Implementing Change to Decrease the Emergency Department Visits for Pediatric Clients Referred to Mental Health Services

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Prospectus Elements 1-10: Implementing Change to Decrease the Emergency Department visits for Pediatric Clients referred to Mental Health

Diane Sandoval

University of San Francisco

N653 CNL Internship

Professor T. Gallo
Prospectus Elements 1-10: Implementing Change to Decrease the Emergency Department visits for Pediatric Patient referred to Mental Health

Clinical Leadership Theme

The clinical nurse leader (CNL) “assumes accountability for patient-care outcomes through the assimilation and application of evidence-based information to design, implement, and evaluate patient-care processes and models of care delivery” (AACN, 2013). The American Association of Colleges of Nurses (2013) states the “CNL is a provider and manager of care at the point of care to individuals and cohorts of patients anywhere healthcare is delivered” (p. 4). The clinical leadership theme for this project is “care environment manager” (AACN, 2013). There are various functions under this theme: team manager, information manager, and systems analyst/risk anticipator.

The global aim statement is that we aim to improve the telephone triage of pediatric clients referred to mental health services to decrease emergency department (ED) visits or psychiatric emergency services (PES) visit rates for pediatric clients receiving mental health services through the ambulatory clinic. The process is initiated by the evaluation of the microsystem to determine the rate of ED visits or PES visits of pediatric clients who are being referred to mental health services. The implementation of an intervention to decrease the rate of ED visits or PES visits of pediatric clients who are being referred to mental health services is the conclusion of the process. The triaging of pediatric clients will lead to improved safety and quality of care provided. Another benefit is the improvement of patient satisfaction rates. The implementation of this improvement idea is essential as it will improve patient satisfaction and can prevent sentinel events in the cohort of pediatric clients receiving mental health services.
The nursing role is constantly evolving which requires organizations as well as health care delivery as a whole to evolve, just as the role of the CNL is evolving. Doody and Doody (2012) explain how the transformational leadership model and its application to nursing involves four components: idealized influence, inspirational motivation, intellectual stimulation, and individual consideration (p.1). This type of leadership is fueled by “higher ideas and moral values” the followers are persuaded to adopt and adhere to these ideas and “sustain the greater good rather than their own interests” (Doody & Doody, 2012, p.1).

**Statement of the Problem**

The problem identified in the microsystem of the ambulatory pediatric clinic is that clients or clients’ parents who reach out to the ambulatory pediatric clinic for mental health services are resorting to going to the emergency department for mental health concerns instead of the ambulatory pediatric clinic due to a lack of timely nursing triage for calls received regarding mental health concerns. Hamrin, Antenucci, and Magorno (2012) note “depression can be more common than asthma and other chronic medical problems in the pediatric population. Assessment and treatment of major depressive disorder (MDD) in children and adolescents is critical in the primary care setting.” Mental health is an important safety issue as it is surrounded by stigma, but it is essential to discuss this topic as depression rates rise from 3% in childhood to 14% in adolescents (Hamrin et al., 2012). Youth who have mental health issues are more likely than their peers to access primary care services. Uspal, Rutman, Kodish, Moore, and Migita (2016) note “Mental health (MH) disorders are common in children, with an estimated 13%–20% of children in the United States experiencing a mental disorder in a given year [and increasing].” Another
subject it addresses is how “the primary care setting is an appropriate venue for screening and identifying depression, and initial management or referral to psychiatric mental health professionals for evidence-based treatments such as psychopharmacologic interventions, cognitive behavioral therapy, and interpersonal psychotherapy (Hamrin et al., 2012). Other issues may present themselves such as the call center team lacking medical terminology as well as having a poor definition of the call process. In order to alleviate the pressure that may rise from these issues, I believe that as a CNL and transformational leader it is important to act as a mentor and support system for the staff. Educating the team in keywords and red flags as well as defining a call process or creating a type of process mapping or flow chart can assist in clearly defining the expectation as well as providing nursing support. This emphasizes teamwork and empowering the staff as an integral part of the team.

**Project overview**

The project is taking place in a county run pediatric ambulatory clinic. We will participate in a shared leadership team to make recommendations for improvement at the microsystem level. I am working with the charge nurse, clinic manager, call center, call center supervisor, pediatric therapist (MFT), and pediatric nurses. We are implementing a workflow to address the problem of missed opportunities to triage pediatric clients who are being referred to mental health services. The tool we are using is a flow chart, please see Appendix C. The objective of the flow chart tool is to implement a standard. It can provide confidence in the call center staff as to reaching out to a nurse for triage. The flow chart includes a list of keywords or “red flag” words that the call center staff can recognize as an indicator of the need for triage by the nurse. The keyword list is
compiled from triage protocols that are used by nurses. The keywords are rewritten so that the terms used were easily identifiable by non-nursing staff.

