Delivering High Quality Behavioral Health Care: Practices and Innovations from Leading Organizations

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This resource was created in an effort to explore the current state of the behavioral health field and to highlight practices that leading organizations have employed to provide high-quality, safe care. The field has an opportunity to collect and spread these effective practices, and an environmental scan has shown there is a need for such information to be spread at the national level. These practices have been collected from freestanding psychiatric hospitals across the United States with diverse payer mixes, patient populations, and geographies, making the practices, tools, and ideas highlighted in this resource implementable by a broad spectrum of facility types.

Designed for freestanding psychiatric hospitals and hospitals with psychiatric units, this resource will provide new ideas and implementable practices that can improve care delivery and safety for patients and workers. The practices presented in this resource have been chosen because of their potential to have a significant impact on clinical and cultural outcomes. The practices included are not exhaustive, and this resource should be used as a complement to existing field resources such as literature reviews and other evidence-based tools.
Section 2: Project Design

This project was based on a combination of data collection and interviews. The Appreciative Inquiry, called AI, methodology was used to collect qualitative data. Appreciative Inquiry is a strengths-based approach to organizational change that aims to learn about the best attributes of an organization or team.¹

The Appreciative Inquiry approach uses intentionally positive questions to create constructive dialogue and builds on past and present strengths and successes. Through one-on-one interviews and group discussions focused on sharing each hospitals’ unique strengths, multidisciplinary teams worked together to self-identify the practices, tools, and cultural and organizational attributes that contribute to the provision of high quality care.

Each hospital participated in a one-day site visit where teams comprised of both leaders and front-line workers self-led interviews and data collection to identify the strongest practices from their respective hospitals.

Five psychiatric hospitals were invited to participate in the project:
- New York State Psychiatric Institute: New York, NY
- North Dakota State Hospital: Jamestown, ND
- Pine Rest Christian Mental Health Services: Grand Rapids, MI
- Rogers Behavioral Health: Oconomowoc, WI
- Sheppard Pratt Health System: Baltimore, MD

Participating hospitals were selected based on a combination of four factors:
1. Inclusion on the U.S. News and World Report Best Hospitals for Psychiatry list. This list identifies the top psychiatric hospitals in the country based on the opinions of practicing psychiatrists.¹⁴
2. A review of outcome data obtained through the Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program.²
3. Consultation with subject matter experts in the field, including staff in the American Hospital Association’s Section for Psychiatric and Substance Abuse Services and leadership at the National Association of Behavioral Healthcare.
4. Consultation with project contacts at state hospital associations across the country. Contacts were consulted to identify the highest performing hospitals in their respective states.

112 hospital employees were interviewed across the five hospitals. A multi-disciplinary group of individuals provided insights for this resource; disciplines included administrative leadership, psychiatrists, physicians, nurses, psychologists, social workers, case managers, quality leads, environmental services staff, dieticians, safety officers, and activity therapists. Two interview protocols were used; one focused on patient and family engagement, and another focused on delivering dignified and respectful patient care (see Section 5).
The table below outlines the six effective practices areas identified for behavioral health facilities. Structured to place emphasis on effective practices within the behavioral health field, this resource includes specific change ideas and case study examples that hospitals can pull from, adapt, and implement to improve the delivery of behavioral health care, to prevent harm, and to improve patient and worker safety. This information was obtained from Appreciative Inquiry interviews at leading psychiatric hospitals, as well as from input from subject matter experts in the field.

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Leading behavioral health providers strive to prevent patient harm through consistently monitoring patient behaviors through direct observation and data collection, proactively assessing patient risk, regularly scanning the environment for safety concerns, and strategically providing individualized care and resources that empower the patient to take control of his or her own behaviors.

CHANGE IDEA 1:
Implement standardized assessments for suicide risk for all patients.

- Identify high risk patients and conduct individualized safety rounds.
  - Form a multidisciplinary team (physician, nurse, therapy aide, social worker, etc.) upon admission to assess sources of agitation, stress, and suicidal ideation and to teach coping strategies.
- Collect self-reported patient data to assess changes in suicidal ideation and to monitor symptoms. Identify the correct frequency for assessment based on the patient’s diagnosis, symptoms, and expressed behaviors.
- When available, use technological tools, like a tablet, to collect and store patient-reported data.
  - Example: Rogers Behavioral Health uses tablets to collect self-reported patient data
- For facilities with an electronic medical record system, incorporate a suicide assessment into the electronic medical record to ensure all members of the interdisciplinary team are aware of a patient’s risk for suicide.
- With guidance from clinical staff, encourage patients with a high suicide risk to self-identify a post-discharge safety plan. Consider the use of a smart phone app that would allow the patient to have his or her safety plan available at all times.
  - Example: New York State Psychiatric Institute uses the Stanley Brown Safety Planning Intervention to help high-risk patients identify personal warning signs, internal coping strategies, people and social settings that provide distraction, how to increase safety in the environment, and professionals and agencies to contact during a crisis.
Effective Practice Area: Preventing Harm

CHANGE IDEA 2: Systematically evaluate the environment of care to mitigate safety hazards.

- Search patient belongings upon intake.
- Secure furniture and evaluate patient care areas for potential ligature risks.
- Use an environmental safety checklist, such as the Mental Health Environment of Care Checklist, to ensure that the environment of care is standardized across all units.  
- Include environmental services and engineering staff in safety rounding to identify safety and ligature risks.

CHANGE IDEA 3: Provide supervised care to patients with eating disorder diagnoses to discourage harmful behaviors.

- Encourage staff to eat with patients with eating disorders to model healthy eating behaviors.
- Support healthy eating habits by eating meals in groups.
- Prevent purging behaviors in bulimic patients by escorting patients to the bathroom, doing toilet checks after the patient has toileted, and keeping track of how long a patient is using the bathroom.

CASE STUDY: Managing Acuity on an Acute Psychiatric Inpatient Unit: Using Standardized Safety Assessments and Twice Daily Safety Rounds

New York State Psychiatric Institute proactively lowers patient suicide risk by completing twice daily safety rounding and by discharging high-risk patients with a self-identified suicide prevention plan. Learn more here.
Section 3: Effective Practices in Behavioral Health

Effective Practice Area: Creating an Environment that Empowers Patients to Self-Manage Behaviors

Behavioral health hospitals can improve patient and worker safety outcomes by implementing processes that prevent and de-escalate unsafe situations and by teaching patients how to self-soothe and self-manage behaviors.

**CHANGE IDEA 1:**
Prevent seclusion and restraint by working with the patient to de-escalate a violent or unsafe situation.

