

---

* "Ministry" is used throughout this document to be consistent with language at Providence and is interchangeable with "hospital"

ED & UP Scale & Spread

This project describes the scale, spread and implementation of the IHI's ED&UP Change Package across the Providence family of organizations.

of ED visits related to primary behavioral health concern, but there is no standard for the delivery of compassionate and reliable evidence-based, whole person care.
(Weiss, 2016)

We will know success when we have an increased patient and employee satisfaction along with a decrease in ED length of stay.

ED & UP Learning Community

IHI, in partnership with Well Being Trust, convened a small group of pioneering U.S. hospitals and health systems, together with their community partners, to create the ED & UP Learning Community. The outcome of this 18-month project is a structured framework for integrating behavioral health into the ED, referred to as a Change Package. The Change Package is guided by the Driver Diagram (see figure 1), which lists best practice interventions and solutions organized around four drivers designed to support ED & UP implementation.

The ED & UP Learning Community aims to improve patient outcomes, experience of care and staff safety while at the same time decrease avoidable, repeat ED visits for individuals with behavioral health and substance abuse issues.

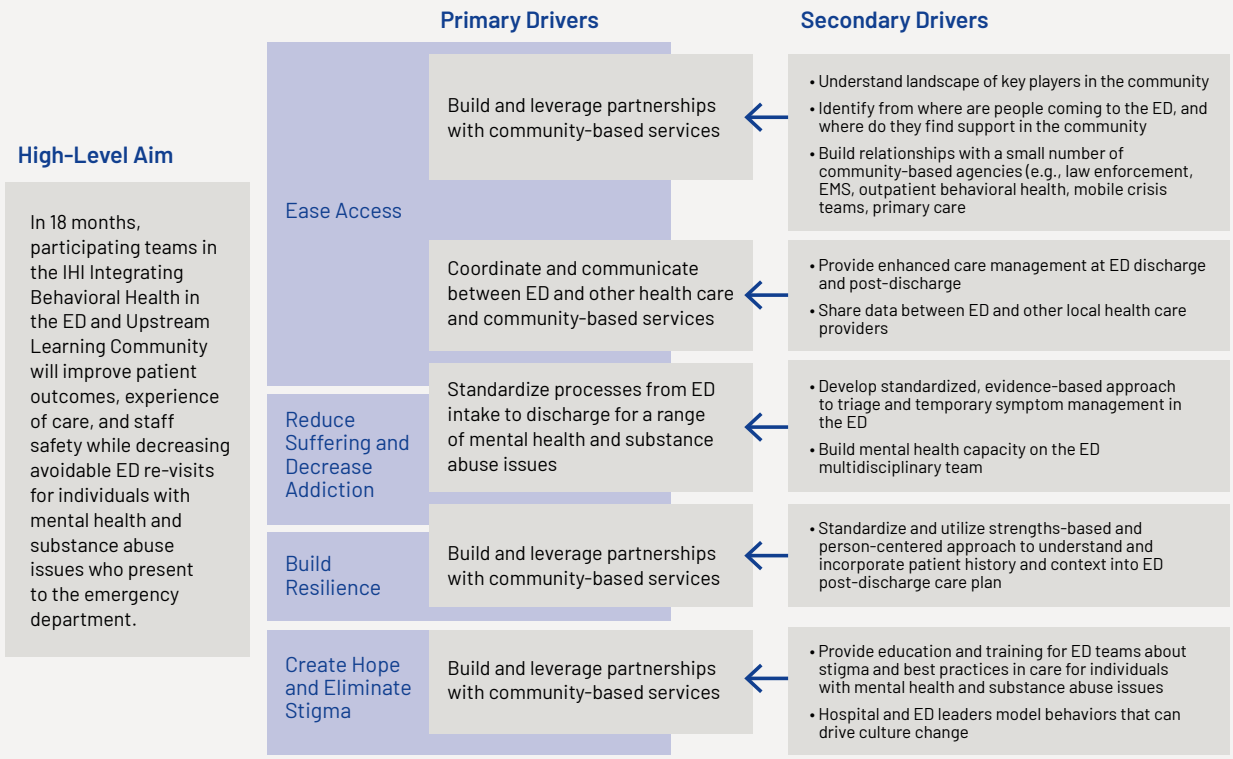
Interested Providence ministry EDs may partner with the Clinical Performance Group (CPG)* to identify local opportunities and select relevant interventions from the Change Package in service of the following drivers:

- Build and leverage partnerships with community-based services
- Coordinate and communicate between the ED and other health care and community-based services
- Standardize processes from ED intake to discharge for a range of behavioral health and substance use issues
- Engage and capacitate patients and family members to support self-management
- Create a trauma-informed culture among ED staff

(Schall M, 2020)

*The Clinical Performance Group is an internal structure within Providence to bring clinical leaders and experts together to share knowledge and support transformation and advancement of best practice and innovation. It has been an instrumental organizational structure to support the roll out of ED & UP among other Behavioral Health related work.

Figure 1 - Driver Diagram: Integrating Behavioral Health in the Emergency Department and Upstream



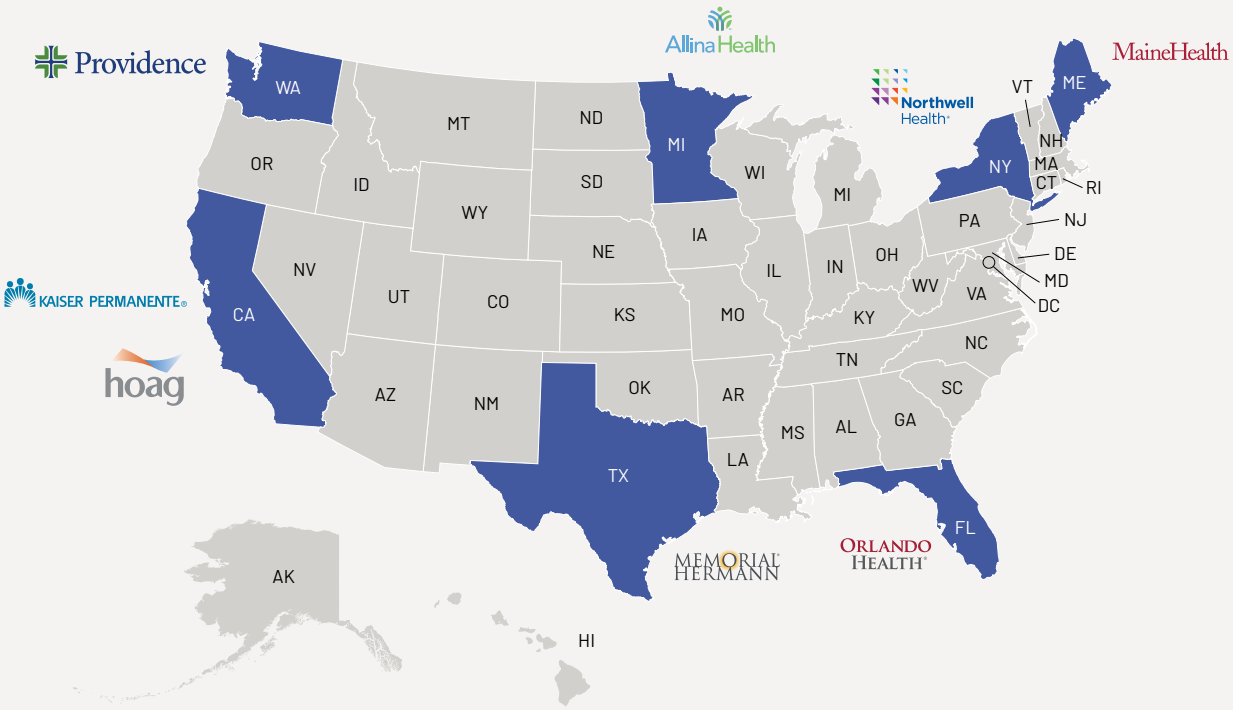
(Laderman, 2018)

What is a learning community?

A learning community is a group of organizations, departments or groups of people coming together to solve a common project. This work originated from a national learning community comprised of the following hospital organizations:

- Abbot Northwestern Hospital
- Cohen Children's Medical Center
- Hoag Memorial Hospital Presbyterian
- Kaiser Permanente South Sacramento
- Main Medical Center
- Memorial Hermann Northeast Hospital
- Providence Regional Medical Center Everett
- South Seminole Hospital

Figure 2 – IHI Original Learning Community Participants

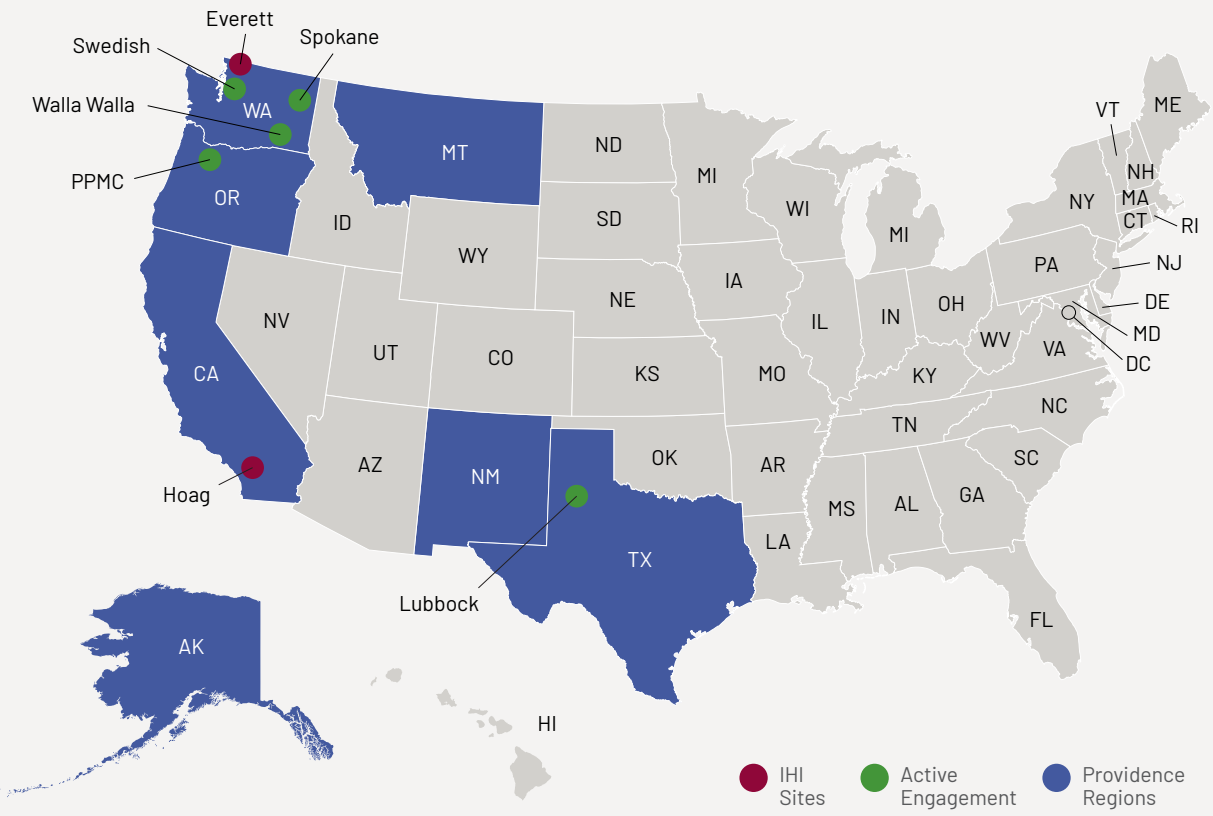


Work at Providence

Scale & Spread

Providence's goal is to implement ED & UP Change Package improvement projects across all 52 hospitals. The objective of this first phase is to launch 12 improvement projects across seven regions (i.e. one ministry in each region) in 2020. The figure below is a summary of the scale and spread status.

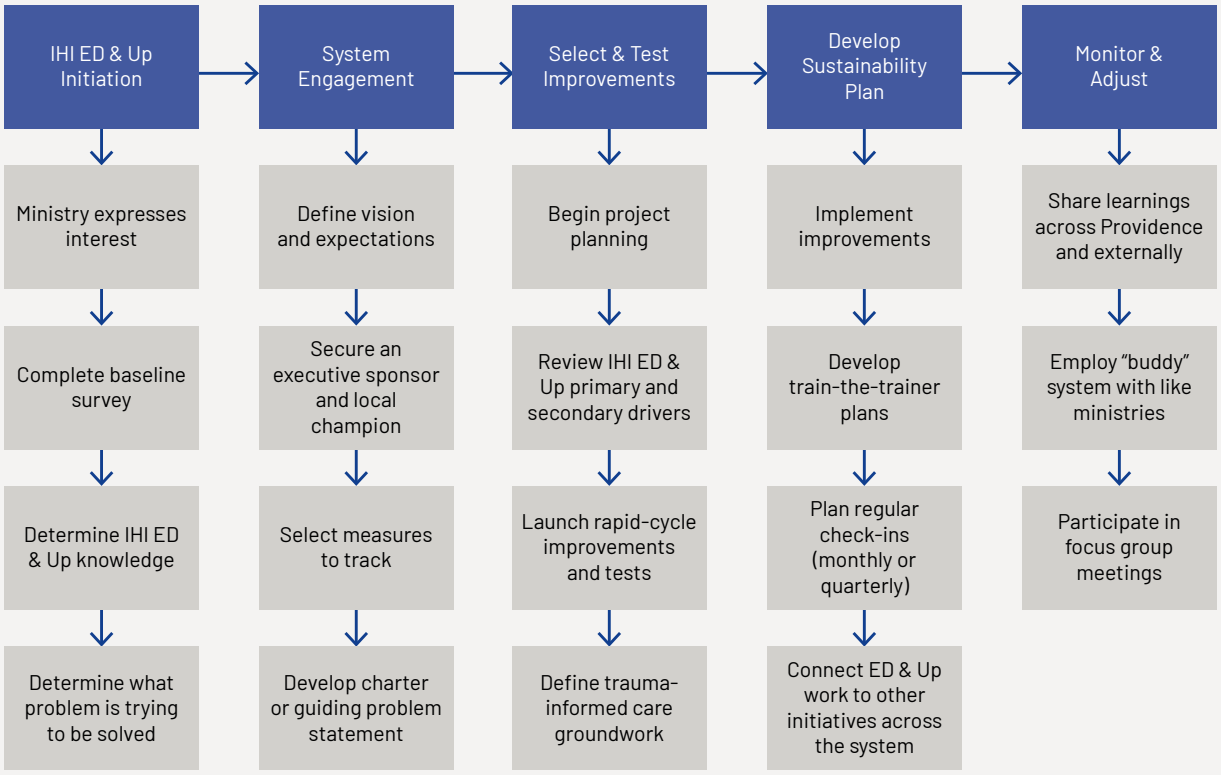
Figure 3 – Providence Scale & Spread, November 2020



Implementation Process

Below is a summary table of the implementation process.

Figure 4 – Model for Implementation Process



Implementation Process

ED & UP Initiation

The ED & UP implementation process begins when a Providence ministry or hospital ED reaches out and expresses interest in addressing challenges they are experiencing. A meeting is scheduled between the inquiring ministry and the MHSU CPG team to answer basic questions and begin discussions around how to incorporate the Change Package into their ministry.

MINISTRY EXPRESSES INTEREST

Most of the time, the ministry expresses interest as a result of presentations given during the Mental Health and Substance Use (MHSU) CPG ED & UP Focus Group.

BASELINE SURVEY

A baseline survey is given to interested ED. The more detailed the questions are answered, and data is acquired during this phase allows for more rich conversations in developing next steps.

DETERMINE IHI ED & UPSTREAM KNOWLEDGE

Upon completion of the survey, a deep dive is conducted to understand the key stakeholders, further define next steps and begin discussions to form a coherent problem statement.

TEAM FORMATION

Developing a functioning and high-well performing team is crucial to project completion. Bruce Tuckman's theory of team development is one popular model used to support teams or groups to maturity. There are four parts to this model:

FORMING	STORMING	NORMING	PERFORMING
How will team members fit in? What will their roles be?	Develop relationships and understand strengths and weaknesses of team members.	Appreciate strengths of team members and begin to work as a cohesive unit.	Members are confident, motivated and can operate with little to no supervision.

Define roles and responsibilities

It is also important to be very clear with roles and responsibilities when launching improvement projects. Here are some possible roles to consider:

Role	Description
Executive Sponsor: CMO, CNOs, CEOs	Remove barriers, approve funding & elevate project
Local Champion: Independent of job title / classification	This role serves as a point person to help drive the project forward within the local context
Data/Clinical Analyst	Support data definition, acquisition and tracking
Key ED Leaders: Physician leadership, RN / Social Work Manager	Helps support intervention implementation
ED Stakeholders	ED staff who may be asked to implement and sustain changes

DEVELOP A PROBLEM STATEMENT

The output (deliverable) of the deep dive is a draft problem statement. Often, the problem statement may reside within the overall Project Charter. (Charter with Problem statement)

System Engagement

DEFINE VISION AND EXPECTATIONS (HOW IS ALIGNMENT ACHIEVED WITH SYSTEMS STRATEGY)

Ideally, this step of the process happens soon after the draft problem statement is completed. The goal is to clearly and succinctly define the vision from a 30,000 foot view and specify expectations for those who will be executing the improvement projects. This is an opportune to time to begin drafting a project charter if one has not been started.