Mental health services include counseling as well as crisis intervention. The therapist may provide crisis intervention, which is “immediate, short-term help to individuals who experience an event that produces emotional, mental, physical, and behavioral distress or problems” (ACA, 2016). The frequency of counseling varies by client need. The specific aim of this process improvement idea is to achieve the triage of 100% of pediatric patients who are being referred to mental health services by August 5, 2016. The purpose of this improvement intervention is to implement a change to decrease emergency department visits or psychiatric emergency services visit rates for pediatric clients receiving mental health services through the ambulatory clinic to increase client safety—by preventing harm to themselves or others—and quality of care provided.

**Rationale**

During the assessment of the microsystem, there was a clear communication issue between the call center and the pediatric ambulatory clinic. The pediatric ambulatory clinic nurses created a reference tool for the call center staff to transfer calls to the nurses. Even with the use of the tool, we noted a weakness related to clients receiving mental health services. The emergency department notifies the pediatric ambulatory clinic via fax that a client was seen in their department. The notification includes the reason for the emergency department visit as well as the recommended follow up time. Before assessing the quantitative data, the qualitative data was surprising. It was noted that pediatric clients were being seen in the emergency department or psychiatric emergency visits
varying by ages. The most common reason for the visit was anxiety. The emergency room or psychiatric emergency services center can be frightening and traumatizing for the psyche of a child; “acute behavioral needs in the ED often fall to security, nursing, and medical staff untrained in MH, increasing threats to patient and provider safety” (Uspal et al., 2016). Especially since many of our clients are immigrants with experiences of immigrating due to criminal or political circumstances in their native country. The immigration process could have also included detainment for months away from their family due to these circumstances. Some also traveled illegally with human traffickers and can vividly recall their experiences. These circumstances can lead an adult to experience anxiety and fears; it is understandable for the pediatric clients to need help coping with these issues. Although the children are resilient, it is essential to provide support and safety in a comfortable environment. The pediatric ambulatory clinic is ideal for the pediatric clients receiving mental health services, as they are familiar with the staff and environment. If a pediatric client is in the clinic for a physical examination or sick visit, and the provider would like to refer the client for mental health services, it may be possible to attempt a warm handoff. A warm handoff is when the provider or nurse can physically assist in transitioning the patient to the therapist. Introducing the client/family unit to the therapist while they are already being seen in the clinic creates rapport with the client and encourages trust and safety in this new relationship with the therapist. The environment of the ambulatory clinic is less threatening than the environment of the emergency department or psychiatric emergency services department.

During the first week of the assessment process, we noted the pediatric clinic
received 36 notifications that pediatric clients were seen in the emergency department, this was only for the last week of May. Of these 36 clients, 3 clients were seen due to mental health reasons. A copy of the data from the last week of May and first week of June can be found in Appendix A. One of which was then referred to psychiatric emergency services. After reviewing the clients’ medical records, it was found that 2 of the clients had a pending mental health referral, and the other client was a pediatric client but was not part of the ambulatory clinic’s panel of patients. As we continued to track the amount of pediatric clients seen in the emergency department/psychiatric emergency services, it became evident that most of these visits could have been avoided by the triaging of the client.

As there is only one therapist and one psychiatrist in the pediatric ambulatory clinic, the referrals may not be addressed the same day if they are not classified as urgent. A copy of the SWOT analysis can be found in Appendix B. The providers are proactive about classifying their referrals as urgent via the electronic health record, but the call center may not be aware of the severity or urgency of the clients’ needs. Therefore there is the need for call classification, call escalation, work process, and medical terminology reference for the call center. The flow chart tool can assist in identifying pediatric clients who may be experiencing suicidal or homicidal ideations and need care in an emergent or timely manner by having the nurses triage the client. There are about four or five nurses in the pediatric clinic through the day and late evening. Therefore, the nurses have the sufficient staff to work with the therapist to triage the clients who are referred or seeking mental health services.
The need for call classification is important as this assists the nurses in quickly identifying the subject and reason for the phone call. Moss (2014) notes, “Telephone triage services are usually performed in health call centers [as they] routinely operate in hospitals, managed care organizations, clinics, or other health organizations.” The need for a tool such as flow chart that clearly defines how to escalate certain calls will prompt the nurses to triage the calls regarding mental health concerns in a timely manner to assess the need for intervention; please see Appendix D. The nurses use “evidence-based, computer accessed decision support algorithms, clinical expertise, and critical thinking skills to provide medical advice regarding the level of care needed” (Moss, 2014). These skills can assist the nurse in addressing the need for a work process that is within the scope of the non-licensed medical staff.