- Upon admission, engage the patient in creating a de-escalation plan. Ask the patient if there are specific activities or therapies that have been successful in the past, such as music, art, or a low-stimulus environment. Once the plan has been identified with the patient, allow both staff and patients to implement these interventions when necessary.
- Create a developmentally appropriate sensory room on each unit and encourage patients to self-direct their use of the room. Fill the room with soft colors, weighed blankets, rocking chairs, music, anxiety toys, and dimmed lights to help the patient relax and to allow the patient autonomy in his or her emotional de-escalation.
- Implement a specific, hospital-wide crisis intervention model and hands-on training to ensure that all staff members are aware of the policies and procedures associated with the model.
  - *Example:* North Dakota State Hospital uses the Therapeutic Options Model, a comprehensive approach to reducing violence and the use of restraint and seclusion that is science-based, person-centered, relationship-driven, prevention-focused and trauma-informed.\(^{12}\)

**CHANGE IDEA 2:**
Prevent a violent situation from escalating further with verbal de-escalation techniques.

- Implement the Motivational Interviewing approach to help patients make positive behavioral changes to support improved health. The approach upholds four principles – expressing empathy and avoiding arguing, developing discrepancy, rolling with resistance, and supporting self-efficacy.\(^{10}\)
- Give the patient full attention through using active listening skills and techniques.
- If a violent situation does occur, gather an interdisciplinary team to debrief the incident and to formulate an individualized safety plan with the patient.
Effective Practice Area:
Creating an Environment that Empowers Patients to Self-Manage Behaviors

CHANGE IDEA 3:
Arrange units to encourage patient safety and wellness.

- Organize units by diagnosis, age group and/or gender to allow for peer-to-peer patient support and diagnosis- and age-specific environments and therapy options. Tailor therapy and interventions to address the specific medical needs of each unique patient population.
  - Examples: Child and Adolescent Eating Disorder Unit, Gender-Specific Emerging Adult Units, Co-occurring Substance Abuse and Depressive Disorder Unit
- Designate a uniformed, clinically-skilled Milieu Officer in each unit to provide a security presence and assure the safety and security of patients, staff, volunteers and visitors. This staff member leads or assists staff in responding to both routine and emergency patient safety situations and works with the patient to de-escalate aggressive behaviors. Include the Milieu Officer in in huddles and meetings as part of your interdisciplinary care team.

CASE STUDY: Milieu Officers Embedded on Inpatient Units
Sheppard Pratt Health System employs a uniformed, clinically-skilled milieu officer in their units to prevent harmful situations before they occur. Learn more here.
Effective Practice Area: Supporting Patient Transitions

Engaging the patient, his or her caregiver, and the community is vital to achieving successful treatment outcomes in behavioral health. Leading behavioral health providers place an emphasis on understanding each patient’s unique needs, engaging the patient’s chosen support system in his or her healing, and partnering with community health providers and social service organizations to ensure the patient has the support and resources necessary for post-hospitalization success.

CHANGE IDEA 1:
Engage partners to promote recovery, reduce stigma, and address social determinants of health.

- Partner with local acute care hospitals and emergency departments to educate leadership and clinical staff on how to care for a patient in need of psychiatric care. Teach providers in the community how to de-escalate a dangerous patient situation, how to appropriately medicate patients, and how to begin care.

- Provide grand rounds presentations on recovery, social stigma and social determinants of health that are open to the public and to community providers.

- Partner with schools, religious institutions, emergency personnel, and civic organizations to provide community de-stigmatization training that educates the public about mental health and wellness.
  - Example: Rogers InHealth, a program at Rogers Behavioral Health, supports community de-stigmatization and mental health education through encouraging patients to share their recovery stories with families, schools, workplaces and other community organizations.¹⁸

- Connect patients to post-discharge job opportunities by partnering with local businesses who are interested in hiring patients after hospitalization. Use therapy time to work on job skills that will prepare patients for employment. Examples of industries with successful hospital partnerships include airports, recycling companies, manufacturing plants, hotels and restaurants.
  - Example: Sheppard Pratt Health System supports patient employment through their Project SEARCH Program.¹¹

- Connect patients and families to resources in the community to encourage healing and wellness. This can include services such as the local housing authority, outpatient care, primary care providers, and situation-specific needs such as domestic violence centers, veteran services or food banks.
Effective Practice Area: Supporting Patient Transitions

CHANGE IDEA 2:
Involve the patient and the caregiver in the patient’s care.

- At admission, meet with the patient and the family or caregiver to understand who the patient’s support system is and who the patient wants to have involved in their care.

- Include the patient’s family in regularly scheduled interdisciplinary care planning meetings to help the family or caregiver understand the diagnosis, their role in the patient’s recovery and how to help the patient stay healthy.

- For families or caregivers of children or adolescents, offer a formalized education program that teaches parents or caregivers how to care for and support their children through treatment and recovery.
  - Example: Rogers Behavioral Health involves parents and caregivers in their children’s treatment through the Parent University program.5

- Facilitate diagnosis-specific family/caregiver therapy groups that provide a therapeutic and supportive environment to learn about the diagnosis and about how to support patients through their diagnoses.

- Utilize a Patient and Family Advisory Council at your hospital to ensure the family and patient perspective is included when decisions are made.
CHANCE IDEA 3:

Honor the individualized needs of each patient by offering personalized and culturally competent services.

- Use telemedicine to provide interventions for patients that need continued support and supervision after hospital discharge, but have limitations for receiving continued care. Patients benefitting from telehealth services may have issues with transportation or finding childcare, or may live far from the hospital but still want to continue their care.
  - Example: Pine Rest Christian Mental Health Services uses telehealth to offer video and phone appointments to its patients.4

- Maintain cultural competency in the delivery of care by honoring the individualized needs of patients, families and communities. Do this by offering educational content in multiple languages, acknowledging and honoring the patient's religious and cultural background, and by working with the family or caregiver to understand the patient's lifestyle and specific needs.

- Provide opportunities for peer-to-peer support through group therapy. Group therapy can be organized by age, diagnosis, and/or gender identity.

CASE STUDY: Project SEARCH: Preparing Young Adults with Disabilities for Meaningful Employment
Sheppard Pratt Health System partners with local businesses in the community to prepare young adults with disabilities for meaningful, gainful employment. Learn more here.
Effective Practice Area: Using Data to Drive Excellence in Care

As the health care field continually becomes more data-driven and outcomes-focused, behavioral health hospitals have an opportunity to use data and technology to improve hospital practices and to design effective interventions that improve patient care.

CHANGE IDEA 1:
Incorporate process and outcome data into daily clinical routines.

- Transparently share outcome data with consumers to increase provider accountability.
  - *Example:* Rogers Behavioral Health shares outcome data segmented by diagnosis and by unit to show the value of their care to potential patients and families.

- Share process and outcome data with clinical teams during interdisciplinary huddles on a regular basis. Depending on the measures being shared, this could happen daily, weekly, or monthly.

- Create multidisciplinary process improvement teams that use process and outcome data to inform suggestions for improvement on hospital procedures and practices.