LOCAL CHAMPION

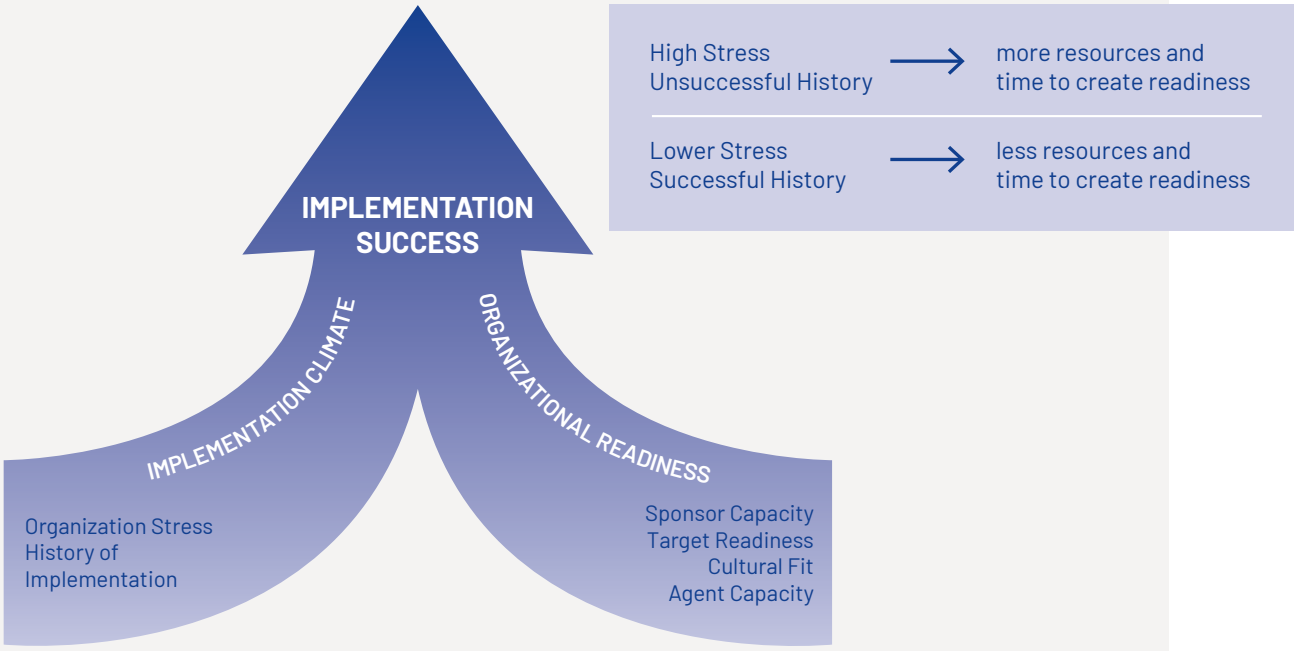
The local champion serves as a key member to the project team. Primarily, this person will help navigate the local environment, provide a lay of the land and participate in stakeholder analysis. Most importantly, the local champion ideally has at least a portion of accountability for getting this work done.

SECURE AN EXECUTIVE SPONSOR

Sponsorship is a key component to ensure project success. Without sponsorship, there may not be enough support to help provide guidance, remove obstacles and barriers and maintain a positive perspective to drive the project forward. The downward flow of responsibility and upward flow of accountability is called "cascading sponsorship" (Harrington, Conner & Horney, 2000). Cascading sponsorship takes place at the executive, director, and local levels, and is extremely helpful in successful project execution. It also includes multiple layers of sponsorship activities and creates a network of sponsor functioning in a way that sustains the projects forward progress (Harrington, 2013).

SPONSORSHIP: ESSENTIAL FOR BUILDING READINESS

Figure 5 – Model for Implementation Climate vs. Organizational Readiness Clinical Value Improvement Workshop (CVI)

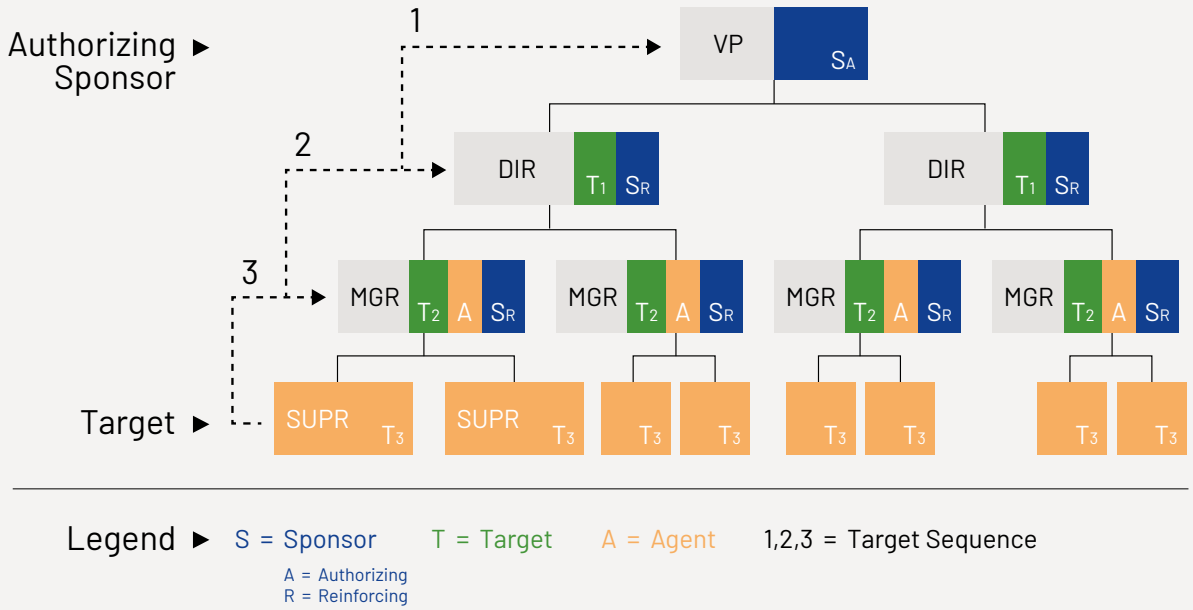


Copyright MA 2013 adapted with permission for Providence

In addition to securing sponsorship, it is important to think through communication. Just like sponsorship, communication is most helpful when a cascading methodology is used, to ensure all key stakeholders at all levels maintain alignment with their goals.

SPONSORSHIP: CASCADING COMMUNICATION

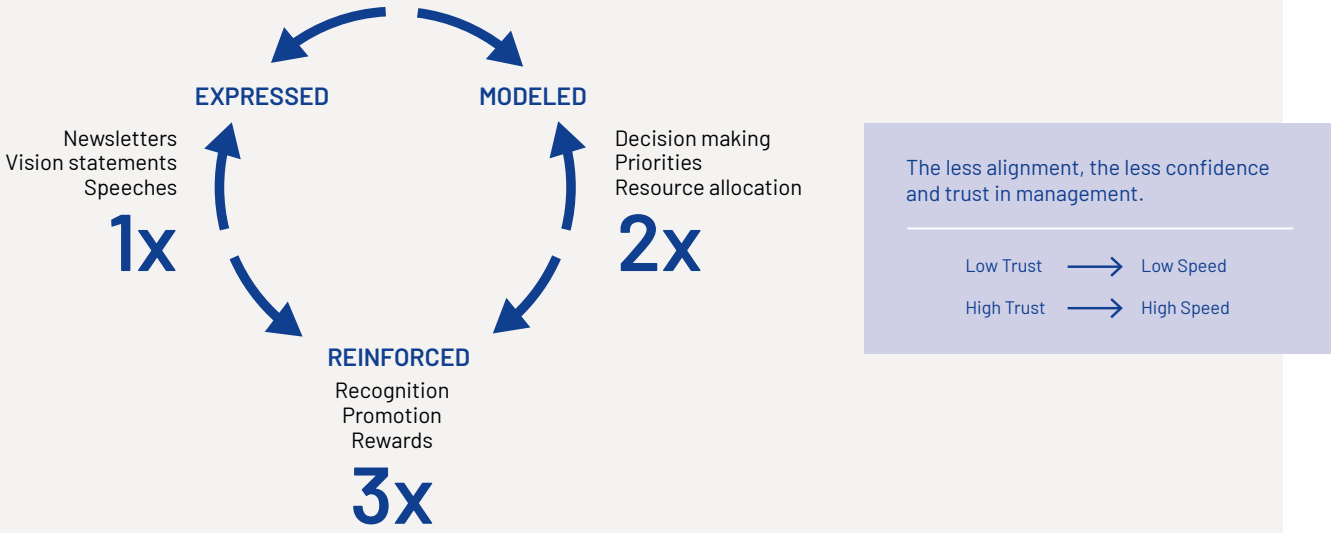
Figure 6 - Cascading Sponsorship and Communication



Copyright MA 2013 adapted with permission for Providence

SPONSORSHIP INVOLVES ACTION

Figure 7 - Model for sponsorship involvement (CVI)



Copyright MA 2013 adapted with permission for Providence

Sponsors must do more than just make sure the project gets launched, or authorize funding for an initiative, or send memos and emails. Sponsors must demonstrate expression, modeling, and reinforcement daily to show their personal commitment to change.

SELECT MEASURES TO TRACK

The key to this step of the project is to select measures to track all of the information gathered thus far (i.e. baseline survey, problem statement and definition of vision and expectations). When considering which measures to track, data availability is of the utmost importance. For best reliability make sure data is measurable, easily accessible, frequently available and observable.

Outcome and Process are two types of measures to track when executing improvement projects. These two measures are the most important to truly drive improvements.

- **Outcome Measure:** How does the system impact the values of the patients, their health and well-being?
- **Process Measure:** Are the parts/steps in the system performing as planned?
- **Balancing measures:** Measures that track unintended consequences. Balancing measures can be used to help track unintended consequences.

IHI HIGH IMPACT KEY MEASURES

Below is a table listing some of the high impact key measures as defined by the IHI Improving Behavioral Healthcare in the ED & UP White Paper.

Table 1 - Sample of high impact measures and associated primary drivers

Measure	Definition	Primary Driver
ED Length of Stay (LOS)	Total time in minutes from initial presentation to the ED to departure from the ED for patients with mental health / substance use disorder diagnosis	ED Processes
ED revisits within 7 days	Total number of patients who revisited the ED within 7 days with mental health / substance use disorder issues after ED discharge for mental health / substance use disorder diagnosis	ED Processes
ED Boarding time	Total time in minutes when disposition decisions have been made to the time of transfer, admission or discharge	ED Processes
Total number of ED patients restrained	Total number of ED patients requiring use of restraints	Provider Culture
Total number of patient-to-staff assaults in the ED (physical/ verbal)	Total number of staff assaults in the ED	Provider Culture
Mental health / substance use disorder patient experience of care	Average of all patient survey response ratings using a five-point scale	Patients
Scheduled follow-up appointments at a community provider	Total number of patients referred to community-based providers for follow-up appointment. This is defined by the facility calling the community provider and scheduling the appointment, and confirming day/time with patient	Community Partnerships

(See IHI Whitepaper for more details on measures)

DEVELOP CHARTER AND/OR FINALIZE GUIDING PROBLEM STATEMENT

This is where a finalized version of an overall project charter and problem statement are created. Each will be used in the selection, testing, execution, and implementation of improvement projects.

One tool that can be used to help elicit ideas from the group and team throughout project work is brainstorming. The objective of a brainstorming session is to collect ideas from all participants without criticism and judgement.

Below are a few sample tools & techniques that can be used to help facilitate brainstorming:

TECHNIQUES

- White boarding
- Sticky Notes
- Mind mapping
- SWOT analysis (Strengths, Weaknesses, Opportunities, and Threats)
- 5 Why's

TOOLS TO CAPTURE IDEAS

- MS Teams & OneNote
- MS Visio
- Lucid Chart Mind Mapping Software
- Driver Diagram – Priority Alignment

Select and Test Improvements

BEGIN PROJECT PLANNING

During this phase of implementation, planning takes place to specify where the improvement projects will be focused, finalize what measures will be tracked and put together initial timelines for the improvement project testing. Project planning is a process, and continues as needed to support continuous improvement.

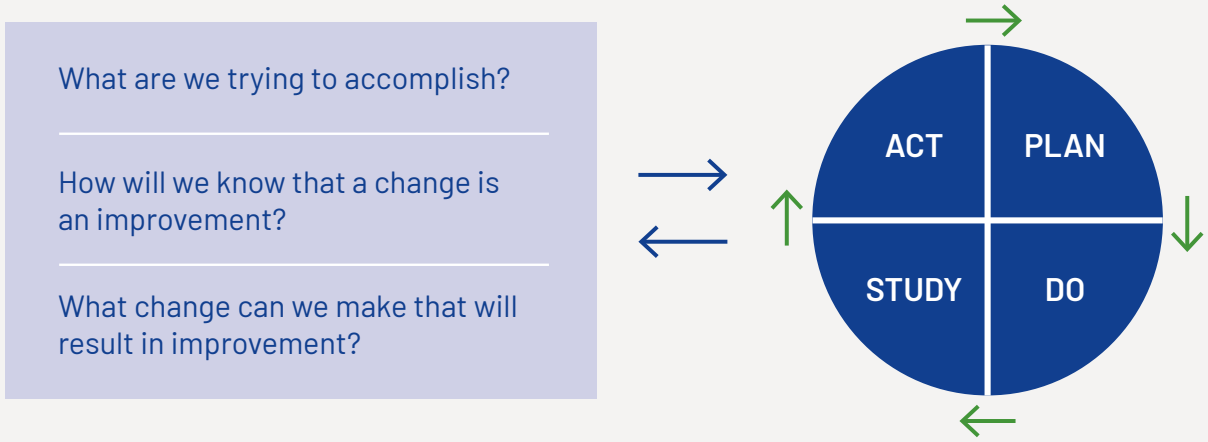
REVIEW IHI ED & UPSTREAM PRIMARY AND SECONDARY DRIVERS

As project planning occurs, it important to maintain alignment between the individual ministry, Providence, and the ED & UP project. A thorough review is conducted to ensure there is alignment between the primary and secondary drivers as stated in the IHI Improving Behavioral Healthcare in the Emergency Department & Upstream.

LAUNCH RAPID-CYCLE IMPROVEMENTS AND TESTS (PDSA CYCLES)

Plan-Do-Study-Act (PDSA) cycles are a component of the Model for Improvement framework, developed by Associates in Process Improvement. This model for improvement is a simple, yet powerful tool for accelerating improvement. PDSA cycles are small short-terms tests used to support continuous improvement by planning it, trying it, observing the results, and acting on what is learned.

Figure 8 – Model for Improvement



This figure has been adapted from the Institute of Healthcare Improvement

CULTURE

When launching an improvement project, it is essential to consider the culture of the team, group, department, or ED. Culture change in the ED is fundamental for improving care for individuals with behavioral health conditions and substance use disorders. One method for considering culture is to conduct a culture assessment. At the very least, a discussion about culture must take place during project planning.

Considerations when assessing culture:

- Education & Training – How do we do this?
- What type of language do we use?
- Are we using the right tools and are they (tools) being used competently?
- Are we addressing fear and discomfort? If not, how can we?

One option that has shown to be effective is trauma informed care training. Teams in the Learning Community tested the trauma-informed care approach by providing training and ongoing support for ED care teams as they made changes in practice during patient care encounters.

Develop Sustainability Plan

IMPLEMENT IMPROVEMENTS

Once interventions have been identified, tested and found to have made desired impact, implement the improvements. This will require communication, education, and training of all stakeholders who will be impacted by the implementation.

DEVELOP TRAIN-THE-TRAINER PLANS

In order to ensure sustainability of the Trauma-Informed-Care, a plan can be developed to specify, who is to be trained (scope), when, how often and to address follow-up support.

PLAN REGULAR CHECK-INS (MONTHLY OR QUARTERLY)

Regular check-ins with team members and ministries across the system who have engaged in similar work is helpful to sustain change. Sharing lessons learned, barriers and solutions promotes learning and sustainability across the system. Participating and sharing in monthly focus group meetings is an easy way to share these learnings.

CONNECT ED & UPSTREAM WORK TO OTHER INITIATIVES ACROSS THE SYSTEM

Connecting project improvement work to initiatives across a hospital ED or healthcare system helps to facilitate scale and spread, which in turn maintains sustainability. Where possible, align the project improvement work to goals, strategies and tactics within your organization. Aligning in this manner bolsters project improvement work momentum, supports project execution and ensures the sustainability of improvements.

Monitor & Adjust

SHARE LEARNINGS ACROSS PROVIDENCE AND EXTERNALLY

When initiating this work, and whenver possible, care should be taken to ensure any tested interventions align with Providence system, Behavioral Health and Regional strategic initiatives. Some examples of where this work can be shared are: focus groups, workshops, conferences, regional and system quarterly meetings.

EMPLOY BUDDY SYSTEM WITH LIKE MINISTRIES

While every ministry & ED is unique, some will share similar patient populations, community demographics, staffing models and overall size. Partnering with like ministries further helps promote lessons learned and supports scaling and spreading this work.