Addressing the problem of missed opportunities to triage pediatric patients who are being referred to mental health services by creating and implementing the use of a flow chart to assist the call center staff in the classification and escalation of these calls, is a low cost intervention that can yield a high impact. Please refer to Appendix E. The value of implementing this tool includes monetary savings as well as intangible savings for the medical center and staff. Szmukler and Rose (2013) note “risk assessment has assumed increasing salience in mental health care in a number of countries.” They emphasize that the frequency of serious violent incidents perpetrated by people with a mental illness is an insufficient explanation.

The pediatric department has daily huddles, as well as weekly and monthly meetings where the teams meet to discuss improvement plans. These meetings do not interfere with patient care as they are scheduled as administration time. The tool itself is
available online, a printed version is also provided to the staff. There is no need for new staff, new equipment, or different work environment as it is a change in the management of common calls that are already received.

The intervention can also prevent the need for emergency department visits or psychiatric emergency services by early identification and intervention of a possible crisis. The cost for a clinic visit where crisis intervention can be performed instead of and emergency visit is more cost effective for the medical center. Szmukler and Rose (2013) also describe an intangible cost, moral outrage—this is associated “with an implied culpability when certain types of tragedy occur.” In general, the project requires minimal new supplies, staff, and staff time, as it is a change in processes. Most importantly, the lack of intervention can lead to the patient hurting themselves or others; “the ED also provides a greater potential for elopement and self-harm than a secure inpatient psychiatric unit” (Uspal et al., 2016).

Methodology

Horizontal leadership involves the “decentralization of power and/or control [and where] there may be multiple individuals who assume leadership of a team or teams in order to achieve a common goal” (King & Gerard, 2016). The change theory guiding the project is Lewin’s model that describes three stages of change. The three stages include unfreezing, moving, and refreezing. The “unfreezing stage,” requires the determination of what needs to be changed and understanding why the change needs to occur. During this stage, the step of assessing the microsystem took place and determination that there is adequate support from administration. The need for change is analyzed and the “why” change is necessary is emphasized. It is also important to address staff concerns. The
“change stage” incorporates planning and implementing the change. Explaining how the intervention will affect the patients and staff is imperative. This is also the opportune time to prepare the team for the intervention and empowering the team to take action by being involved in the process. The “refreezing stage” includes developing ways to maintain the change and develop ways to ensure barriers are being addressed. Adaptation may also be necessary during this stage. Lewin’s model is appropriate for this intervention as it involves improving and standardizing a process that is occurring, but not standardized and occurring without a guideline. The goal with the change of adding the intervention of a flow chart for triaging pediatric clients referred to mental health services or inquiring about mental health services is to improve client safety and quality of care provided.

Once the flow chart is implemented, I will continue to monitor the mental health referrals, mental health related telephone encounters, and emergency department/psychiatric emergency services notifications. Another area that would be interesting to track is the rate of “likelihood to recommend” option for the pediatric ambulatory clinic via the Press Ganey software; please see Appendix I. Although this includes various aspects of the microsystem, the mental health services are an integral part. I predict that there will be an increase in the triaging of pediatric clients receiving mental health services and as a result a decrease in pediatric client visits to the emergency department for these services. I will use the same measurements to determine if my predictions were correct.

I would like to accomplish the triaging of all pediatric patient calls made regarding mental health concerns. The team would include the call center as they receive
the calls, call center supervisor, nurses, clinic manager and medical director. Together through the workflow diagram assisting non-licensed/non-nursing staff with little medical terminology history, streamline the calls received regarding mental health. This flow chart will help ensure patient safety through timely triage.

**Data Source/Literature Review**

The data for the improvement change was collected through the review of electronic medical records, including the therapist’s telephone encounter, referrals, and emergency department/psychiatric emergency services visits. This provides data for comparison when the flow chart is implemented.

In order to collect literature to support the improvement change project, a PICO statement was developed. The patient/population statement was clients seventeen and under with mental health concerns who call the clinic requesting services. The intervention statement was forwarding these calls to the registered nurses for triage. The comparison statement was if no forwarding of these calls to the registered nurses and the clients wait for outreach from the therapist. The outcome statement was a decrease of emergency department/psychiatric emergency services visits and prevent missed opportunities for outreach to patients with emergent/urgent mental health concerns. These statements aided in the search for literature to support the improvement idea.

As deinstitutionalization and the establishment of crisis assessment teams and “mental health triage services in the late 1990s, this responsibility has predominantly shifted to nursing and allied mental health professional” (Elsom et al., 2013). In the pediatric population, this can provide an environment that is comfortable and familiar. Especially since “depression can be more common than asthma and other chronic
medical problems in the pediatric population [therefore] assessment and treatment of major depressive disorder (MDD) in children and adolescents is critical in the primary care setting” (Hamrin et al., 2012).