- Incorporate the use of Patient Reported Outcome Measure (PROM) data into the care plan.
  - *Example:* Rogers Behavioral Health and Sheppard Pratt Health System both collect PROM data at intake, at regular intervals throughout the hospitalization, and at discharge to assess changes in self-reported patient outcomes and to inform individualized patient care plans.

- Use qualitative data collection strategies to understand the patient experience and to improve care delivery.
  - *Example:* C-Suite leadership at Sheppard Pratt Health System participate in direct observation rounding, where each member of the team shadows a patient to better understand a process or procedure and to see how hospital practices can be improved.
**Section 3: Effective Practices in Behavioral Health**

**Effective Practice Area:** Using Date to Drive Excellence in Care

**CHANGE IDEA 2:**

Leverage technology to improve care delivery and treatment outcomes.

- Collect Patient Reported Outcome Measure (PROM) data using mobile technology to improve the care of both individual patients and aggregate patient populations.
  - *Example:* Rogers Behavioral Health uses PROM data to incorporate the patient perspective into care delivery, to inform clinical decision making, and to understand the patient experience across specific diagnoses or patient populations.
- Integrate PROM data into the electronic medical record so that it becomes part of the information available to clinicians to make decisions about a patient’s care.

**CASE STUDY: Utilizing Patient Reported Outcomes Measures**

By electronically collecting patient-reported data and including it in the patient’s electronic medical record, clinicians at Rogers Behavioral Health are able to use real-time data to make decisions about a patient’s treatment plan. [Learn more here.](#)
Effective Practice Area: Promoting Workforce Safety and Wellness

Organizations that value staff wellbeing understand that investing in staff empowerment, education and development can contribute to improved patient outcomes. When staff members feel supported and safe, they are better equipped to provide care that is compassionate and innovative and are at a lower risk for burning out.

CHANGE IDEA 1: Invest in employee wellness initiatives.

- Enhance staff-staff and staff-patient interactions by training staff in the principles of Emotional Intelligence and teaching staff how to manage their emotions and the emotions of others in stressful situations.³
- Train staff to build personal resilience, to set compassionate boundaries, to understand personal limitations and to engage in self-care.
  - Example: Through the Rogers InHealth program, Rogers Behavioral Health offers Compassion Resilience Training to staff at risk for compassion fatigue.⁷
- Implement a training program that provides staff with a set of tools for addressing professional burnout.

CHANGE IDEA 2: Invest in training programs intended to keep staff safe.

- Train staff at orientation and then annually on how to diffuse violent situations and to protect themselves and patients from patient-staff and patient-patient violence. Train all staff in violence prevention tactics, regardless of role and of their direct contact with patients.
  - Example: North Dakota State Hospital supports a violence reduction training program with multiple training opportunities each year.

CHANGE IDEA 3: Create opportunities for continuing staff education.

- Offer internal and external opportunities for growth and continued education to staff through travel and conference stipends, bringing in speakers, and supporting staff committees focused on internal process improvement.

CASE STUDY: Using Therapeutic Options to Reduce Hospital Violence

North Dakota State Hospital trains all employees, regardless of role, on how to de-escalate unsafe patient situations to improve patient and worker safety. Learn more here.
Effective Practice Area: Engaging Your Board of Directors in Quality and Patient Safety Issues

Involving the hospital’s board of directors in quality and patient safety efforts is paramount to success. By regularly including the Board in discussions about quality and patient safety, leading hospitals ensure that all levels of their organizations, from the board to frontline staff, are engaged in and committed to meeting the same goals.

CHANGE IDEA 1:
Foster strategic partnerships between board members and hospital leadership to improve engagement and outcomes.

- Invite a diverse group of individuals from the community to serve on the board, including clinicians, community leaders, and patients and family members.
- Provide all new board members with an orientation from c-suite leadership.
- Support board committees that focus on specific clinical issues, such as quality and patient safety, harm reduction, or patient and family engagement. Encourage the board to lead the committees and invite clinical staff to participate on them to create buy-in.

CHANGE IDEA 2:
Share quality and patient safety data at every board meeting.

- Set clear and consistent quality and patient safety goals that are supported by the board and regularly shared with the board.
- Create a dashboard to share with board members that provides the feedback needed to hold administration and clinicians responsible for quality and patient safety goals.

CASE STUDY: Engaging the Board in Quality and Patient Safety

Pine Rest Christian Mental Health Services includes their board of directors in all of their quality and patient safety decision making. Learn more about the relationship between the board and hospital leadership here.
Each hospital featured in this resource was identified as excelling exceptionally in at least one of the effective practice areas. The following case studies are intended to provide a more detailed look into an area in which each leading organization excels so that their practices can be adapted by and spread to other behavioral health facilities.
About The Hospital

Pine Rest Christian Mental Health Services is a 198-bed, freestanding psychiatric hospital located in Grand Rapids, Michigan.

Pine Rest is composed of four distinct divisions; Hospital Based Services, Community and Residential Services, Behavioral Health Solutions, and the Professional Practice Group.

The services offered across those divisions include psychiatric inpatient, partial programming, 12 addiction treatment beds, community services and outreach, telehealth, mother & baby programs, 219 residential beds, geriatric, pastoral care, dialectical behavioral therapy and crisis intervention counseling.

Outpatient Services are provided through 21 locations in Northern & West Michigan and in Iowa offering assessment and testing, classes and support groups, counseling and therapy, developmental disabilities support, electroconvulsive therapy, and transcranial magnetic stimulation. Pine Rest also offers a variety of short term and longer term residential treatment facilities providing care and support in structured “home like” environments that are in close proximity to the main campus to preserve psychiatric support.

EFFECTIVE PRACTICE

Engaging Your Board of Directors in Quality and Patient Safety Issues
About The Hospital (continued)

Pine Rest provided 298,010 outpatient visits and had 8,451 hospital admissions in 2017.

Pine Rest is mission driven and faith-based. The main campus is over 100 years old and was originally founded on a family farm. The newly constructed Cypress Unit is the first operating ‘Psychiatric Flex’ unit, with the ability to treat adolescents and adults as needed.

Who Is Involved

Pine Rest’s full board of directors, the board chair and special sub-committees of the board are all actively involved, as are the CEO, the entire C-suite and select department directors, managers and staff.

Opportunity for Improvement

Dramatic changes in reimbursement during the 1990s (shortened lengths of stay, heavy influence of managed care) had required the board and management to be intensely focused on managing expenses and operations. The majority of the time at board meetings was spent on reviewing the financial performance of various services lines. While this financial focus of the board was perhaps critical to the survival of the organization at that time, as a consequence very little time was left to spend discussing quality indicators at the full board level. Intended or not, this focus on financial performance signaled to management that excellence of care was less important than financial success.