Process Tools/Strategy Table

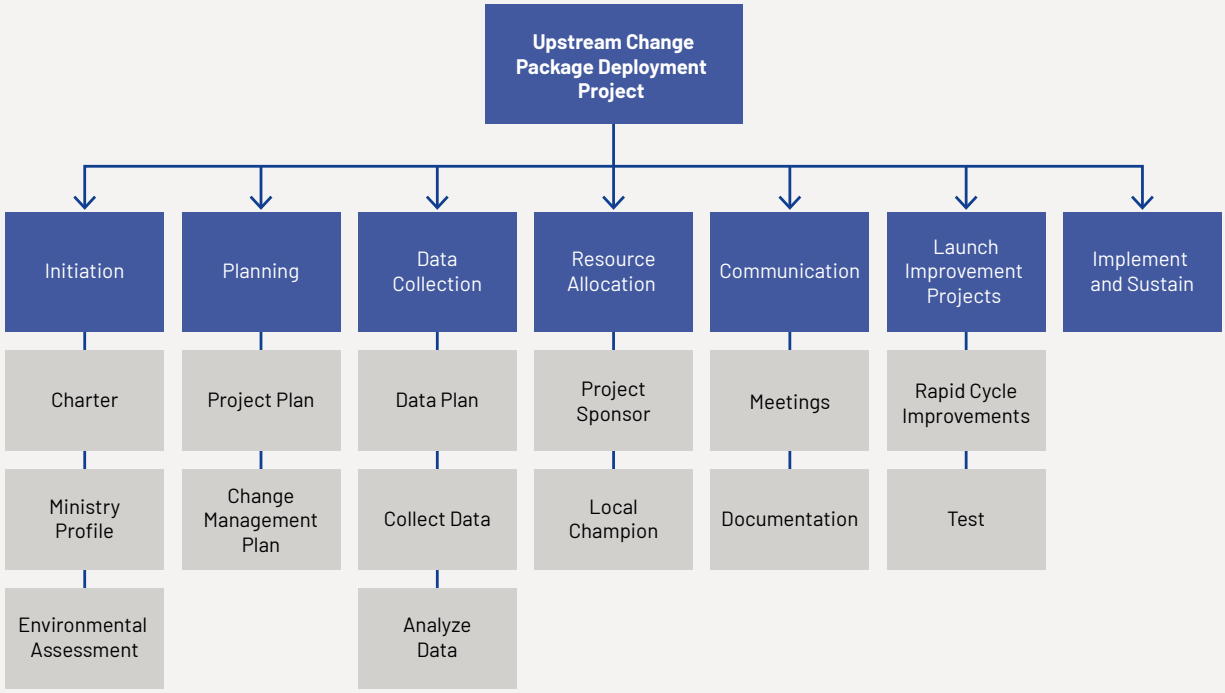
Project Management Fundamental Toolkit

Below is a table highlighting several process/project management tools. Templates for using these tools are available in the appendix of this document.

Tools	Purpose
🟢 Project Charter	Document that formally authorizes work to start. Used to define high-level objectives and deliverables, stakeholders, risks, constraints and assumptions.
🟢 **Project Tracker**	A tool used to monitor progress towards the completion of project deliverables and meeting of major milestones.
🟢 Project Plan	A document that defines how the project is executed, monitored, and controlled.
🟢 **Elevator Pitch**	A technique/tool used to persuade and share project goals with sponsors and stakeholders. It's recommended to have a short and long version.
🟠 SIPOC	A process improvement tool used to summarize inputs and outputs of one or more processes. It stands for Suppliers, Inputs, Process, Outputs, and Customer.
🟠 Customer Promise	A tool used to identify customers and to understand their pain points and problems. A "promise statement" is often used to explicitly state how customer pain points and problems can be addressed and the the resulting impact.
🟠 Work Breakdown Structure	A tool used to identify all project deliverables broken down into smaller components.
🟢 Executive Summary	A document, or section of a document, used to summarize the project in its entirety.
🟢 PDSA Cycle Tracker	An improvement project tracking tool used to monitor the status of PDSA cycles.
🟠 Fishbone Diagram	A cause-and-effect diagram used to identify the root cause of problems.
🟢 Baseline Profile Survey	An online tool used engage with stakeholders about pain points and challenges. It is instrumental in the beginning to frame the problem statement conversation.
🟢 Driver Diagram	A visual display of a team's theory of what "drives" or contributes to the achievement of a project aim.

🟢 Highly Recommended Tools 🟠 Helpful / Suggested Tools

Example Project Body of Work Breakdown Structure



COMMUNITY PARTNERSHIPS

To be successful in this work, each organization must collaborate with community partners to support patients in managing their health through ongoing, preventative care and appropriately accessed emergency care during acute crises. EDs are well-positioned to provide care in acute and emergency situations, but ongoing preventive care is outside the scope of the ED and squarely within that of community-based providers. These partners may include:

1. County services (I.e. housing, mental health, etc.)
2. First responders (i.e. police, firefighters, ambulance)
3. High schools, colleges, and universities
4. Community crisis response teams
5. Partner hospitals and clinics
6. Local behavioral health and substance abuse treatment organizations

Below are some examples of how ED can work to partner with community organizations to develop partnerships:

- Participate in monthly meetings of community-wide mental health and trauma-informed care coalitions to address challenges to care access and problem-solve ways to coordinate care with patients and families.
- Develop a centralized database of community providers that the ED care team uses to generate a tailored list of potential referrals for each patient.
- Partner with local police to embed social workers in their response system, who can then take the lead in developing mental health and substance use disorder care plans.
- Partner with schools, pediatric practices, and community health centers to streamline referrals and facilitate continued support in the community for patients and families following ED discharge.

EXAMPLES OF HOW COMMUNITY PARTNERSHIPS CAN WORK

Adopting Hoag's National Alliance on Mental Illness Connects Approach

When Hoag engaged with the National Alliance on Mental Illness (NAMI) to bring a first-of-its kind program that stations non-clinical "Family Mentors" in the ED, they saw great success. The program opened up a new world of peer support that increased patient and family satisfaction, and began to reduce ED visits for individuals in crisis that really didn't need the ED level of care. Providence Portland was inspired by their story, and began working with NAMI Multnomah to replicate this program, bringing peer support to their ED that began in the fall of 2020. The peer-based, mental health support and navigation program uniquely designed for the hospital ED and focuses on supporting individuals exhibiting depression or suicidality and their families, who are admitted for urgent psychiatric care. Through NAMI Connects, NAMI Multnomah will support adults.

ED Addiction Screener

Providence Portland's ED bustles with individuals with serious mental illness, addiction, chronic pain, and homelessness. Through a unique partnership with Multnomah County, there is now an addiction counselor in the ED, who can assess individuals and engage them in treatment in real time during their visit. This resulted in increased engagement in treatment services, and reduced recidivism to the ED.

Change Management

Overview & Guidance

One of the most challenging aspects of implementation any new intervention or program is managing change. All project implementations and process improvement work involve change. Change management is the process, tools and techniques to manage the people side of change in order to achieve the desired outcome (INC, 2020).

Key considerations:

- What is the "why" for participating in this work. How does it relate to organizational/department/unit goals?
- How will project information be communicated? Do you have a communication plan in place?
- What is the governance structure? Who will be accountable for project work being completed?
- How will key stakeholders be engaged? What is the call to action?
- What are some strategies for addressing resistance to change?

Often, project management methods, tools, and processes overlap. However, there are distinct differences between project management and change management.

Project Management is the application of knowledge, skills, tools, and techniques to project activities to meet project requirements. Change Management applies processes and tools to manage the people side of change from a current state to a new future state to achieve the desired results of the change and expected return on investment (Creasey, 2020).

Change Management Tools

Below is a table highlighting several change management tools.

Tool	Description
● Road Show	A presentation used to share with key stakeholder to inform, engage, and influence. Generally this is accompanied by a slide deck.
● Flowcharts & Process Maps	Diagrams and/or graphics used to map out workflows and processes in support of identifying issues that may affect project completion.
● Gantt Charts	A visual view of tasks scheduled to be completed over time (2020 ProjectManager.com, Inc, 2020).
● Run Charts	A time series data plot to show the order in which evens have occurred (George, Rowlands, Price, & Maxey, 2005).
● Control Charts	A tool like a run chart, but with additional data points to identify special cause variation (George, Rowlands, Price, & Maxey, 2005)
● Force Field Analysis	A tool used for making decisions by analyzing the forces for and against change and communicating the reason behind your decision (Ramalingam, 2006).
● Stakeholder Analysis	A tool used to identify and prioritize stakeholders before the project begins (Westland, 2020).
● Communication Plan	A written document used to inform the communication objective, medium, frequency, audience and owner.
● Meeting Cadence	A group of regular meetings to continue the momentum of work.

● Highly Recommended Tools ● Helpful / Suggested Tools

Recommendations & Insights

Recommendations

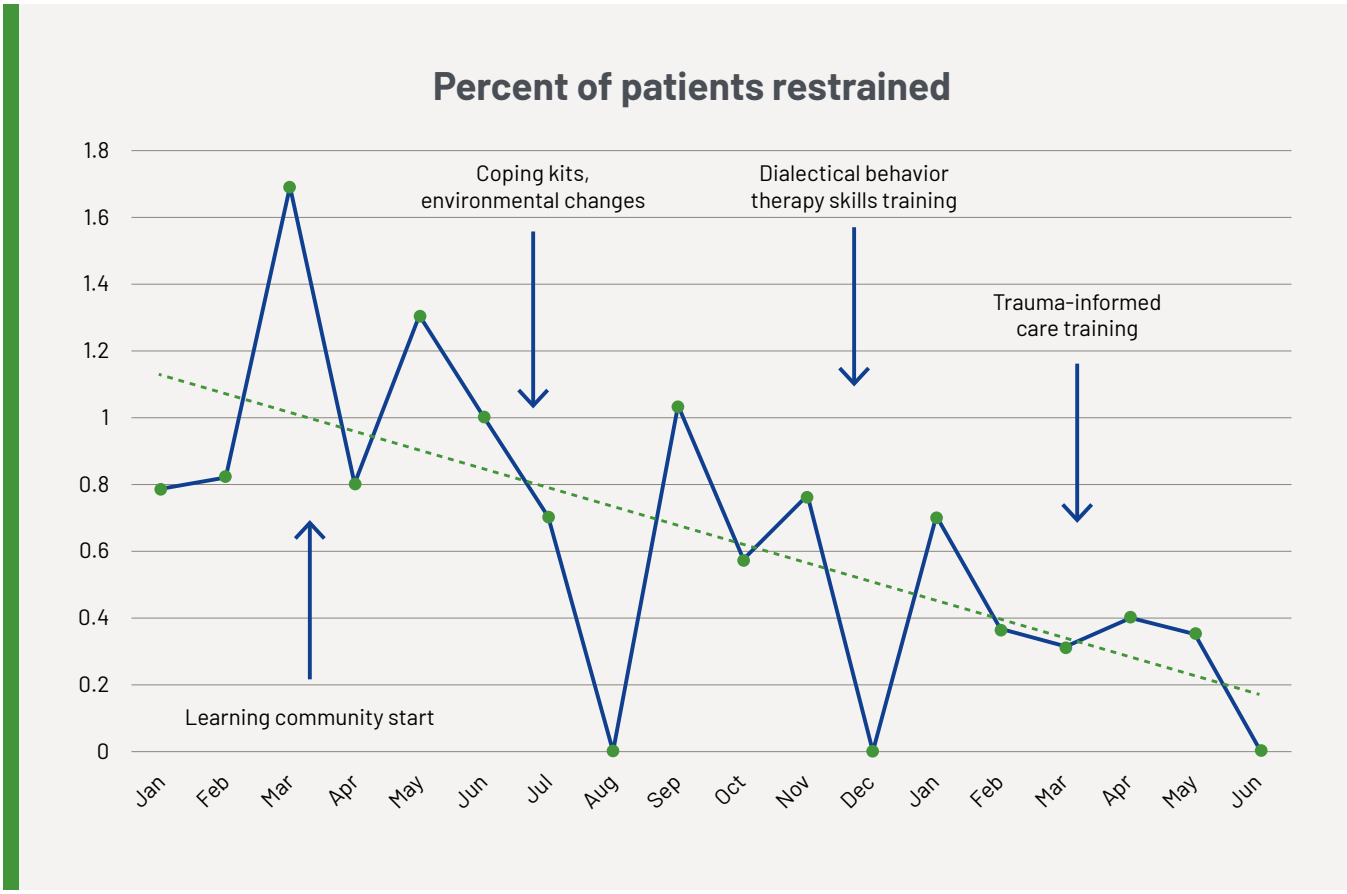
1. Where possible, leverage existing structures. If there are clinical governance groups or other quality improvement teams, partner with them to share ideas, support testing, track data and implement changes.
2. Expert to expert learning is crucial to implementation success. Ministries who have experience implementing portions of the change package will have an impact by sharing with those who have not. Likewise, those ministries who are starting their journey will benefit from seeking out other ministries with experience to hear lessons learned.
3. Assemble a diversified team of subject matter experts, key stakeholders and project sponsors (cascading sponsorship). Executive sponsorship is just as important as local/front-line sponsorship and demonstrates the support for change.
4. Clearly identify the problem trying to be solved. Create a Problem Statement document to be used as the North Star throughout the improvement project.
5. Select two to three high impact interventions that can be tested that leverage the Model for Improvement. A few examples are:
    - Standardization of processes (admit or discharge)
    - Trauma-informed care training and education implementation (for RNs, social workers, and providers)
    - Implementation of an evidence-based triage tool and agitation management
    - Streamline processes to work with partnerships in the local community (e.g. improve the process to work with county or other community organizations regarding involuntary holds)
6. Align Interventions with ED & Upstream primary drivers (process, providers, patients, and partnerships) and Providence strategy. Linking the interventions to system-wide initiatives helps redesign the journey of behavioral health and substance abuse disorder patients across departments, service lines, and facilities. Additionally, tie these interventions and the goals for improvement to strategic goals to support operational plans.
7. Leverage PDSA cycles for continuous improvement.
8. When collecting data, select a process and outcome measure. Measure on a monthly basis (vs. quarterly or yearly) to be able to adjust improvements more rapidly. It is essential to avoid getting bogged down by collecting too much data. Doing so may negatively impact the PDSA cycle.
9. Develop a succinct scale up plan. Include a specific aim and a timeframe for accomplishing short, medium and long term goals. This will help to understand the timing of the PDSA cycles.

Insights

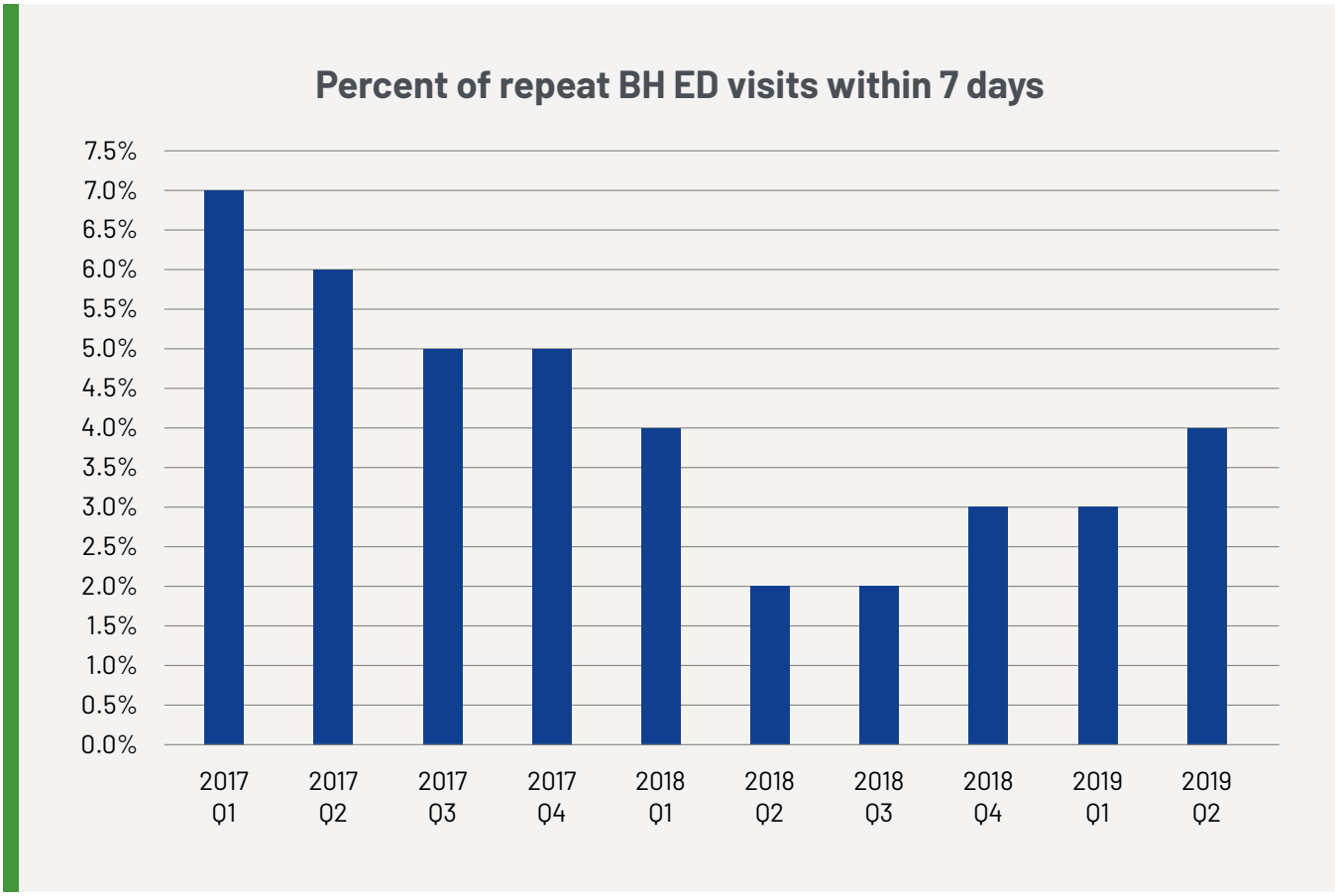
These insights were developed based on the outcomes of the participants of the ED & UP Learning Community. It is important to point out that these outcomes are directly related to the various tests of change, interventions, and projects these hospitals conducted and are not guaranteed. As hospital embark on improvements in the ED, intention should be given to the size of the hospital, number of resources & staffing, local community partnerships, and the presiding culture. A few examples lessons learned and overall insights are shared below.

Hospital A

Hospital A engaged in a project to reduce the use of restraints and decrease repeat ED visits within seven days for behavioral health patients. The ED implemented interventions including coping kits, environment changes, and the introduction of dialectical behavior therapy skills and trauma-informed care training. Over the course of 18 months, there was a significant decrease in the percentage of behavioral health patients restrained and repeat BH emergency department visits within seven days.

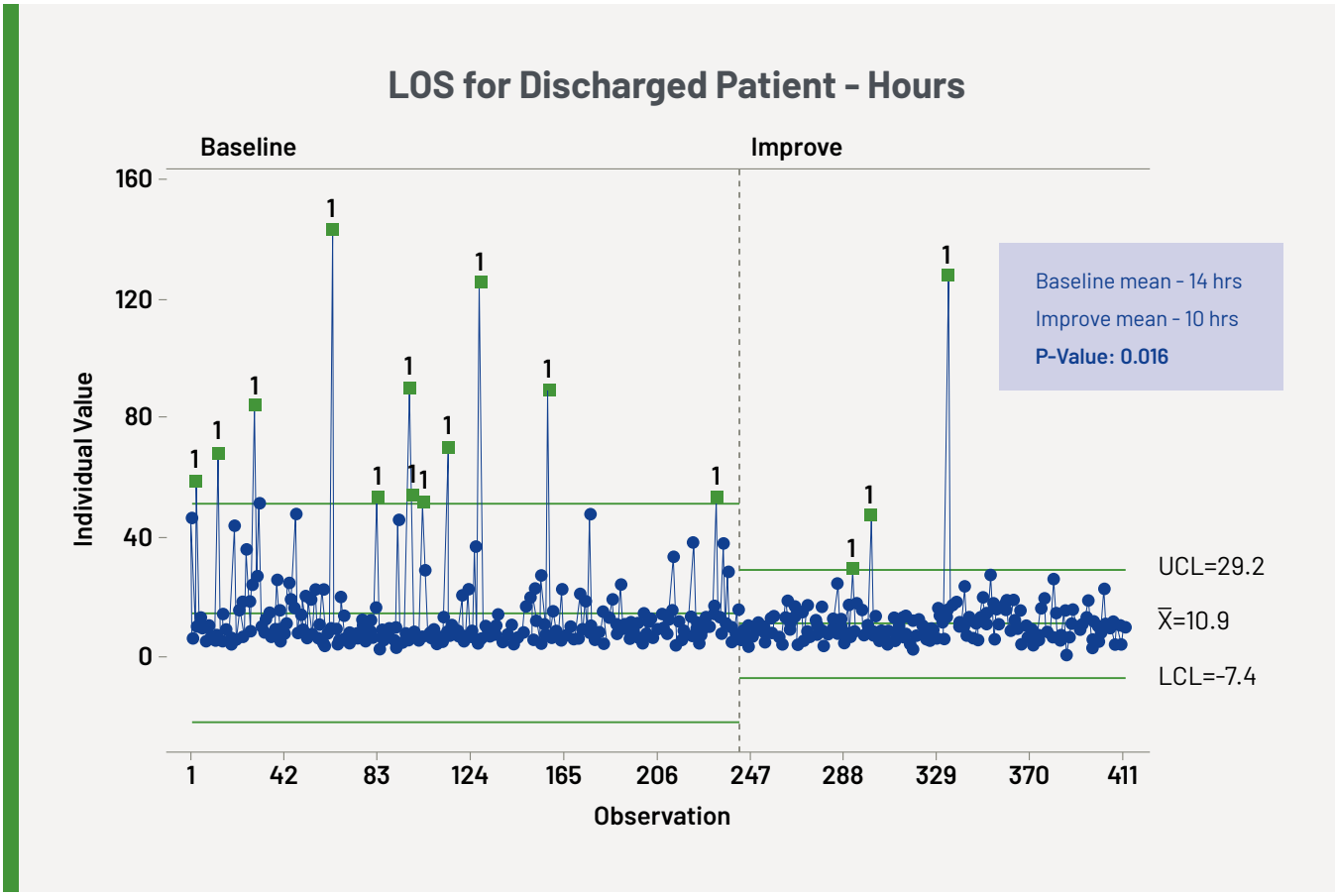


As a result of the interventions described above, there was a significant decrease in the percentage of behavioral health patients restrained and repeat BH emergency department visits within seven days.



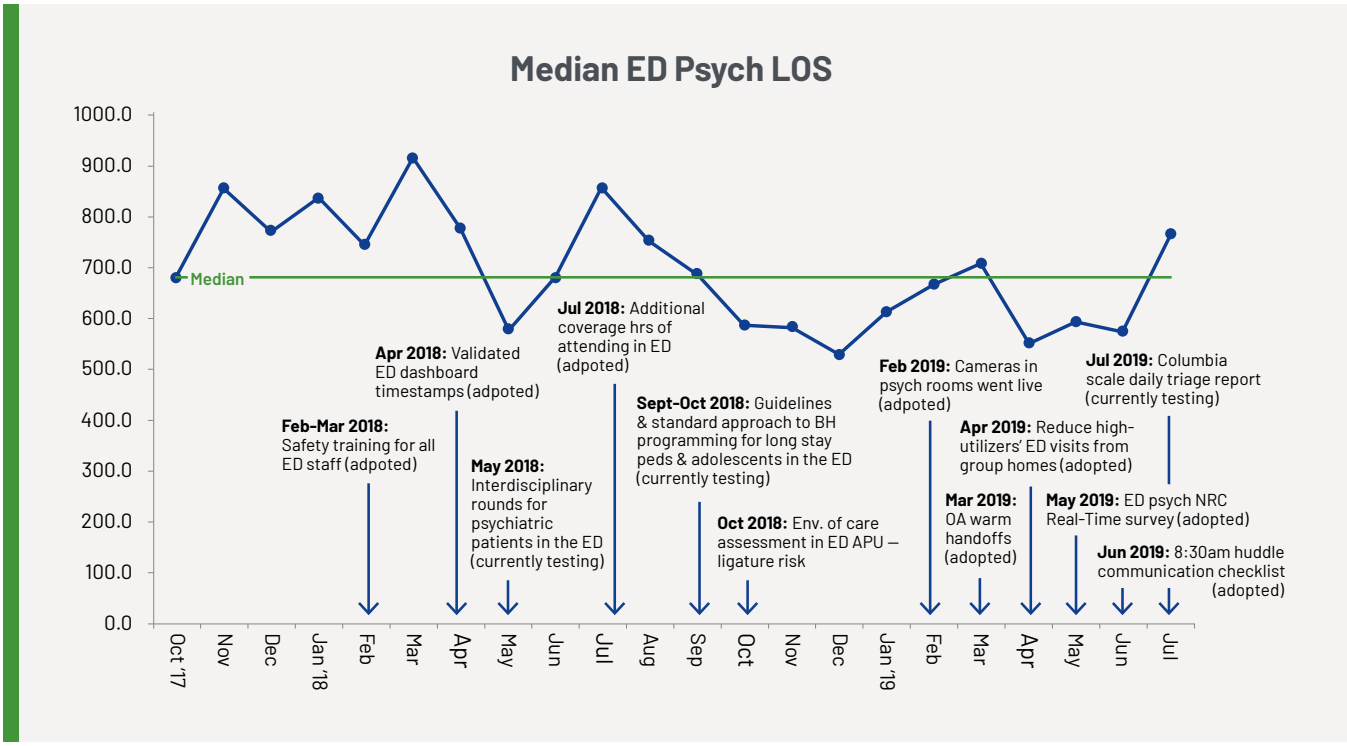
Hospital B

Hospital B engaged in a project to pilot multiple interventions to reduce the ED length of stay (LOS) for discharged behavioral health patients. These interventions included implementing a post-psych response evaluation huddle, medication algorithm, new standardized intake process for behavioral health patients and an integration of trauma informed care lens. The length of stay for discharged behavioral health patients went down from 14 to 10 hours.



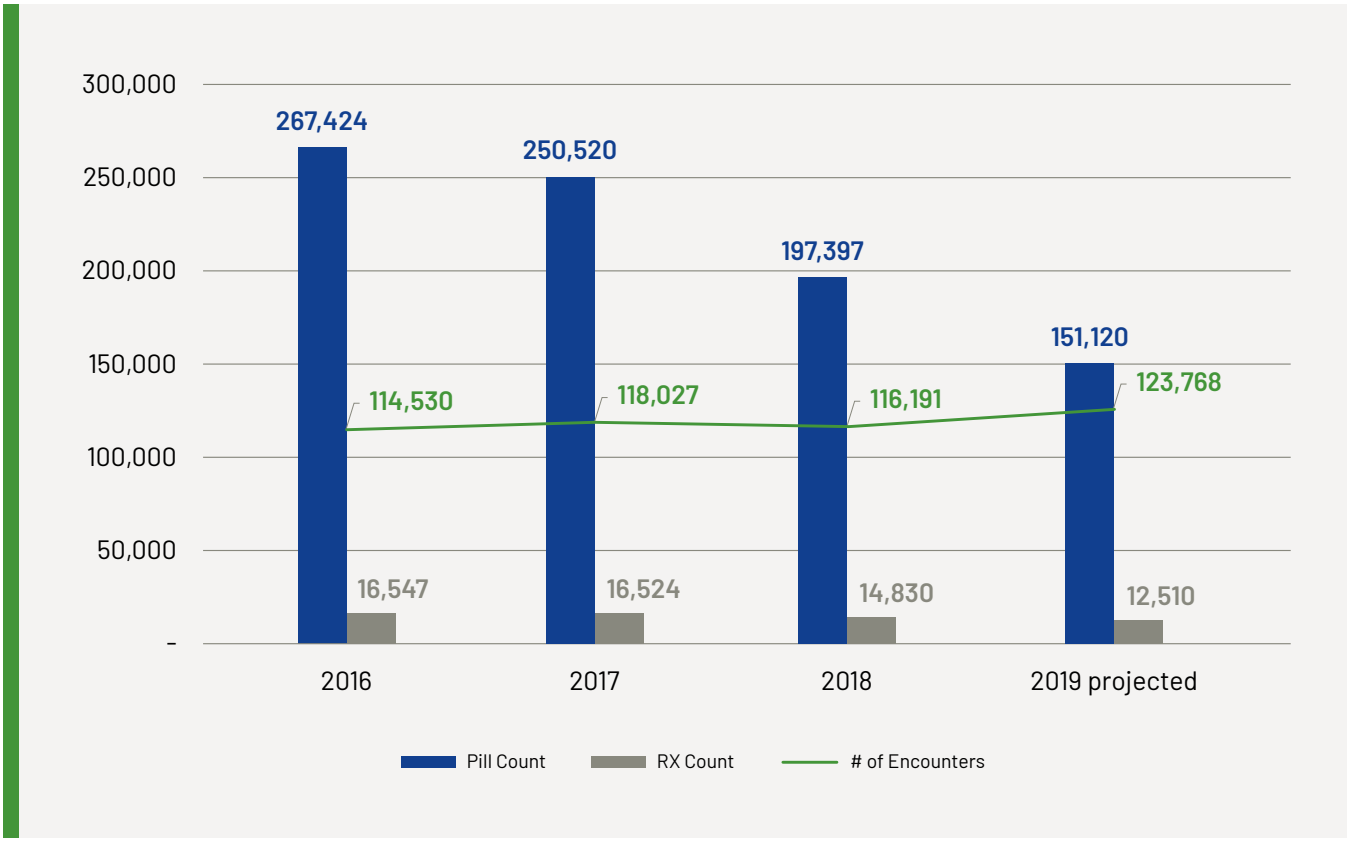
Hospital C

Hospital C engaged in a project to reduce the ED length of stay for psychiatric patients and incidences of workplace violence in the ED. Some of the interventions that were tested and implemented were safety training for all ED staff, ED dashboard time stamps, interdisciplinary rounds for patients, development of guidelines and standardization for pediatric in the ED, cameras in the psych rooms and the adoption of warm hand-offs. The work resulted in a decrease in the median length of stay from 900 minutes to 800 minutes.



Hospital C

Hospital C engaged in a project to test several interventions to improve care delivered in the emergency department. One intervention piloted was a project to reduce the variation amongst providers by chief complaint when prescribing opioids. From 2016 through 2019. Hospital C's trend for prescribing opioids on discharge decreased. The pill count went down by approximately one-hundred and eighteen thousand (e.g. from 267,424 to 151,120) or 44% and the number of prescriptions went down from approximately sixteen thousand five-hundred to twelve thousand five-hundred (e.g., 16,547 to 12,510) This occurred despite the number of encounters increasing by approximately 8% (e.g., 114,530 to 123,768).



References

ProjectManager.com. (2020). Gnatt chart. Retrieved from https://www.projectmanager.com/gantt-chart.

Toggle.com. (2020). 5 Stages of Team Development. Retrieved from https://toggl.com/track/stages-ofteam-development.

Alsher, P. (2017, March 2). *Change Leadership: Three Actions Needed by Every Sponsor*. Retrieved from https://www.imaworldwide.com/blog/change-leadership-the-three-actions-needed-by-every-sponsor.

Creasey, T. (2020). *Change Management and Project Management*. https://blog.prosci.com/change-management-and-project-management-comparison.

George, M. L., Rowlands, D., Price, M., & Maxey, J. (2005). *The Lean Six Sigma Pocket Toolbox.*

Harrington, H. (2013). *The Sponsor as the Face of Organizational Change*. Retrieved from Project Management Institute: https://www.pmi.org/learning/library/sponsor-face-organizational-change-11131.

Heagney, J. (2016). *Fundamentals of Project Management, Fifth Edition.*

Prosci.com. (2020). *Definition of Change Management*. Retrieved from https://www.prosci.com/resources/articles/change-management-definition.

Laderman M, Dasgupta A, Henderson R, Waghray A, Bolender T, Schall M. (2018) *Integrating Behavioral Health in the Emergency Department and Upstream*. Institute for Healthcare Improvement. Retrieved from IHI.com.

Providence. (2020, January). Clinical Value Improvement Workshop in Renton, Washington.

Ramalingam, B. (2006, July) *Tools for Knowledge and Learning, A Guide for Development and Humanitarian Organisations*. Retrieved from https://www.odi.org/sites/odi.org.uk/files/odi-assets/publications-opinion-files/188.pdf.

Schall M, Laderman M, Bamel D, Bolender T. (2020) *Improving Behavioral Health Care in the Emergency Department and Upstream*. Institute for Healthcare Improvement. Retrieved from http://www.ihi.org/resources/Pages/IHIWhitePapers/Improving-Behavioral-Health-Care-in-the-Emergency-Department-and-Upstream.aspx.

Scholtes, P. R. (2018). *The Team Handbook, Third Edition.*

Institute for Healthcare Improvement. *Science of Improvement: Establishing Measures*. (2019). Retrieved from http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementEstablishingMeasures.aspx.

Westland, J. (2020, March 10) *The Ultimate Guide to Stakeholder Management*. Retrieved from https://www.projectmanager.com/stakeholder-management.

Prosci.com. (2020). *What is Change Management and How Does it Work?* Retrieved from https://www.prosci.com/resources/articles/the-what-why-and-how-of-change-management.

Appendix

Table of Contents

31	A. Baseline Hospital Profile Survey
37	B. Presentation Slides
56	C. Customer Promise Tool
58	D. SIPOC Diagram
60	E. Fishbone Diagram
62	F. Charter
64	G. Project Planning Form
66	H. Driver Diagram Template
67	I. Driver Diagram – Priority Alignment
68	J. PDSA Cycle Tracker (IHI)
69	K. A Patient's Perspective on the ED experience

A. Baseline Hospital Profile Survey

26 total questions

* Required

1. Name? *

Who is completing this form?