The organization began to stabilize financially in the early 2000s. New board and executive leaders began to re-assert the importance of the mission of the organization to change lives and provide the highest quality care possible, and recognized that the board of directors was not well equipped to lead the organization toward quality improvement. The board of director’s involvement in quality was delegated to a “Joint Conference Committee,” which consisted of a few board members, the chief medical officer, chief nurse executive, the president of the medical staff, and a quality manager. The CEO did not attend this meeting. The meeting often consisted of a review of detailed quality data points found in pages and pages of spreadsheets, focusing on minute details. These spreadsheets were then included in the packet presented at the full board, but often received no discussion at that level.

Strategy and Intervention

It became clear that if the organization was to re-emphasize quality of care, the board’s involvement would be crucial, and the board would need to have a meaningful understanding of the quality issues facing the organization. Meaningful metrics that would engage the entire board would be crucial, and a complete restructuring of the board involvement at the committee level was required.
First, management completely re-evaluated its quality data collection efforts. Over the years the amount of data points collected by the quality improvement team had grown to over 900 (no one felt empowered to stop collecting anything, so the number kept growing). As one surveyor put it “you collect a lot of data around here; it’s not clear that you do much with it.” The quality team started with a blank piece of paper, asking the question, “What data indicators are crucial to our success?”

Second, an educational board retreat was held to help all board members understand the quality demands of managing a large behavioral health organization. At that retreat, the board was asked to weigh in on what would help them understand the quality outcomes of the organization. At one critical moment a very thoughtful board member whose family had been impacted by mental illness summarized the view of the board by saying, “There is lots of regulatory information we need to understand, but when it comes right down to it, as community representatives we need to know if our patients are getting better under our care.” This simple, board-led question, “Are our patients getting better?” has become the focus of the quality program at Pine Rest.

Third, after the retreat an entirely new clinical dashboard was created that summarizes key quality metrics of the organization. This dashboard is simple and can be easily understood by the entire board, regardless of clinical expertise.

Fourth, after the retreat the tiny “Joint Conference Committee” of the board was re-structured into the “Quality and Safety Committee.” The membership expanded, adding several more board members and senior management team members (including the CEO, COO, and clinical division leaders) who were ultimately accountable for the quality of care in the organization.

At current committee meetings, there is an in-depth review of the dashboard, and staff presenters are asked to come to the meeting with patient stories that bring the numbers on the dashboard to life, illustrating what the improvements and declines of the numbers mean in terms of patient wellness. Staff are encouraged to be transparent with board members about problem areas as well as successes. Highlights of the Quality and Safety Committee are repeated in discussion at the gathering of the full board of directors.

**Impact**

The full board of directors now spends roughly the same amount of time at its meetings focusing on quality as they do on financial performance. The board now has a more broad view of what corporate success looks like, and most board members can now articulate broad quality themes of the organization.

The board’s renewed interest in quality has signaled the importance of quality outcomes to the management team. They know board members care about these metrics, so they are very focused on making the numbers move in a positive direction. Improved board accountability has moved the quality culture at Pine Rest from a data reporting culture to one of continuous improvement. This shift has directly improved patient care, and has resulted in much smoother regulatory surveys with fewer findings over the past few cycles.
Lessons Learned

It is critical to keep the board operating at a strategic level. It is tempting and easy for the board to get into the weeds and for them to become problem solvers for operations. That is not the point of the board, nor is it the most impactful course towards achieving your mission or goals. To keep the board operating at this level, Pine Rest team offers three pieces of advice:

1. The metrics that the board reviews needs to be reflective of the organization’s strategic vision and mission. This doesn’t mean only good data goes on the dashboard; the metrics that will show if we are headed in the right direction or veering from course.

2. Transparency is key to trust. Don’t be afraid to share bad news with the board, but be prepared. Have a plan to address and fix the problem, but don’t wait to fully resolve the issue before reporting.

3. Make board meetings interesting. Telling a compelling story about a success or why this business plan furthers the mission of the organization. This does a better job of engaging members than a spreadsheet or presentation. It has the potential to be even better when it can be delivered by a staff member intimately involved in the story.

Sustainability

To ensure board engagement and understanding are sustained, management offers regular “refresher courses” designed especially for new board members to help them understand the quality improvement process and quality metrics; these trainings have been well received by the board.

By implementing a new board structure of enhanced metrics, a meaningful committee, and regular reports to the full board, the desired gains have been sustained. Our quality metrics and dashboard are constantly being revised to make them more accessible to board members, and process improvements are implemented when needed ensure continual improvement.
About The Hospital

The North Dakota State Hospital (NDSH) is a freestanding psychiatric rehabilitation center located in Jamestown, ND, a community of 15,440 (2016). The hospital serves clients at both and inpatient level of care and a residential level of care. With 108 inpatient beds, it serves clients with acute and/or persistent mental illness, and also those with substance use disorders. There are 15 transitional living beds, 45 beds for civilly committed sexual offenders, and 106 Department of Corrections contracted beds for those with substance use disorders.

NDSH is part of the North Dakota Department of Human Services and in 2017 had 1423 admissions across all programs.

Who Was Involved

NDSH has improved its ability to manage violence risk over the past three years utilizing a new violence reduction strategy known as Therapeutic Options. The program utilizes a bottom-up approach and many levels of staff have become trainers in the system including CNAs, LACs, and nurses. All NDSH staff are trained in Therapeutic Options and receive an initial two-day training and a subsequent half day training annually.

EFFECTIVE PRACTICE

Promoting Workforce Safety and Wellness
Opportunity for Improvement

Therapeutic Options was started in 2015, due to a need to improve the treatment of clients that are at high risk for violence. The use of seclusion and restraint was deemed too high.

Strategy and Intervention

The team at NDSH placed a stronger emphasis on violence reduction and researched several programs and approaches. The Director of Inpatient Services presented Therapeutic Options to the Executive Counsel and it became the agreed upon approach as the system heavily emphasizes violence prevention.

According to their website, Therapeutic Options is “a comprehensive approach to reducing violence and the use of restraint and seclusion in behavioral health care, health care, habilitation, and education settings” (Therapeutic Options, Inc., 2018). This intervention is science-based, person-centered, relationship-driven, prevention-focused, and trauma-informed.

The Impact

When comparing seclusion and restraint statistics between 2014 and 2017, there was an 85% reduction in seclusion and restraint hours. Additionally, both patient and staff harm events have been prevented, given that injuries often occur during the process of utilizing seclusion and restraint.

Recent data shows that there was an 11% decrease in trauma-related incidents when comparing Quarter Four, 2017 to Quarter One, 2018. These improved violence reduction strategies, backed by indisputable data, have obvious benefits for clients, staff, the community and the hospital.

Lessons Learned

The team experienced challenges when attempting to improve the culture. Staff at all levels at times show a tendency to apply old ways of doing things and there was some resistance to the new system. For this reason, NDSH suggests finding a violence reduction strategy that involves all levels of staff heavily during the implementation and training phases.