2. Hospital name? *

If this is being completed for a group of hospitals or region, please list all hospitals

3. Region *

- ◯ Alaska
- ◯ Oregon
- ◯ New Mexico/Texas
- ◯ Washington/Montana
- ◯ NorCal
- ◯ Swedish
- ◯ SorCal

4. What are the top 3 problems in your ED? *

A. Baseline Hospital Profile Survey cont.

5. Is there a dedicated space in the ED for patients with Mental Health and/or Substance Use challenges?

6. If Yes, is it a locked/secure space?

7. How many psychiatric beds are available in the ED?

8. What is the volume of patients with mental health challenges and/or substance use disorder?

   Average volume per day and week

9. What is the LOS of this patient population (please include both average and median LOS)?

10. Do BH providers see patients?

◯ Yes ◯ No ◯ Not sure

A. Baseline Hospital Profile Survey cont.

11. Provider Type?

- ◯ Psychiatrist
- ◯ Psychologist
- ◯ Nurse Practioner
- ◯ Social Worker
- ◯ Other

12. If other, please specify

13. What is the average wait time from triage to see a BH provider?

14. Please list the top 5 MH diagnoses seen in the ED.

15. Does the ED have dedicated staff to support patients with Mental Health or Substance use challenges?

- ◯ Yes
- ◯ No
- ◯ Not sure
- ◯ Not needed

A. Baseline Hospital Profile Survey cont.

16. If yes, please specifcy

17. Is Tele-psych available?

◯ Yes ◯ No ◯ Not sure

18. How are BH patients tracked via data/reports?

19. Operationally, how are BH patients identified by data (e.g. diagnosis, EDW BH Flag, BH Safety Tab, other)?

A. Baseline Hospital Profile Survey cont.

20. On average, how many patients are on involuntary hold at a given time? If possible, describe a pattern.

21. How is a patient's involuntary legal status documented in EPIC?

22. What screens and/or assessments are used in the ED? How is it determined who is screened?

(depression, suicide, SUD or other)

A. Baseline Hospital Profile Survey cont.

23. Does your facility have an inpatient psychiatric unit on site?

◯ Yes ◯ No ◯ Not sure

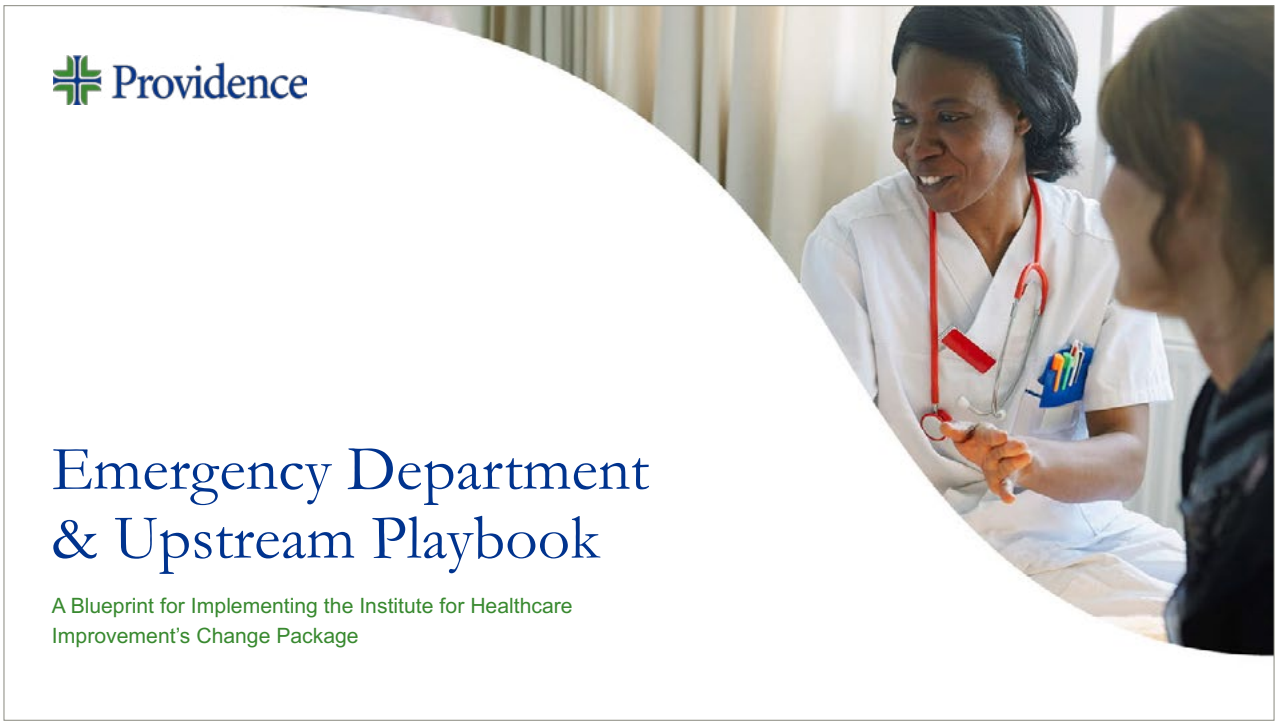
24. If BH patients have to be transferred to another hospital for Acute Psychiatric Care, what is the process to get patients in those beds?

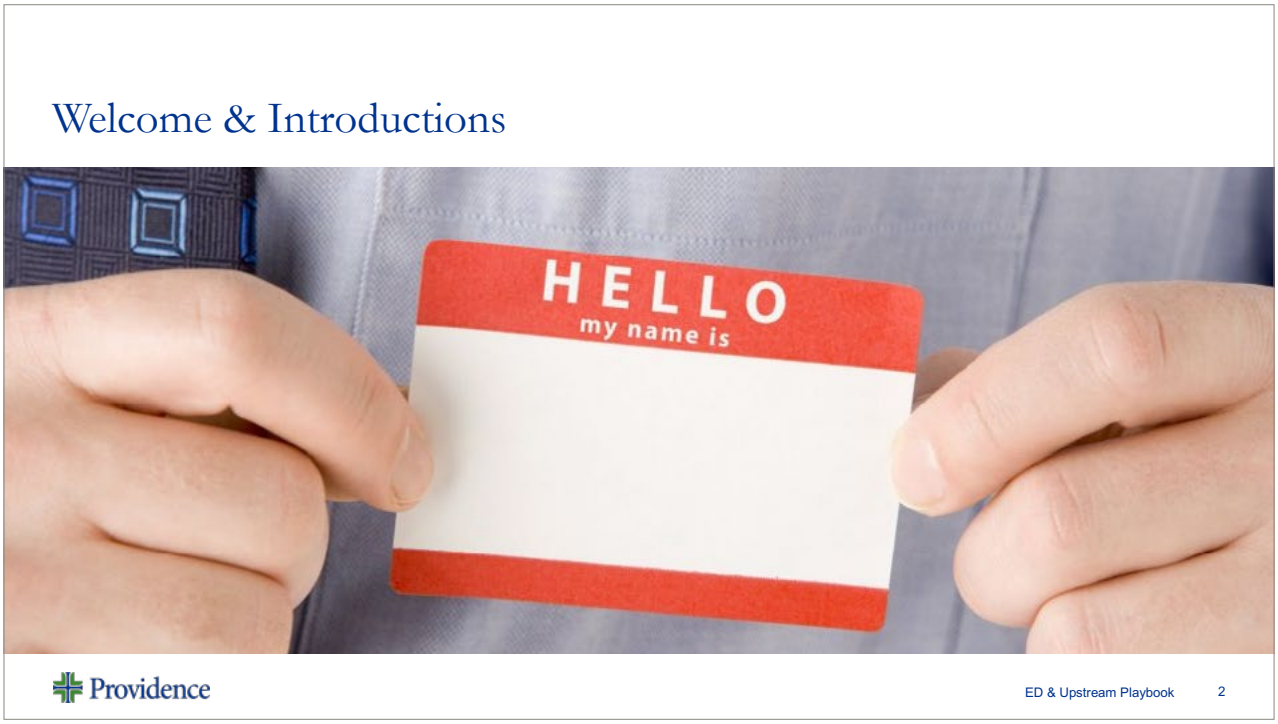
25. What are the main care settings/facilities to which patients with MH needs are referred from your ED?

◯ Inpatient
◯ Outpatient
◯ Partial hospital
◯ Other
◯ Intensive outpatient

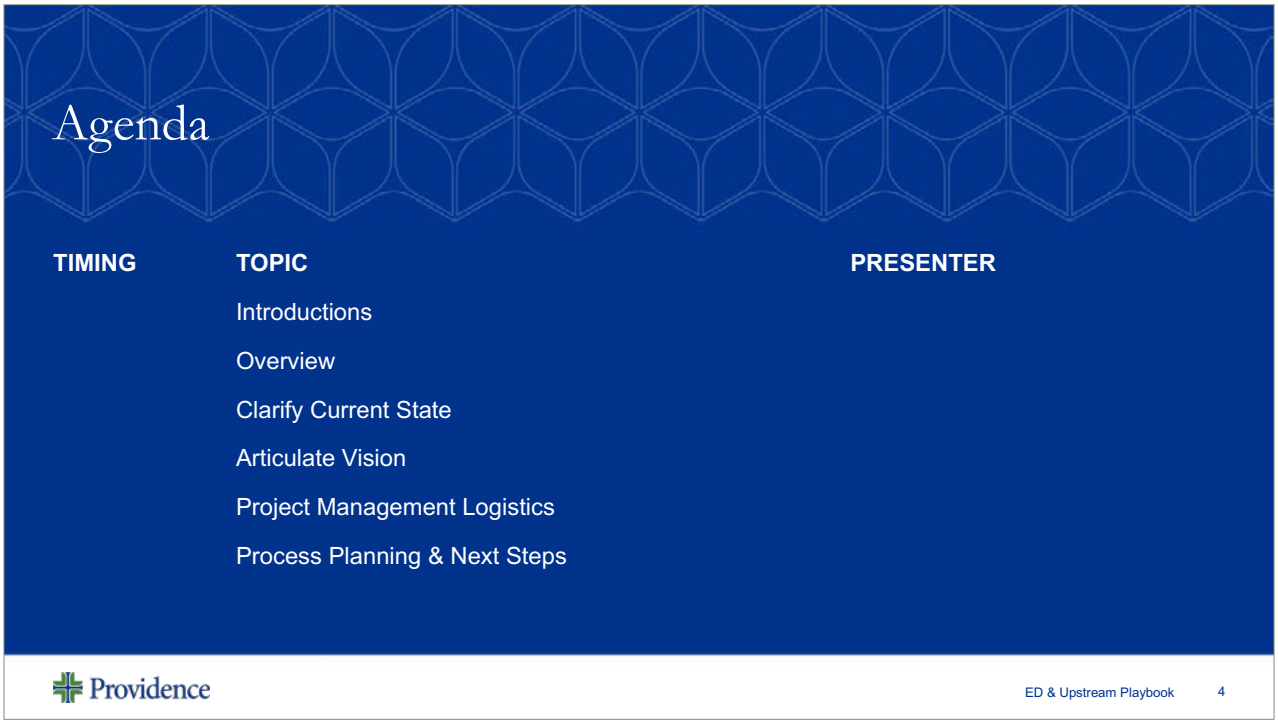
26. If other, please describe

B. Presentation Slides





Reflection / Ice Breaker
Provided by:
Providence
ED & Upstream Playbook 3


Agenda
TIMING
TOPIC
PRESENTER
Introductions
Overview
Clarify Current State
Articulate Vision
Project Management Logistics
Process Planning & Next Steps
Providence
ED & Upstream Playbook 4

Presenter(s)

Overview

Providence

ED & Upstream Playbook 5

Throughout the United States, individuals with behavioral health conditions or substance use disorders frequently present to the hospital emergency department (ED) for care, yet many ED teams lack the capacity to adequately support these individuals. This dynamic often results in prolonged periods of “psychiatric boarding,” where patients wait in the ED for transfer to another care setting; lack of care coordination and care management; and few alternative options to the ED to prevent and address crises. These issues contribute to poor patient outcomes and experience of care that may have recurring and serious consequences.

Providence

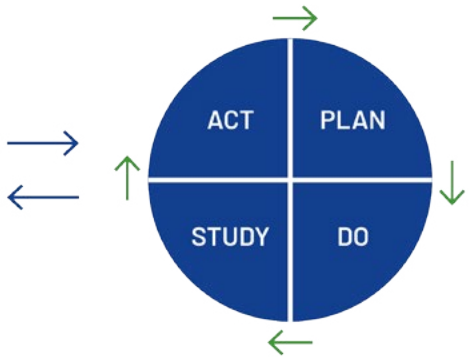
ED & Upstream Playbook 6

Model for Improvement

What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in improvement?



Providence

ED & Upstream Playbook 7

IHI ED & Upstream Goals

IMPROVE PATIENT OUTCOMES	IMPROVE THE EXPERIENCE OF CARE	DECREASE ED VISITS
• Enhance and Test New Intake/Triage Processes	• Introduce Trauma Informed Care Training • Create a Supportive Physical Environment	• Enhance Communication with Family • Develop Community Partnerships

Providence

ED & Upstream Playbook 8

Example

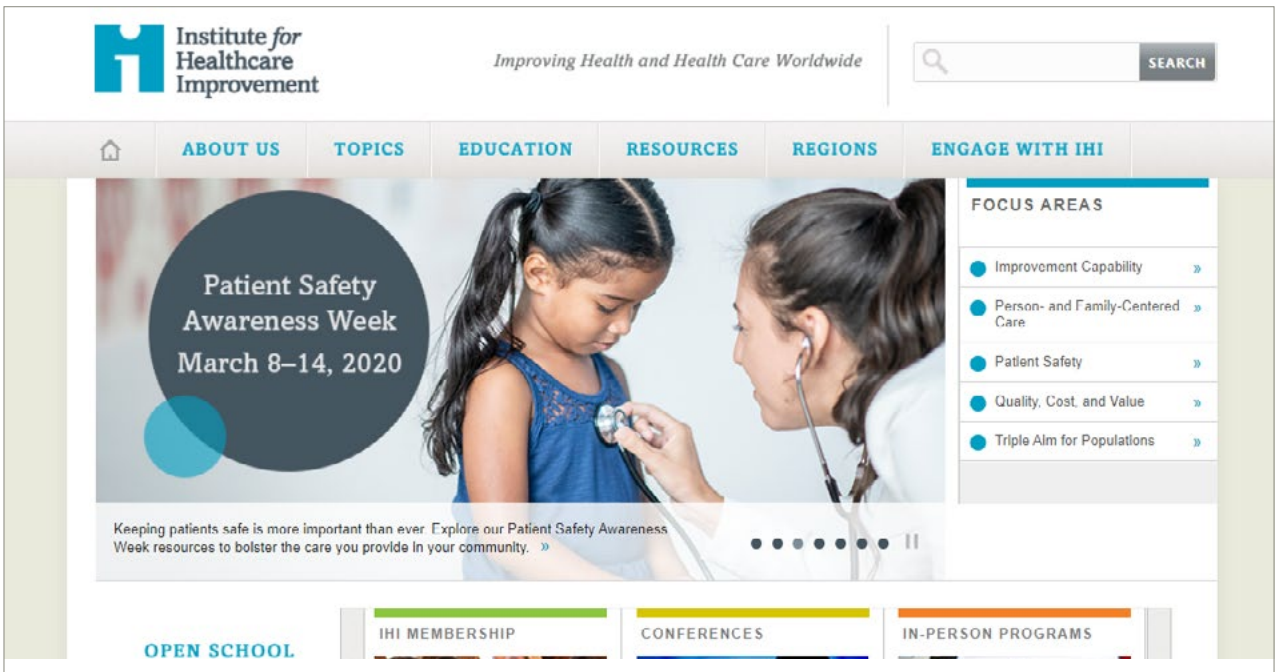
Tackling The Mental Health Crisis In Emergency Departments: Look Upstream For Solutions

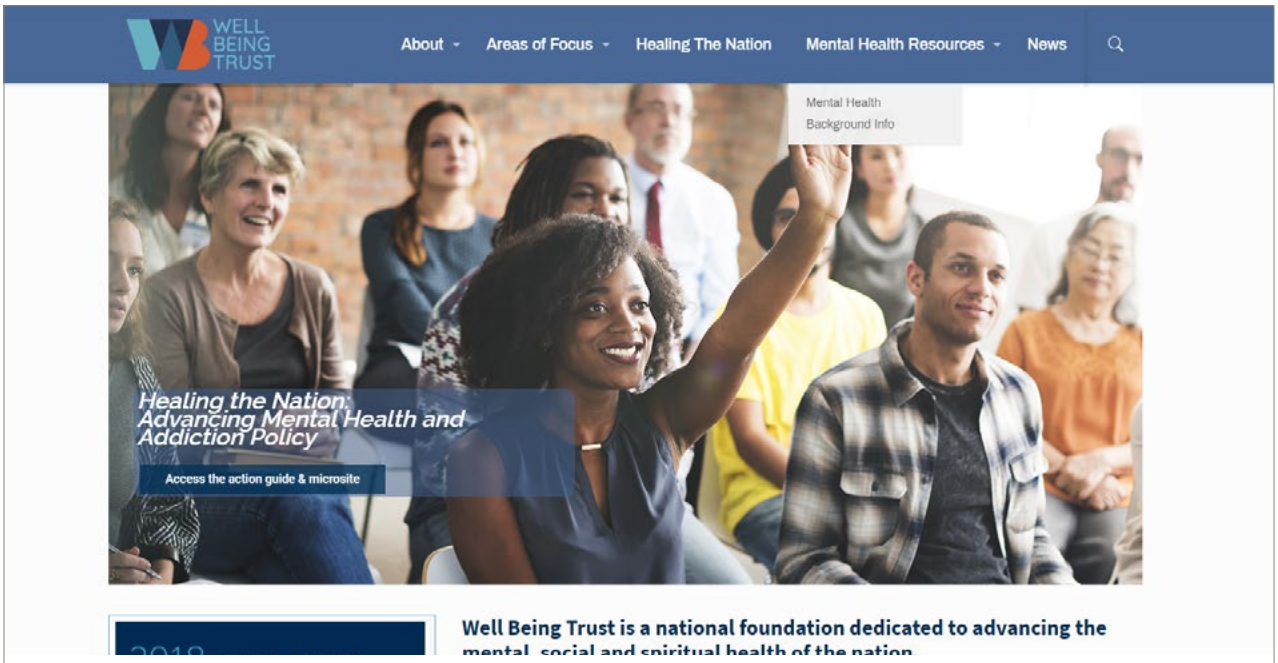
Mara Laderman, Amrita Dasgupta, Robin Henderson, Arpan Waghray

JANUARY 26, 2018 10.1377/hblog20180123.22248

TOOLS SHARE

The United States is in the middle of a well-documented mental health crisis. In 2015, 127,500 Americans died from drug or alcohol-related causes or suicide. This translates into 350 deaths per day, and one person dying of a preventable cause every four minutes. This crisis, which

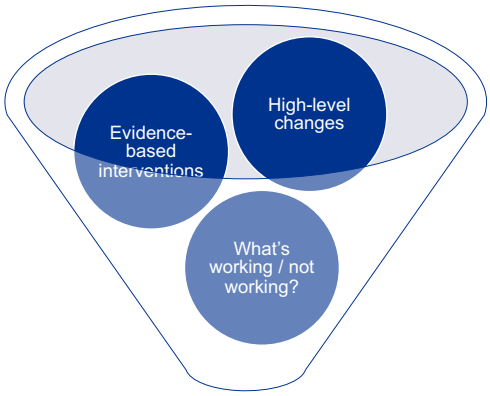




Providence

What is a Learning Community?

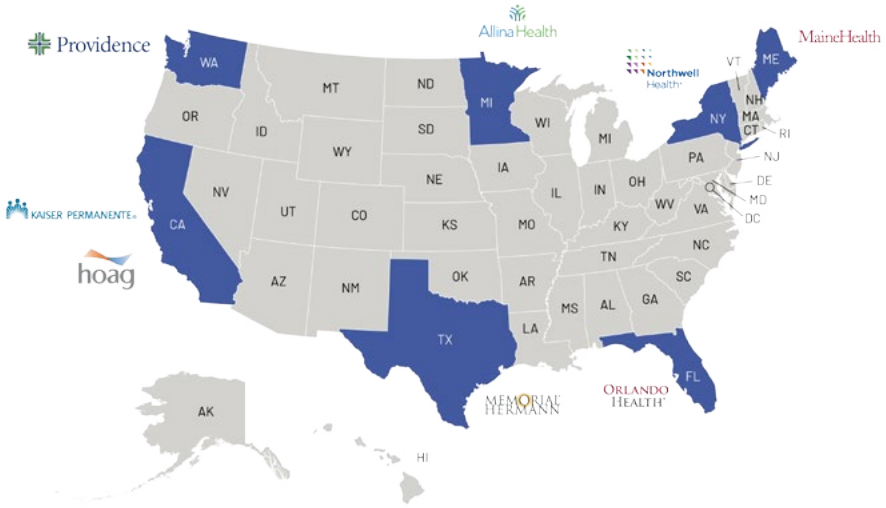
Well Being Trust funded a group of hospitals coming together to share how to tackle common problems



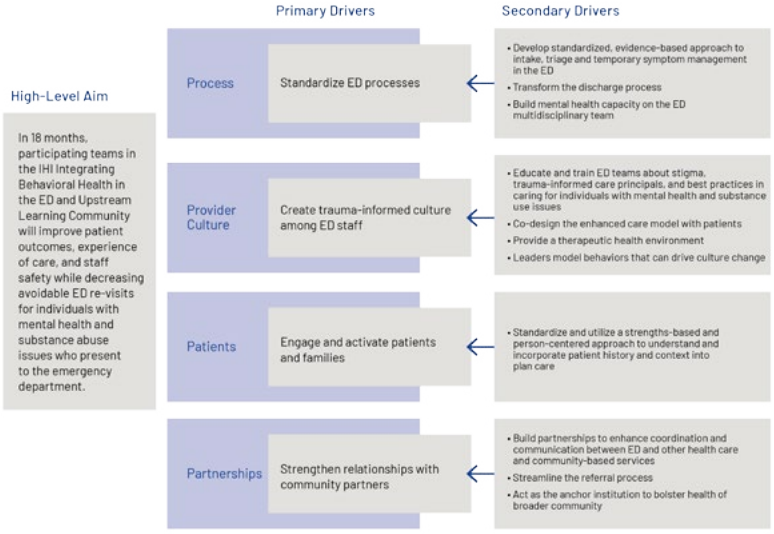
Change Package

Providence

ED and Up Learning Collaborative

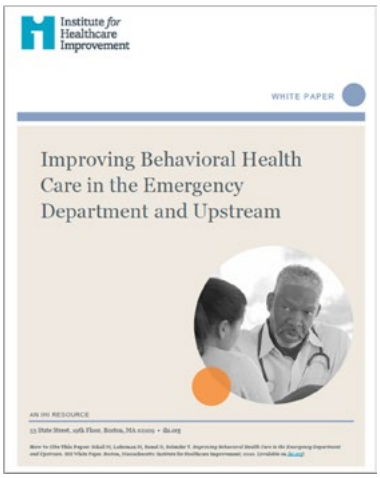


IHI ED & Up Change Package Driver Diagram

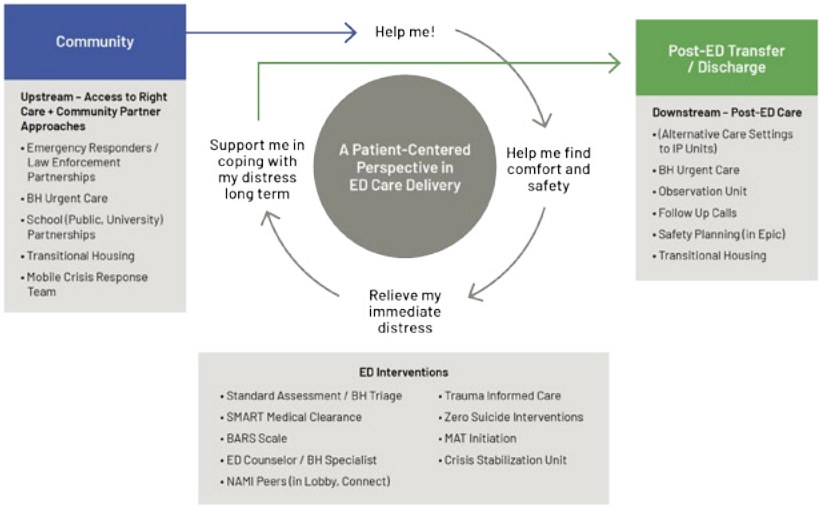


IHI ED & Upstream Change Package Scale & Spread

- The official IHI Change Package has been released in the form of a white paper.
- This white paper includes lessons learned, suggested measures, tools & resources and a list of essential elements for improvement.
- This document can be found at http://www.ihi.org/resources/Pages/IHIWhitePapers/Improving-Behavioral-Health-Care-in-the-Emergency-Department-and-Upstream.aspx

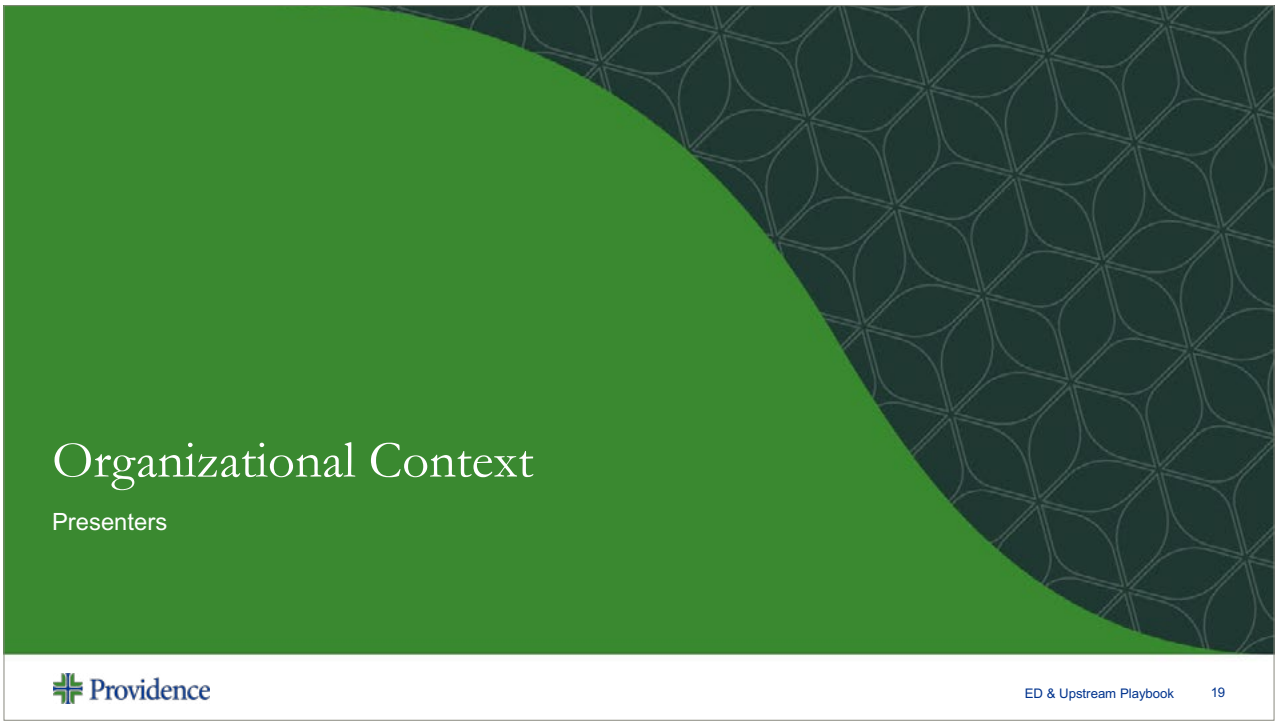


A Patient's Perspective on the ED experience



IHI ED & Up Change Package – Vignettes

IHI ED & Up Change Package - Supporting Data



Mental Health & Substance Use CPG Intent

Our regions offer a variety of acute, ambulatory, specialty and primary care behavioral health services

Combined with our own health plan, we have the opportunity to transform how behavioral health services are supported, integrated, delivered and paid for through leveraging the collective knowledge within Providence family of organizations

In alignment with the foundational purpose of Clinical Program Services (CPS), the MHSU CPG will:

- Optimize expert-to-expert collaboration
- Design, develop and deploy clinical standardization
- Scale innovation across the organization

MHSU CPG Aspirational Vision

Transforming our Health System to Prevent Deaths of Despair

Aligned with Health 2.0:

We will be our communities' health partner, aiming for physical, spiritual, and emotional well-being. We seek to ease the way of our neighbors in their journey to good life.

MHSU Leadership Council

Co-Chairs: Robin Henderson, PsyD (OR), Arpan Waghray, MD (Swedish)
Members: Renee Rafferty, LPC (AK), Tamara Sheehan, RN (WA/MT), Mark Wakai (WA/MT), Paul Giger, MD (OR), Jeannette Currie, MD (NCa), Dan Schurman (NCa), Julie Fortune (SCa), Mary Giles, RN (TX), Jessica Nelson, MD (TX), Kevin Fleming, Phil Capp, MD (PHP), Karen Boudreau, MD (Pop Health), Dora Barilla, DrPH (CHI), Bailey Raiz, DBH (Pop Health), Howard Mun, PharmD (Phys Ent)
Director: Jordan Johnson

MHSU FOCUS GROUPS

- **Addiction Leads:** Renee Rafferty, LPC (AK) and Jim Walsh, MD (Swedish)
- **BH Integration in Primary Care Leads:** Chris Avelino, MD (SoCal) and Vanessa Casillas, PsyD (OR)
- **BH in the ED & Upstream Leads:** Ryan Keay, MD (NW WA) and Bonnie Wilson, RN (OR)
- **Zero Suicide Leads:** Howard Mun, PharmD (Physician Enterprise) and Paul Giger, MD (OR)
- **BH Clinical Decision Team (CDT) Leads:** Gale Springer, RN, ARNP (NW WA)

2019 Executive Metrics & Operating Commitments

Mental Health & Substance Use CPG			
Executive Metric	**Baseline**	**Target**	**YTD Performance**
1. Percent of patients age 12+ in a primary care setting who were screened for clinical depression using a standardized instrument.	52.39%	Threshold: 54.64% Outstanding: 55.39%	**61.7%** *Thru end of October*
2. The Zero Suicide Organizational Self-Study (all 23 items) is completed by all 7 regions.	0%	Threshold: 75% of regions Outstanding: 100%	**100%**
3. Increase digital engagement, measured as # of unique patient users, in depression treatment solutions.	40	Threshold: 230 Outstanding: 1000	**457 patients** *Thru end of October*
Operating Commitment	**Baseline**	**Target**	**YTD Performance**
1. Launch Inpatient Opioid Use Disorder Pathway	0 sites	Threshold: 3 sites Outstanding: 5 sites	**2 Sites (PAMC, PRMCE)** *4 additional planning*
2. Leverage IHI BH in the ED & Upstream Change Package to implement improvement projects in ED's across PSJH	2 sites	Threshold: 5 sites Outstanding: 9 sites	**3 sites implemented** *8 additional planning*
3. Create & study learning metric for Depression Screening + Follow-Up in primary care	No Metric	Threshold: Metric Developed Outstanding: Metric Developed + Action Plan	**Draft metric developed** *validation in process*

Scale Strategy

- "Go where the will is"
- Convene scale & spread "SWAT Team"
- Share results – data & stories
- Start with promising interventions
- Leverage IHI Change Package
- CPG 2019 Operating Commitment to implement new projects:

Operating Commitment	Baseline	Threshold	Outstanding
Leverage IHI BH in the ED & Upstream Change Package to implement improvement projects in ED's across Providence	2 sites	5 sites	9 sites

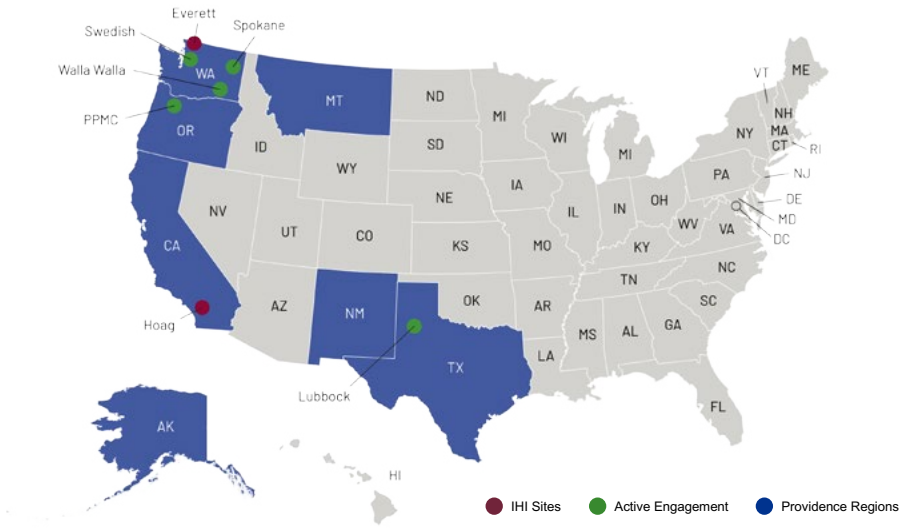
2020 Executive Metrics

Executive Metric	Definition
Depression positive screening + treatment response rate	Primary care patients with a depression dx whose PHQ-9 at 12 months from index shows either a reduction in score by 50% or a total score of <10
Medication-Assisted Treatment access for opioid use disorder	Unique patients across all care settings who are administered buprenorphine or methadone
Digital BH Growth	Number of patients served across a number of BH-related digital tools, including MyStrength, Silvercloud, Lyra, Quartet, BH Concierge and others

2020 MHSU CPG Operating Commitments

Operating Commitment	Baseline	Target
1. Implement Inpatient Opioid Withdrawal Pathway	1 site	**Threshold:** 3 sites **Outstanding:** 5 sites
2. Leverage IHI BH in the ED & Upstream Change Package to implement improvement projects in ED's across Providence	3 sites	**Threshold: 6** sites **Outstanding: 10** sites
3. Establish suicide metrics across system	No Metric	**Threshold:** Metric Developed **Outstanding:** Metric Developed + Validated
4. Develop Zero Suicide Playbook	No Playbook	**Threshold:** Screening & Assessment **Outstanding:** Screening/Assessment, Safety Planning & Means Safety

ED & Upstream Reach Across Providence



Providence

ED & Upstream Playbook 27

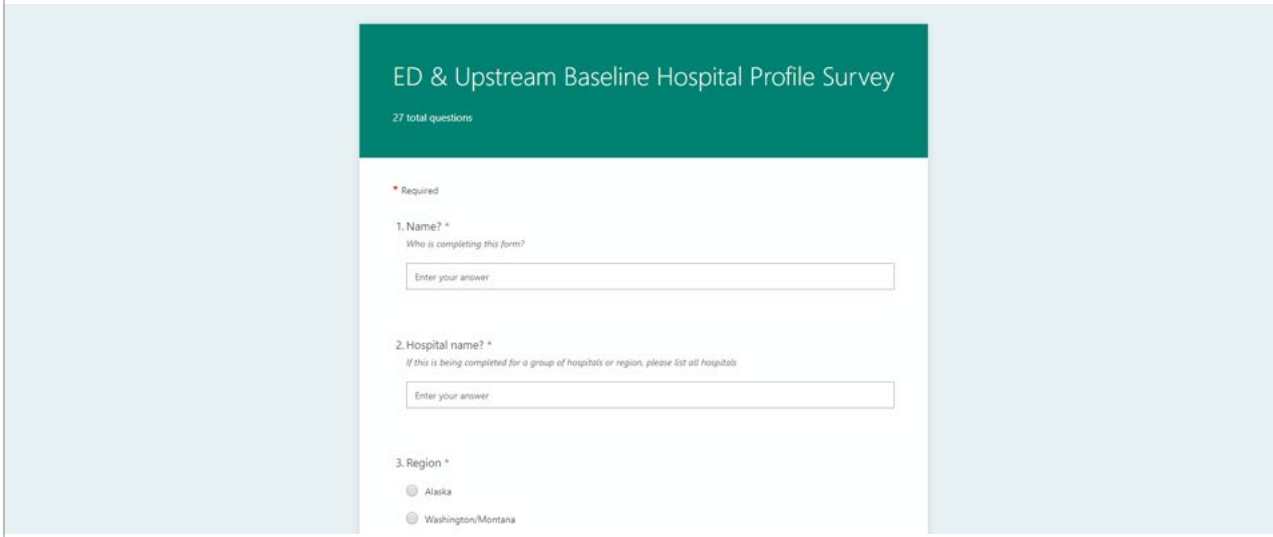
Presenter(s)

Current State

Providence

ED & Upstream Playbook 28

Assessment



Develop Problem Statement (aim)

Talk through baseline profile survey

- What came up?
- Top issues?
- Benchmarks (LOS/Boarding times)

When do we hand over to local champion?