Sustainability

Data shows that NDSH has utilized less seclusion and restraint successively each year since 2014, and the team has recently opened a new unit that focuses on individualized behavior modification, low stimuli and more 1:1 time. Staff from the community mental health center have also been trained in the Therapeutic Options model.
About The Hospital

The New York State Psychiatric Institute (NYSPI) is the nation’s oldest psychiatric research institution and has been a leader in advancing the understanding of mental illness since its founding. NYSPI is located on the campus of Columbia University Medical Center in the Washington Heights section of Upper Manhattan. The Institute is designed to support a range of specialized psychiatric research activities for children, adolescents, and adults through inpatient units and outpatient services. Because of the specificity of the clinical research, all patients are screened for admission based upon the protocols currently under study and can draw from communities across the country.

The Washington Heights Community Service program at NYSPI provides psychiatric services to individuals with serious mental illness in the Inwood and Audubon communities of Manhattan through admission of patients to an acute inpatient unit and to two off-site patient adult clinics and one continuing day treatment program.


Case Study

EFFECTIVE PRACTICE

Preventing Harm
About The Hospital (continued)

NYSPI is a freestanding psychiatric teaching hospital that is part of a multi-hospital system under the direction of the New York State Office of Mental Health. The State has charged NYSPI with the responsibility for conducting research that will ultimately improve the mental health of its citizens. Most scientists at NYSPI are also faculty members of the Department of Psychiatry of Columbia University. This affiliation enables them to conduct their research in close contact with other scientists in a broadly based academic medical center setting. NYSPI enters agreements with New York Presbyterian Hospital, the College of Physicians and Surgeons of Columbia University, and other agencies to provide comprehensive services to its patients.

Who Was Involved

All clinical disciplines participate in risk assessments for all inpatients. Unit psychiatrists complete the Suicide Safer Care Protocol Assessment form on admission and discharge that describes past and present suicide behaviors and ideation. Mitigation of risk begins with a thorough assessment that encompasses all factors that contribute to suicide risk, followed by an informed clinical judgement about patient risk level (low, medium or high), formulation of a safety plan that includes an appropriate level of observation, treatment of the underlying psychiatric symptoms, mitigation of stressors and placing the patient in the environment that is safe and conducive to healing. Risk assessments are discussed daily during morning report, and individuals identified as high-risk participate in twice daily safety rounds. Rounds include the unit chief (psychiatry), team attending (psychiatry), social worker, charge nurse, mental health therapy aid, and clinical trainees assigned to the case (e.g., psychiatric resident).

On discharge, all patients work with the treatment team to develop the Suicide Safer Care Plan which is given to them at discharge. The plan includes patient-generated list of coping strategies to use, and people and organizations to call in the event of suicidal ideation.

Opportunity for Improvement

Inpatient units at NYSPI manage high acuity patients with psychiatric illnesses. A review of several events involving patient self-harm, agitation or aggressive behavior identified that these commonly happened during the late afternoon or evening hours, many hours after the unit completed its morning clinical discussions. The timing of these incidents also raised the question about whether change-of-shift for unit personnel may represent a time of enhanced vulnerability for patients. We hypothesized the change in unit personnel was particularly difficult for some psychiatric patients and recognized that the oncoming evening staff were at a therapeutic disadvantage since their schedule did not allow them to participate in morning’s multi-disciplinary clinical discussions. The clinical team decided to pilot, and then implement, a system that would include twice daily proactive multi-disciplinary “mini-team” discussions on all high-risk patients. The second of these would occur around the change-of-shift time to bring day and evening staff together into a short multi-disciplinary meeting with the patient. Additionally, these meetings would include review of patient’s thoughts of violence or suicide, observed behaviors, including agitation...
since last assessment, and review of medications used for agitation during the period prior to the safety rounds, effective coping strategies and interventions that had positive outcomes for the patient, and level of observation needed to ensure the patient’s safety. A short form that summarizes the meeting is included in the patient’s record.

**Strategy and Intervention**

The new procedure required identification of risk levels in the discussion at morning report. Once identified, every high-risk patient is asked to attend two brief “safety rounds” meetings each day, one of which follows morning report and one that takes place around the change of shift time. To ensure more consistency in the completion of the suicide safer assessments, staff were trained in the use of the Columbia-Suicide Severity Rating Scale (C-SSRS, the basis for the Suicide Safer Protocol), individual and static risk factors, diagnoses, and proximal symptoms that increase the risk of suicide. Training also included our environmental risk assessment and efforts, where possible, to reduce any suicide risks in the environment. Treatment planning includes creating behavioral goals around any identified suicidal ideation or behaviors, and the completion of a plan that addresses all risks that can be mitigated.

**The Impact**

The interventions are relatively new, but the initial results are positive. As a small hospital (total 55 beds) with an exceedingly small number of patient incidents, this report focused on the efforts surrounding suicidal risk. A parallel process for assessing risk for aggressive behaviors and proactive treatment interventions was implemented after a string of incidents involving psychiatric agitation and aggression last summer. Since implementing this new process there have been fewer incidents of self-harm or harm to others.

The new initiative has benefitted staff morale, as staff regularly report feeling better that the system is more proactive by engaging high-risk patients in risk reduction planning before problematic behaviors develops. Evening staff are particularly satisfied with being exposed to multi-disciplinary team discussion, rather than only receiving the discipline-specific “change-of-shift” reports. Patients are benefitting from this intervention if it is indeed diminishing the numbers of adverse incidents, but further collection of data is necessary to demonstrate that the intervention is truly impacting numbers of events.

**Lessons Learned**

Any new initiative is met with some reluctance to change. Staff may believe that a change indicates criticism of previous practices, or believes that a new procedure “won’t make any difference.” The clinical team was motivated to try some new procedures last summer after a string of patient incidents, and this helped convince staff to “give a try” to a new way to promote safety. Staff learned quickly how much better it felt to be included in frequent structured meetings with high risk patients. Examining data from the current year causes the team to be hopeful that they have in fact had an impact on frequency of clinical incidents.

Ongoing training and reinforcement of important elements of the process are critical. Post hoc discussion of all events (as proximal to the event as possible) are very helpful in reviewing these elements.
Sustainability

NYSPI is sustaining success by ensuring completion of risk assessments and discussion of results in morning report and the daily unit reports. Ongoing training and review of each incident, and aggregate results of all incidents, remind staff of important elements of this process.

The C-SSRS form for suicide risk assessment and safety rounds form to assist other hospitals in implementing this initiative is included.

SUPPORTING RESOURCES

1. Suicide Safer Care Protocol
2. Patient Safety Plan Template
3. Safety Rounds

Our Team
About The Hospital

Sheppard Pratt Health System is a non-profit, freestanding acute psychiatric hospital located in Towson, MD with 322 beds at the Towson location and 92 beds in the Howard County facility. The hospitals are part of Sheppard Pratt Health System, which is comprised of a large, statewide behavioral health continuum of wholly owned services that provides all levels of behavioral health (inpatient, outpatient, day hospital, residential, psychiatric rehab, residency training, special education and supportive employment.