Diagram of activities

Providence

ED & Upstream Playbook 31

Presenter(s)

Vision & Expectations

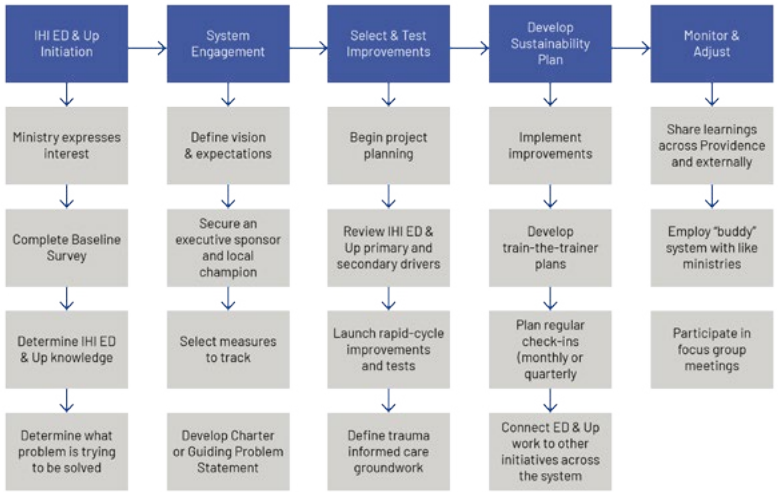
Providence

ED & Upstream Playbook 32

Align Priorities with Driver Diagram

IHI PrimaryDrivers	Ministry Opportunities	Secondary Drivers
ED Processes		• Develop standardized, evidence-based approach to intake, triage and temporary symptom management in the ED • Transform the discharge process • Build mental health capacity on the ED multidisciplinary team
Provider Culture		• Educate and train ED teams about stigma, trauma-informed care principles, and best practices in caring for individuals with mental health and substance use issues • Co-design the enhanced care model with patients • Provide a therapeutic health environment • Leaders model behaviors that can drive culture change
Patients & Families		• Standardize and utilize a strengths-based and person-centered approach to understand and incorporate patient history and context into plan care
Community Partnerships		• Build partnerships to enhance coordination and communication between ED and other health care and community-based services • Streamline the referral process • Act as the anchor institution to bolster health of broader community

IHI ED & Upstream Implementation Process



List of Key Project Management Activities

DATA COLLECTION	DOCUMENT STORAGE	MEETING CADENCE / LOCATIONS
• Baseline Survey for initial data • Define Measures • Determine length of time to track	• MHSU CPG SharePoint site	• Monthly vs. Bi-monthly • Kick off in person • Weekly check-ins PDSA cylce

Presenter(s)

Process Planning & Next Steps

Key Next Steps

C. Example: Customer Promise Tool

Identify your target customer, then write down 3 of the most important goals.

DESIRED OUTCOMES

These should be from the patient perspective.

Target Customer

Hospital, Medical and Nursing Leaderships

Customer Goals

1. Manage balanced portfolio of work
2. Provide high quality care, sustainable cost
3. Avoid staff burnout

Target Customer

Patients and Families

Customer Goals

1. Tools and resources
2. How I can better care and support
3. Treat my loved one with excellent work

Target Customer

ED Caregivers / BH Caregivers

Customer Goals

1. Tools & training to assess
2. Culture perspective change
3. Understanding population

PAINS & PROBLEMS

What Pains & Problems do patients & caregivers face in order to reach the desired outcome? Identify the barriers.

Barriers

Competing priorities

Concern over bandwidth of managers and caregivers

Financial resources

Fear & perception (stigma)

Large problem many potential solutions

Barriers

Separated from decision making

Misinterpretation of HIPAA

Lack of understanding of f/u care

Unsupportive environment with a culture of fear

Unclear processes

Lack of secure, supportive home and community resources

Barriers

Lack of training

Fear, perception

Unclear processes

PROMISE

What are you prepared to promise your customer and what impact do you hope to have?

If you trust us we will apply a proven framework and disciplined methodology to support and guide your discovery of what the problems are, what improvement means and which potential interventions will lead to success as well as testing the theory of improvement that is developed in hopes of creating sustainable transformed care.

C. Template: Customer Promise Tool

Identify your target customer, then write down 3 of the most important goals.

DESIRED OUTCOMES

These should be from the patient perspective.

Target Customer	Target Customer	Target Customer
Customer Goals	**Customer Goals**	**Customer Goals**
1.	1.	1.
2.	2.	2.
3.	3.	3.

PAINS & PROBLEMS

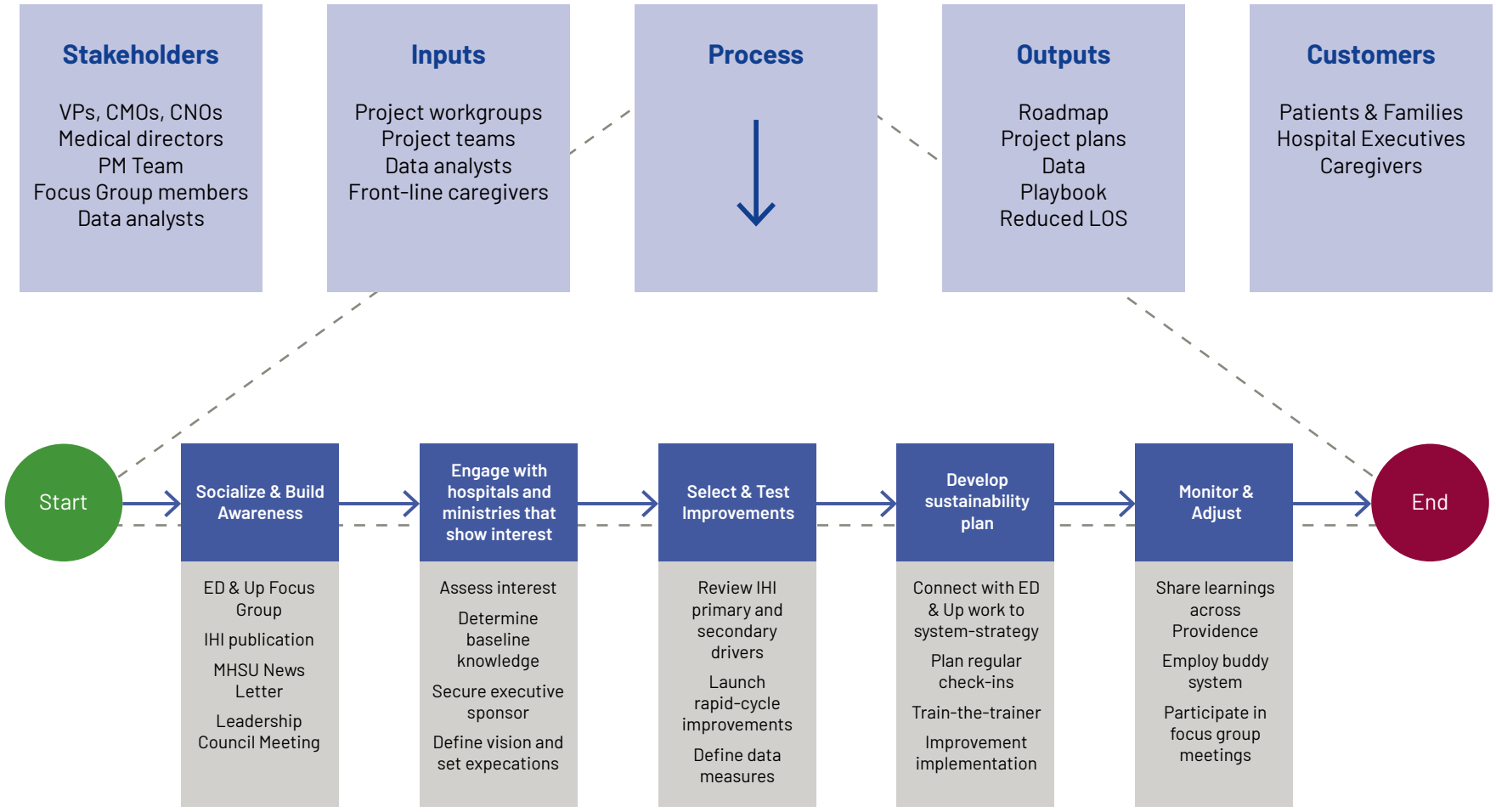
What Pains & Problems do patients & caregivers face in order to reach the desired outcome? Identify the barriers.

Barriers	Barriers	Barriers

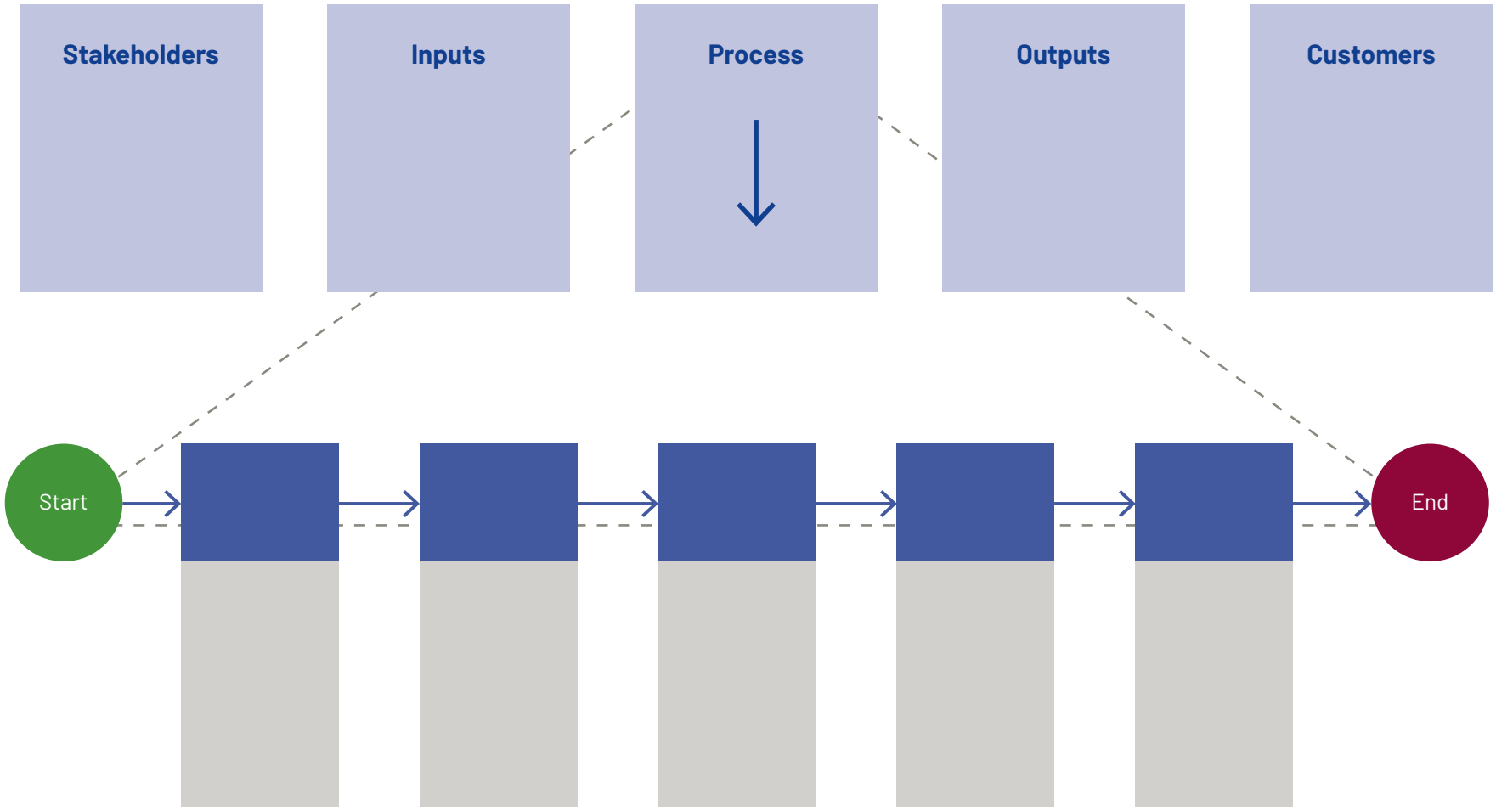
PROMISE

What are you prepared to promise your customer and what impact do you hope to have?

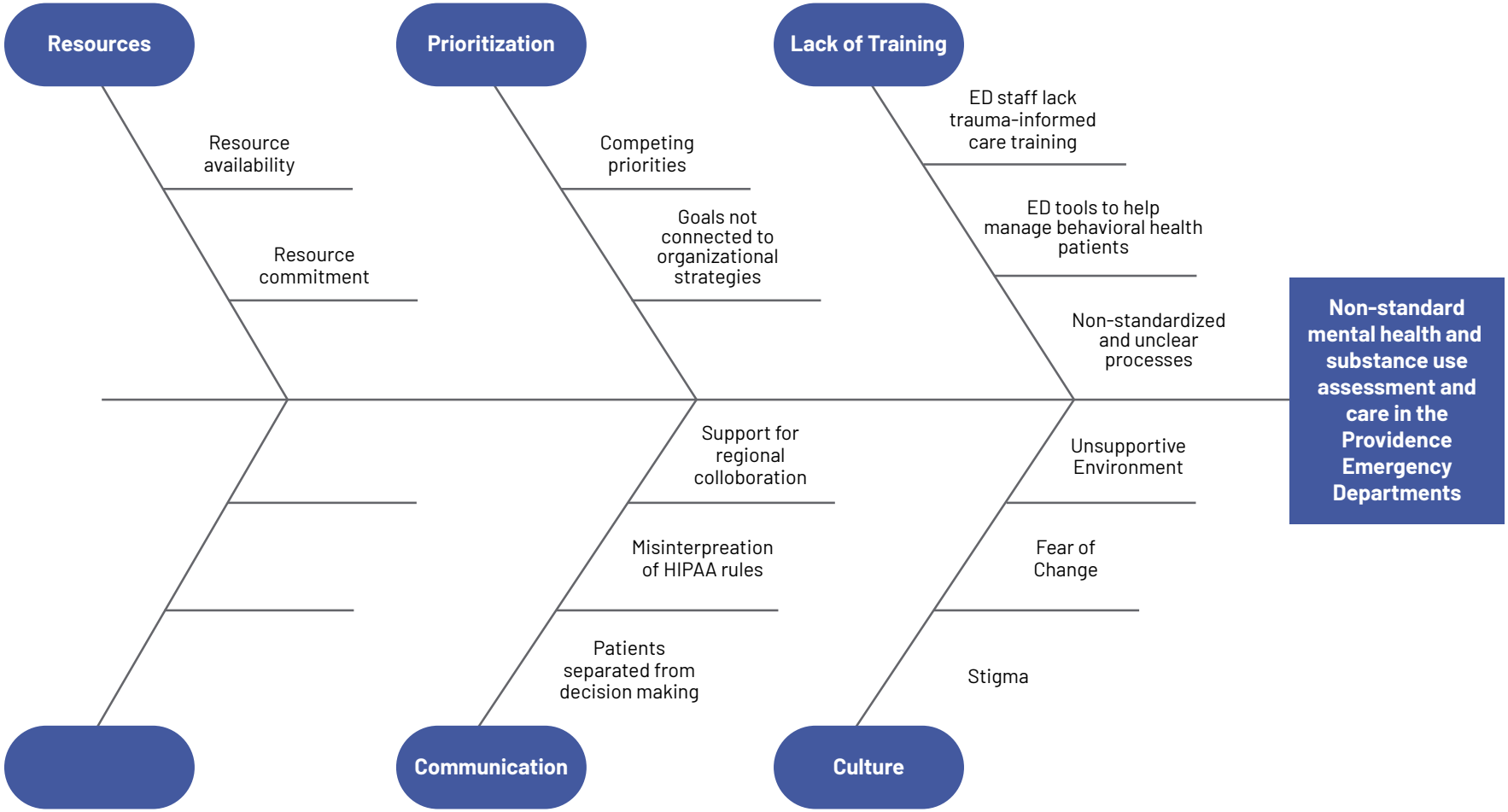
D. Example: SIPOC Diagram



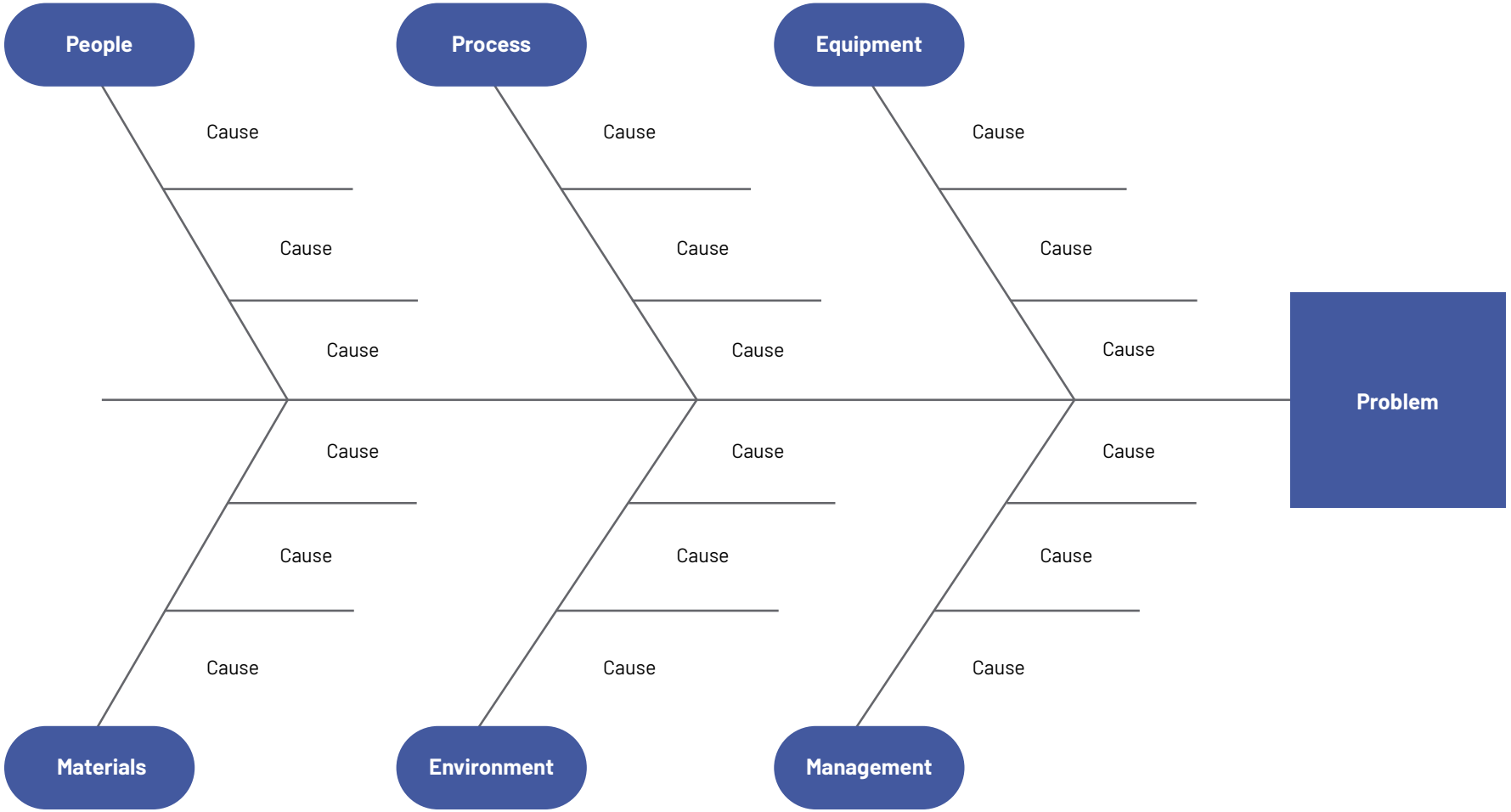
D. Template: SIPOC Diagram



E. Example: Fishbone Diagram



E. Template: Fishbone Diagram



F. Example: Charter

[Project Name] Charter

Problem Statement:

Suggested format: ***What*** *(what is the problem),* ***Who*** *(who is involved),* ***When*** *(frequency of problem occurrence),* ***Where*** *(Location of the Problem),* ***How/How Much*** *(how bad is the problem)*

Aim Statement:

Measures you ultimately want to move. All projects must have a SMART (Specific, Measurable, Agreed Upon, Realistic, Time Bound) outcome goal. (i.e. I will arrive to meetings on time 100% of the time within 3 months.)

Outcome Measurement:

Measures you ultimately want to move. They tell you how the system is performing, i.e., what is the ultimate result? (i.e. percent of the time you arrive punctually to meetings)

Balancing Measures:

Measures to track that you do not unintentionally decrease a different component of the quadruple aim (outcomes, cost, patient experience and caregiver satisfaction)

Project Scope:

Words –what is included and excluded

Forecasted Financial Benefit:

$000,000

Strategic Alignment:

Words

Project Sponsor:

Name

Project Scope:

Names

Project Scope:

Names

Process Owners:

Name(s)

F. Template: Charter

_____ Charter

Project Title

Problem Statement:

Aim Statement:

Outcome Measurement:

Balancing Measures:

Project Scope:

Project Sponsor:

Process Owners:

Forecasted Financial Benefit:

Project Team Members:

Strategic Alignment:

Quad Members:

G. Example: Project Planning Form

Team: John, Sally, Mark, Dave, Laura, and Beth **Project**: Lowering Depression Scores: Achieve a 15-point decrease in PHQ-9 scores for 50% of depressed patients by May 1.

Driver – list the drivers you'll be working on	Process Measure	Goal
1. Patient education	% of patients in depressed population receiving education materials before leaving office will have documented use of education materials	90% of patients in depressed population will have documented use of educational materials before leaving office
2. Follow-up assessment	% of patients in depressed population that have a follow-up assessment within the first eight weeks of their initial diagnosis	75% of patients in depressed population have a follow-up assessment within the first eight weeks of their initial diagnosis
3.		
4.		
5.		
6.		

Driver Number (from above)	Change Idea	Tasks to Prepare for Tests	PDSA	Person Responsible	Timeline (T = Test; I = Implement; S = Spread)													
					Week													
					1	2	3	4	5	6	7	8	9	10	11	12	13	14
1	Provide pamphlet and link to short video at time of patient discharge	Need to make sure we have enough pamphlets on site; need to ensure link to video works	Nurse will hand materials to patient before leaving the exam room with all patients scoring high on the PHQ-9	Beth and Mark	**T**	**T**												
2	Patients will come back to the office for a follow-up assessment within eight weeks of depression diagnosis	Need to schedule appointments within timeframe and get patients to attend follow-up appointment; need to make sure secretaries are aware of this test	Have secretaries write down the date and time of the follow-up appointment on the back of the clinic's business card	Laura	**T**	**T**												

This form has been adapted from the Institute of Healthcare Improvement

G. Template: Project Planning Form

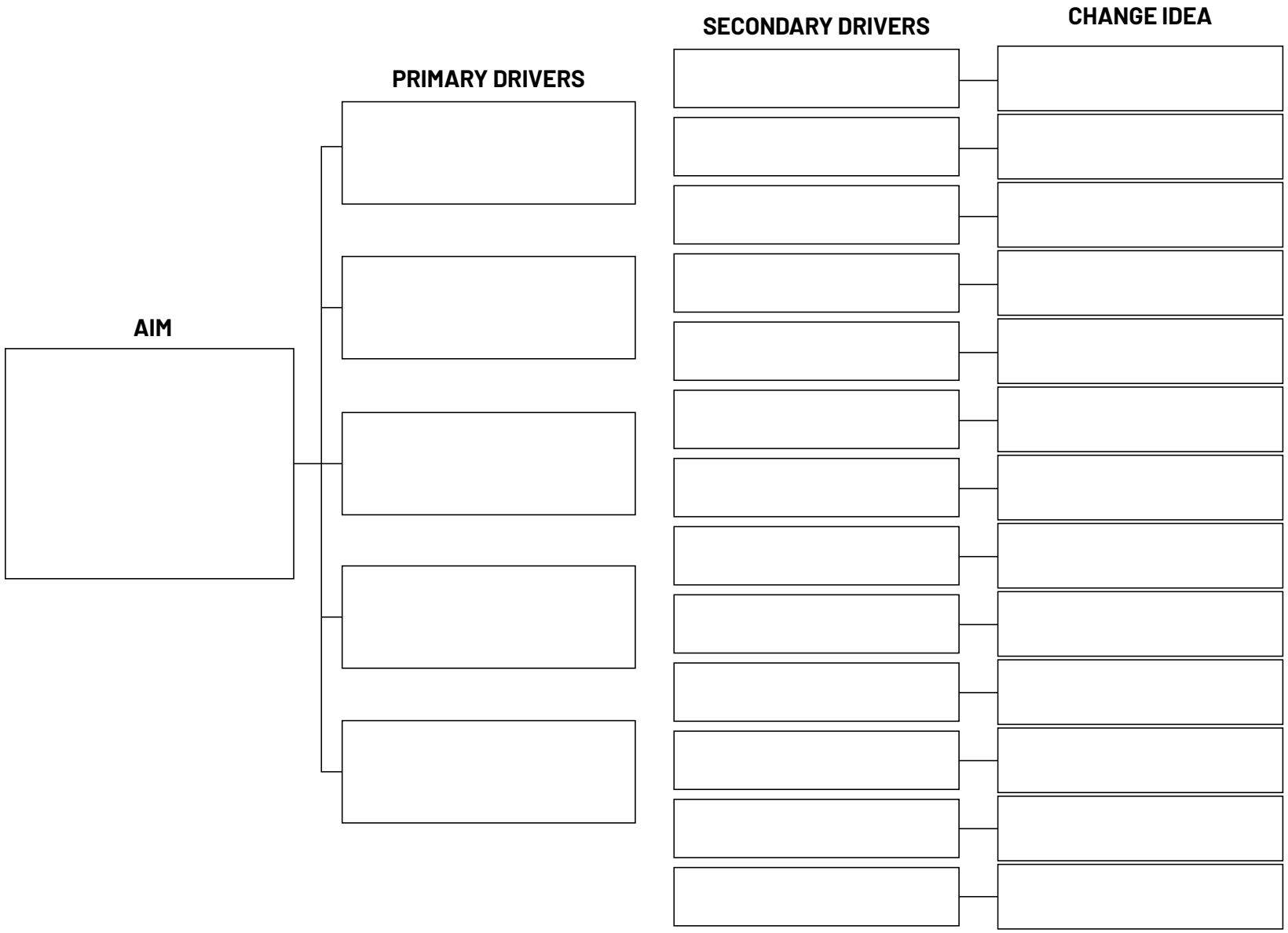
Team:	**Project**:

Driver – list the drivers you'll be working on	**Process Measure**	**Goal**
1.		
2.		
3.		
4.		
5.		
6.		

Driver Number (from above)	**Change Idea**	**Tasks to Prepare for Tests**	**PDSA**	**Person Responsible**	**Timeline (T = Test; I = Implement; S = Spread)**													
					Week													
					1	2	3	4	5	6	7	8	9	10	11	12	13	14

This form has been adapted from the Institute of Healthcare Improvement

H. Driver Diagram Template



Adapted from the Institute of Healthcare Improvement

I. Driver Diagram – Priority Alignment

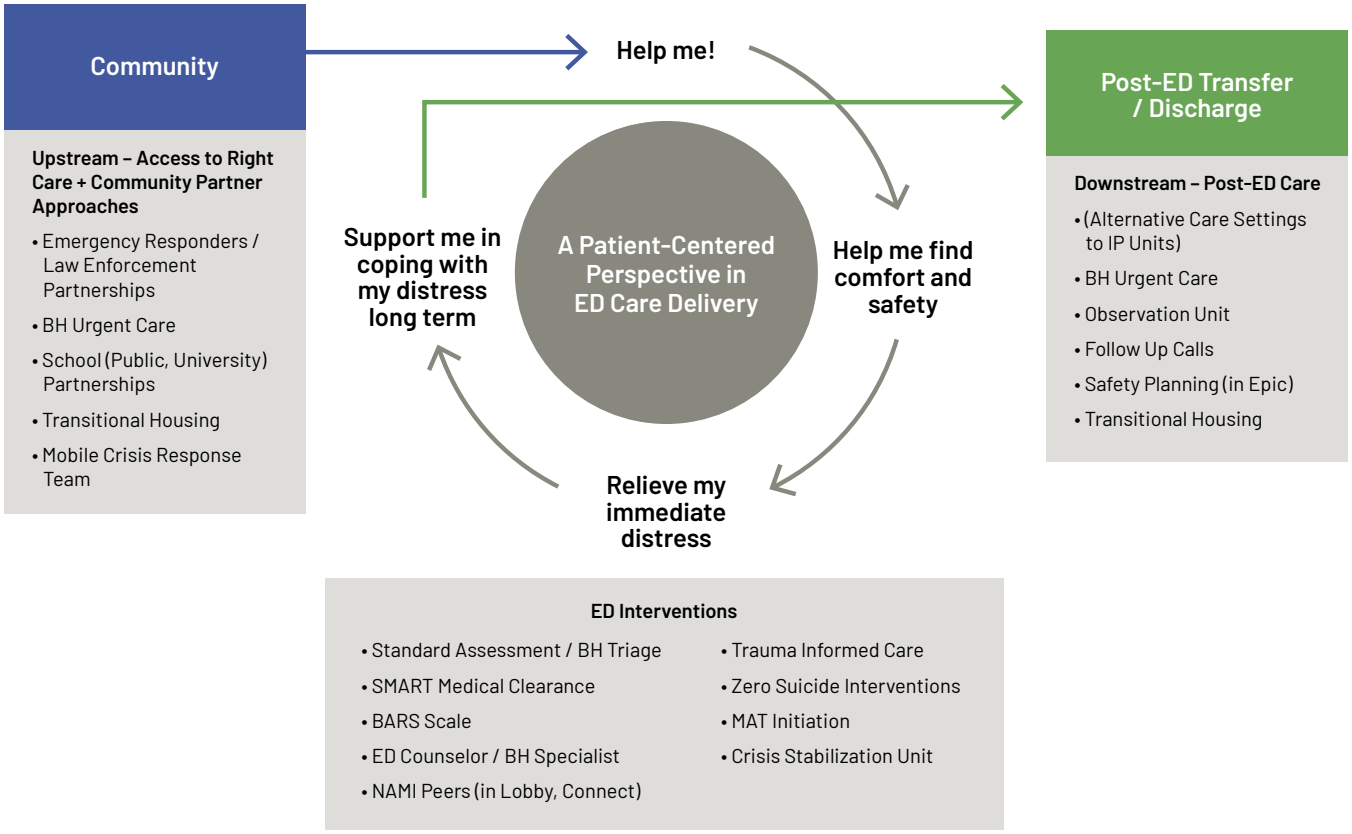
IHI PrimaryDrivers	Ministry Opportunities	Secondary Drivers
ED Processes		• Develop standardized, evidence-based approach to intake, triage and temporary symptom management in the ED • Transform the discharge process • Build mental health capacity on the ED multidisciplinary team
Provider Culture		• Educate and train ED teams about stigma, trauma-informed care principles, and best practices in caring for individuals with mental health and substance use issues • Co-design the enhanced care model with patients • Provide a therapeutic health environment • Leaders model behaviors that can drive culture change
Patients & Families		• Standardize and utilize a strengths-based and person-centered approach to understand and incorporate patient history and context into plan care
Community Partnerships		• Build partnerships to enhance coordination and communication between ED and other health care and community-based services • Streamline the referral process • Act as the anchor institution to bolster health of broader community

J. PDSA Cycle Tracker (IHI)

PDSA	Person Responsible	Timeline (T = Test; I = Implement; S = Spread)													
		Week													
		1	2	3	4	5	6	7	8	9	10	11	12	13	14
Nurse will hand materials to patient before leaving the exam room with all patients scoring high on the PHQ-9	Beth and Mark	**T**	**T**												
Have secretaries write down the date and time of the follow-up appointment on the back of the clinic's business card	Laura	**T**	**T**												

PDSA	Person Responsible	Timeline (T = Test; I = Implement; S = Spread)													
		Week													
		1	2	3	4	5	6	7	8	9	10	11	12	13	14

K. A Patient's Perspective on the ED experience



This figure has been adapted from the Institute of Healthcare Improvement

Providence | WELL BEING TRUST