Fiscal Year 2017 had nearly 12,000 admissions to the inpatient day hospital and intensive outpatient programs had more than 46,000 outpatient visits.

Sheppard Pratt was founded in 1853 as the Sheppard Asylum as a result of the substantial bequest of Baltimore Quaker Moses Sheppard, who admonished the institution to use only the interest and never the corpus of his gift for the construction and operation of the facility. The hospital continues to operate and transact business in accordance with Quaker principles.

Case Study

Milieu Officers Embedded on Inpatient Units at Sheppard Pratt Health System

EFFECTIVE PRACTICE

Creating an Environment That Empowers Patients to Self-Manage Behaviors
Who Was Involved

The milieu officer position was first created on the Towson campus of Sheppard Pratt Health System. A multidisciplinary team, which included administration, nursing, physicians, mental health workers, and social workers, met to discuss possible solutions to mitigating the increasingly violent behaviors of patients on inpatient units. A smaller subset group visited a local hospital in Maryland to review their security model and process to manage aggressive and violent behaviors within the hospital.

Opportunity for Improvement

The decision to embed milieu officers into some of the inpatient units on the Sheppard Pratt Towson campus occurred after a noticeable increase in violence on units that treat adults with thought disorder illnesses, such as schizophrenia.

There was an increase in patient to patient and patient to staff violence, resulting in injuries to both staff and patients. A severe injury on the unit demonstrated the need to think outside of the box in an effort to reduce violence and injury incidents in the treatment milieu.

Strategy and Intervention

A small Sheppard Pratt team visited another local hospital in Maryland to see what security measures and models they had in place to combat aggressive behavior and violence in the hospital. After visiting, the group discussed the pros and cons of this particular model, which was primarily focused on security. From this discussion, the group realized they wanted a solution that fit the health system and not purely be part of overall hospital security, but instead have this position be part of the unit based team, have clinical skills, and know how to de-escalate patients.

Staff meetings were held to discuss what had been happening on the units, as well as to share ideas and feedback on possible solutions. This led to the development of the model that is currently in use with a “milieu officer.” The milieu officer is dressed to resemble a security officer, and although they have special training in de-escalation techniques, they are not sworn officers.

It was important to educate clinical staff early on in this process about the purpose and roles and responsibilities of this position. Originally, staff wanted this position to have more clinical duties, but it was conceptualized that this person would be the eyes and ears of the unit to ensure the safety and security of everyone as part of a patient’s treatment. Additionally, there needed to be an understanding and agreement with the security team to differentiate roles and responsibilities. Security intervenes when the matter is not clinical or behavioral and has escalated.

The milieu officer was introduced five years ago to the Psychotic Disorders unit, which treats many individuals with chronic and persistent illnesses. Within the last two years, it has expanded to other units, including the unit that treats individuals with co-occurring mental illness and substance use disorder and the adolescent male unit. It has also expanded to the hospital in Howard County, which now has milieu officers in rotation throughout the hospital.
Patients who arrive on the unit are told who the milieu officer is and the purpose of the role is explained. When someone is admitted and identified as a patient with aggressive behavior, a meeting with the patient/their family, treatment team, and milieu officer occurs to discuss this behavior and how they can work together for the treatment of the patient and safety and security of everyone on the unit.

There has been additional clinical staff training for the prevention of aggressive behaviors on units since the adoption of this model, which included a shift from 1:1 monitoring to a unit-wide “zone observation” staffing model. All unit staff are now trained in the management of aggressive patients and all can provide support to one another when necessary.

Currently there is a milieu officer for each shift (day and night), 7 days a week, for the units where they are utilized.

**The Impact**

There was an initial concern about how patients would respond to having a milieu officer on the unit. However, patients responded well and they, as well as staff, reported feeling safer and more secure.

Following the severe injury on the unit that prompted the outside-the-box thinking, staff injuries due to violence were monitored. Between August 2014 and October 2015, the number of assaults on staff members resulting in even minor injury was reduced by 50% from 1.6 to 0.8 per month. This was a result of a number of new processes and procedures implemented, including the addition of the milieu officer. There was also a decrease in workers compensation claims.

**Lessons Learned**

Having unarmed security personnel who are specially trained in verbal de-escalation techniques can be helpful on units providing care to psychotic patients. These officers can anticipate and prevent violence and can reduce the risk of incidents.

When hiring for this role, we learned that just because a candidate had prior security experience, it did not necessarily make them a good fit for the milieu officer role. Potential candidates needed to have clinical skills in order to partner with clinical staff and to be part of the care team. We also quickly realized the importance of thoughtfully introducing a new role into the organization and educating others about its purpose. The need to differentiate and define the milieu officer role to distinguish it from security became clear, as security officers do not have the same clinical responsibilities as the milieu officers on the unit. It was important to make sure that staff, patients and families all understood the difference between the two roles.
Sustainability

It is important to continue to provide milieu officers with ongoing education. This includes clinical training to keep their skills sharp and honed to encourage the best outcomes. Sheppard Pratt also plans to provide ongoing education to staff about the role and to educate patients and their families on the role and its importance on the unit.

Since the implementation of this role, there has been a shift in our patient population. More patients with a history of violence and aggressive behavior are being admitted, and the team recognizes that as the population changes, there may also be a need to expand the milieu officer role to more units or to increase the number of milieu officers per unit.

As a health system, we recognize that having milieu officers on staff who are specially trained in verbal de-escalation techniques can be extremely helpful in our units in preventing violence and reducing the risk of incidents.
About The Hospital

Sheppard Pratt Health System is a non-profit, freestanding acute psychiatric hospital located in Towson, MD with 322 beds at the Towson location and 92 beds in the Howard County facility. The hospitals are part of Sheppard Pratt Health System, which is comprised of a large, statewide behavioral health continuum of wholly owned services that provides all levels of behavioral health (inpatient, outpatient, day hospital, residential, psychiatric rehab, residency training, special education and supportive employment.

Fiscal Year 2017 had nearly 12,000 admissions to the inpatient day hospital and intensive outpatient programs had more than 46,000 outpatient visits.

Sheppard Pratt was founded in 1853 as the Sheppard Asylum as a result of the substantial bequest of Baltimore Quaker Moses Sheppard, who admonished the institution to use only the interest and never the corpus of his gift for the construction and operation of the facility. The hospital continues to operate and transact business in accordance with Quaker principles.

Project SEARCH at Sheppard Pratt Health System

Case Study

Supporting Patient Transitions
Who Was Involved

Project SEARCH Transition-to-Work Program is a unique, business-led, one-year employment preparation program that takes place entirely at the workplace. Started at Cincinnati Children’s Hospital in 1996, it has grown to over 450 sites and continues to expand. Sheppard Pratt has operated the program since 2012. Project SEARCH’s primary objective is to secure competitive employment for people with disabilities. The program combines classroom instruction, career exploration and relevant training at the host business for students with disabilities during their last year of entitlement with the school system. The program is based on true collaboration amongst partner agencies.

Sheppard Pratt Health System partners with two worksites, a busy local hotel and a large community hospital, to employ students from local school systems, public rehabilitation agencies, and other various agencies working with individuals with intellectual disabilities. Current personnel include a program coordinator, two instructors, and two vocational program assistants, all provided by Sheppard Pratt, and two skills trainers from a contracted partner.

Opportunity for Improvement

The Project SEARCH model has an excellent and well documented record of getting young adults with disabilities meaningful, competitive employment. As of 2013, the national employment rate of adults with intellectual disabilities was approximately 22%, which is significantly below the same statistic for adults without intellectual disabilities. (Journal of Vocational Rehabilitation, 2013).

Project SEARCH aligns with Sheppard Pratt’s mission: to improve the quality of life of individuals and families by compassionately serving their mental health, addiction, special education, and community support needs.

Strategy and Intervention

A staff member from one of Sheppard Pratt’s therapeutic high schools for students with emotional disabilities and autism reached out the founder of Project SEARCH, which resulted in Sheppard Pratt becoming a contracted site in 2012. Program staff from the Cincinnati program trained Sheppard Pratt staff Project SEARCH’s methodologies and interventions, and the team identified a partner school system and two partner work sites (a hotel and a hospital) to participate.

Since then, Sheppard Pratt has had 95 student interns participate in the program. Funding to support staff in the program is roughly $20,000 per student, which comes from the enrolling school system or from a social service agency.

The Impact

Employment rates of the hospital based interns have been above 70% every year since 2013. For the 2017-18 school year, 100% of interns were employed by graduation. The employment rates at the hotel are also well above the national rate of 22%. During the 2017-18 school year, the hotel program had 83% of interns employed by graduation. The successful results of this program do not just benefit the interns; their families are positively
impacted as well, as Project SEARCH has given families and caregivers the opportunity to see their children contribute to society in a way that may have not been possible before.

The Project SEARCH program also benefits the host businesses. Host businesses are models of diversity and inclusion in the workplace, which can enhance their reputation in the community. Host businesses have reported an increase in workplace morale, as their employees have seen value in the opportunity to work alongside differently-abled workers like the Project SEARCH interns. Several interns have been hired permanently by their host business, lowering the turnover rate for entry-level positions.

**Lessons Learned**

There weren’t any significant barriers for implementation, as all partners were excited to be bringing Project SEARCH to the impacted county. The Project SEARCH leadership team, based in Cincinnati, supports the whole process from the start to the implementation of the intervention at the host businesses. They offer ongoing educational opportunities at their annual conference, which provides all partner members a chance to network and share best practices in special education, particularly in areas of vocational and transition skills.

**Sustainability**

All partners work together to interview and assess potential interns for upcoming cohorts. Sheppard Pratt works together with families so that all parties are aware of program expectations and that families are informed and engaged throughout the process. Employment planning meetings are hosted four times a year to discuss interns’ progress and their plans for future employment. Sheppard Pratt advertises and provides workshops for families who might be interested in the program for their child years before they are eligible to participate. Program Coordinators provide training and support for the staff at each site to ensure quality classroom instruction and well-developed, challenging internships for the interns. Even if an intern is not employed by graduation, the growth and development of Project SEARCH interns is significant and notable.

Moving forward, Sheppard Pratt looks to continue with exceptional employment rates for the interns. Sheppard Pratt is also committed to forming a Business Advisory Council in partnership with community and contracted agencies.
About The Hospital

Located in Oconomowoc, Wisconsin, Rogers Behavioral Health provides comprehensive mental health and addiction services by providing a wide range of inpatient hospital, residential and specialized outpatient treatment options. As the parent organization for Rogers Memorial Hospital, Rogers Behavioral Health Outpatient Centers, Rogers Memorial Hospital Foundation, and Rogers InHealth, Rogers Behavioral Health services patients with a wide range of diagnoses including addiction (alcohol, opioid and substance abuse), eating disorders, depression and other mood disorders, obsessive-compulsive disorders and related anxiety disorders, and posttraumatic stress disorder.

As the largest provider of behavioral health services in Wisconsin, Rogers Behavioral Health has 222 inpatient beds at three hospital campuses across the state, offering residential, partial hospitalization, and intensive outpatient programs. Additionally, Rogers Behavioral Health operates specialty outpatient clinics in Wisconsin, Florida, Illinois, Minnesota, Pennsylvania, and Tennessee. In the last year, Rogers admitted more than 20,000 adult, teen, and child patients across its continuum of care.

EFFECTIVE PRACTICE

Using Data to Drive Excellence in Care
Who Is Involved

The team includes the chief clinical officer Dr. Brad Riemann, executive director for continuous improvement Brian Kay, chief medical officer Dr. Jerry Halverson and the Manager of Clinical Effectiveness, Jessica Cook.

Opportunity for Improvement

Measurement based care provides more robust outcomes for behavioral health patients. The ability for patients to describe their symptoms utilizing validated instruments allows clinicians to create better treatment recommendations. Rogers sought to implement a method to systematically collect patient-reported outcome measures and integrate the findings back into the patient’s care.

Strategy and Intervention

For more than 20 years, Rogers has been working to understand treatment effectiveness in the most scientifically reliable way. Having refined the approach over time, Rogers conducts outcomes studies each year by analyzing approximately 600,000 assessments that patients take when they start treatment, at various points along the way, at discharge, and for many programs – 12 months post-discharge. These self-reported answers to the valid voluntary questionnaires allows the Rogers team to see improvement in quality of life, depressive symptoms, obsessions and compulsions, and other indications of the patient’s mental health. By developing an electronic data capture system, as well as integrating patient-reported outcome information into the medical record they are able to drive patient care utilizing these measures.

The Impact

Rogers is on track to collect over 600,000 patient reported outcome measures this year. The mass amount of data has allowed the team to monitor treatment interventions, aid in program improvements, as well as reduce harmful incidents through advanced analysis.

Through this work they have also contributed to a larger scientific base. Annually, Rogers publishes 20-30 peer-reviewed publications.

This work gives caregivers the ability to provide high quality, individualized treatment for patients. The ability to utilize the assessments has allowed clinicians to create patient treatment plans based on these measures and to more strategically monitor a patient’s progress.
Lessons Learned

Many of the barriers that were encountered revolved around change management. Clinicians initially viewed these measures as either solely research or as a tool for performance to be evaluated. Through the work of the chief clinical officer and chief medical officer, training was provided on how these measures could be utilized within practice. They were also deliberate in utilizing any program analysis for only improvement, rather than for punitive reasons. These efforts were paired with the continuous improvement program to better integrate program improvements any marry them with clinical improvements.

Semantics is a critical piece in implementing a larger patient reported outcome measurement system. The ability to drive the importance of measurement to the clinician and defined ways to integrate it back to their treatment is critical.

Sustainability

Rogers has done work in creating a culture of outcomes across the organization, by allowing staff to understand the importance of these measures and how to utilize the measures in care.

Patient reported outcome data collection has been spread to all programs within the system including inpatient hospitalization. Within the inpatient setting, individual questions on assessments are being used to drive particular treatment plan interventions. This has allowed high quality treatment plans that are based on our patients’ self-reported symptoms.

Rogers is continually investing in this space to provide more advanced analytics from this data and are utilizing the data to predict treatment response, as well as to determine who may be at risk of suicide, or leaving prematurely. These algorithms internally are being integrated into the electronic health record to be utilized in real time.

Our Team

Bradley C. Reimann, PhD  
Chief Clinical Officer

Jerry L. Halverson, MD, DFAPA  
Chief Medical Officer

Brian Kay, MS, Executive Director,  
Continuous Improvement
PSYCHIATRIC HOSPITAL APPRECIATIVE INQUIRY PROTOCOL 1: PROVIDING DIGNIFIED AND RESPECTFUL PATIENT CARE

In partnership with the Centers for Medicare and Medicaid (CMS), the American Hospital Association has been tasked with identifying high performing hospitals across the country to learn more about the clinical practices, cultural norms and tools they use to provide high quality, safe care to their patients. Your hospital has been identified as one of these high performers. We are using a qualitative data collection approach called Appreciative Inquiry to collect stories from hospital employees that showcase the great practices that occur every day at these hospitals. This interview will take 20 minutes. At the end of your interview, please return this protocol to your hospital’s project lead or a member of the AHA team.

Title/Position of Interviewee (Do Not Include Person’s Name): ________________________________

[Before asking Question 1, read the below statement to your interviewee.]
An important feature of hospital improvement is to establish dignified and respectful care to enhance treatment and meaningful outcomes for patients, families, and communities.

Question 1
As you think back over your time working here helping our patients, tell me about a time in which a patient care experience convinced you of the power of compassion. Recall and tell me a story about one of those special moments in which you were involved, and a patient benefitted from your actions.

Probe for Details
Give the person you are interviewing a few moments to think. Once they begin their story, wait to hear the big picture. Then try to get details, definitions of projects or information on programs unique to your hospital or their role.

To help them share specifics try some follow-up questions:
- What do you mean by __________?
- Was that the first time __________ happened?
- What gave you that idea?
- How exactly did you do that?
- What happened in that moment that was better than usual?
- Did that change what you did in the future? How?
Section 5: Appreciative Inquiry Protocols

**Question 2**
Without being humble, what do you value about yourself in that story?

**Honor the Effort**
Once the question has been answered, encourage the person you are interviewing to tell you a little more.
Ask what about this time made them feel they were doing their best, making an extra effort, or showing that they cared in a special way.

**Question 3**
Tell me about how your personal values contributed to your actions.

**Uncover the Heart**
As the person you are interviewing provides this insight, take note of the ideals or personal principles that they brought to life in that story.
Find out what in this person’s work ethic or personal beliefs made them confident that this was the right thing to do.
Question 4
Who was involved in any capacity that allowed you to do something that special?

Find the Levers
As the question is answered, listen for why this person was able to do the extraordinary.
Ask about the people, procedures, alternatives, extra resources, materials or technologies that made doing more, acting easily, or going the extra mile a possibility at that time.

Question 5
Imagine that your hospital is helping people like you to make moments like these happen each day. What would you need to make that happen? What three wishes do you have?

1.

2.

3.
PSYCHIATRIC HOSPITAL APPRECIATIVE INQUIRY PROTOCOL 2: ENGAGING PATIENTS, FAMILIES AND COMMUNITIES IN CARE DELIVERY

In partnership with the Centers for Medicare and Medicaid (CMS), the American Hospital Association has been tasked with identifying high performing hospitals across the country to learn more about the clinical practices, cultural norms and tools they use to provide high quality, safe care to their patients. Your hospital has been identified as one of these high performers. We are using a qualitative data collection approach called Appreciative Inquiry to collect stories from hospital employees that showcase the great practices that occur every day at these hospitals. This interview will take 20 minutes. At the end of your interview, please return this protocol to your hospital’s project lead or a member of the AHA team.

Title/Position of Interviewee (Do Not Include Person’s Name): __________________________

[Before asking Question 1, read the below statement to your interviewee.]

Keeping the individualized needs of patients, their families and their communities at the forefront of treatment is the ideal approach to providing high quality psychiatric health care. Our ability to deliver that care in a setting that honors the patient and works towards positive outcomes makes a difference in the ultimate health of the patient.

Question 1

Think about a time when you were involved in supporting a patient in an extraordinary way that took into account their uniqueness as a person, their family, and their community in such a manner that their care reached positive outcomes more readily. Tell me the story of what was happening in that particular moment. What did you do? What did you honor that benefitted the patient’s care?

Probe for Details

Give the person you are interviewing a few moments to think. Once they begin their story, wait to hear the big picture. Then try to get details, definitions of projects or information on programs unique to your hospital or their role.

To help them share specifics try some follow-up questions:

▶ What do you mean by __________? __________________________
▶ Was that the first time ___________ happened? __________________________
▶ What gave you that idea? __________________________
▶ How exactly did you do that? __________________________
▶ What happened in that moment that was better than usual? __________________________
▶ Did that change what you did in the future? How? __________________________
Section 5: Appreciative Inquiry Protocols

Question 2
Without being humble, what did you do in that story that you are proud of?

Honor the Effort
Once the question has been answered, encourage the person you are interviewing to tell you a little more.
Ask what about this time made them feel they were doing their best, making an extra effort, or showing that they cared in a special way.

Question 3
What made it possible for you to help that patient in such an extraordinary way that was part of your hospital’s leadership, people or resources?

Find the Levers
As the question is answered, listen for why this person was able to do the extraordinary.
Ask about the people, procedures, alternatives, extra resources, materials or technologies that made doing more, acting easily, or going the extra mile a possibility at that time.
Section 5: Appreciative Inquiry Protocols

Question 4
Tell me about how your values inspired what you did in that story.

*Uncover the Heart*
As the person you are interviewing provides this insight, take note of the ideals or personal principles that they brought to life in that story.

Find out what in this person’s work ethic or personal beliefs made them confident that this was the right thing to do.

Question 5
Imagine that your hospital was helping people like you to make moments like these happen each day. What three wishes do you have for the kinds of support you need to allow you to do that?

1.

2.

3.
Section 6: Bibliography