The role of the call center as non-clinical staff shows the evolution and growth in health care to provide better quality of care the clients. Kaur (2016) emphasizes “to ensure non-clinical workers play an effective and lasting role in the healthcare system, new care models will need to demonstrate value to existing care teams, payers of health services, and patients.” Teamwork between the various disciplines providing care is another important aspect in providing quality care.

The benefit of decreasing pediatric emergency department visits is not only for the clients, but also for the emergency department. It was noted that in 2007, “patients with mental health complaints comprised 12.5% of 95 million emergency department visits” (McCullumsmith et al., 2015). In addition to overcrowding, there may be extended emergency department stays which have “been associated with multiple factors linked to lack of availability of outpatient services: homelessness, lack of insurance, and public insurance” (McCullumsmith et al., 2015). There are a variety of mental health concerns, “mental health problems include conduct disorders, anxiety, depression, self-harm, eating disorders and hyperkinetic disorders” (Membridge, 2016).

Moss (2014) notes that children and adolescents are clearly a vulnerable group who are presenting with more and more complex issues. There is a benefit to preventative programs where “early intervention, better promotion of positive mental health and positive parenting programs undoubtedly have their place in supporting better
outcomes for our children and young people as they take their place in society” (Moss, 2014).

**Timeline**

The improvement change project began in May 2016 and will conclude in August 2016. The implementation of the improvement project will occur over the course of roughly two months. A detailed timeline can be found on the Gantt chart in Appendix F. The initiation of the project began with the assessment of the microsystem. This stage occurred from the last week in May 2016 until mid June 2016. The assessment of the microsystem included reviewing the telephone encounters sent to the MFT, referrals sent to the MFT, and the emergency department/psychiatric emergency services notifications sent to the pediatric ambulatory clinic for the month of May and June 2016. Next the leaders of the improvement change project met to discuss the project. The benefit of the daily huddles was the ability to discuss the project—although briefly—on a daily basis. Next, the participants such as the call center, therapist charge nurse, and pediatric nurses also met in the first week of June. This was when we decided to focus on the mental health aspect of telephone triage. The next two weeks were spent researching evidence-based practices and developing the keywords and flow chart. This process includes the team and underwent several revisions. Then, the approval from the leaders was necessary. At this time, the flow chart has been approved by the charge nurse and medical director and is set for implementation the week of July 4th, 2016.

**Expected Results**

The long-term result is the decrease of emergency department (ED) visits or psychiatric emergency services (PES) visit rates for pediatric clients receiving mental
health services through the ambulatory clinic. These results should be attainable in the designated time as there has not been a large volume of referrals or telephone encounters thus far. The call center and pediatric nurses see the value and benefits of triaging pediatric mental health clients; therefore I anticipated the specific aim is attainable. In order to update the staff on the progress of the intervention, we will continue to address it on the daily huddle board.

The nurses have the sufficient staff to assist the therapist with her referrals and telephone encounters, especially during the summer break when the clinic is less busy. External barriers may include the therapist not being available to provide emergency crisis intervention for various reasons, such as not being in the office or the client is unable to go to the ambulatory clinic. Crisis intervention may be needed during hours that the clinic is not open; therefore the crisis intervention service or triaging may not be an option. Established patients will also have an action plan or de-escalation plan when they feel their symptoms exacerbating. Supplementary services can be provided after the initial assessment of the patient, whether that is by the therapist or via nurse triage.

Nursing Relevance

The nursing relevance of decreasing the rate of ED visits or PES visits of pediatric clients who are being referred to mental health services is great. The flow chart is designed by nursing staff for non-nursing staff. This type of workflow can also be applied to other nursing areas to ensure the safety of the clients. This would benefit clients and their family who are receiving mental health services through the clinic. The project will fit with under the IOM category of safety. The main nursing ethical principal the improvement project relates to is beneficence. It relates to compassion, “taking
positive action to help others; desire to do good;” which is the core principle of our patient advocacy (AACN, 2013). The lack of triaging of mental health clients means that patients who may be experiencing suicidal or homicidal ideations are not receiving care in an emergent or timely manner. The lack of intervention can lead to the patient hurting themselves or others.

**Summary Report**

The average rate for pediatric emergency department visit related to mental health concerns was 8%. Of this 8% of clients seen for mental health concerns, there was an average of 67% of clients/clients’ parents/guardians that had reached out to the pediatric clinic for mental health services. The global aim statement is that we aim to improve the telephone triage of pediatric clients referred to mental health services to decrease emergency department (ED) visits or psychiatric emergency services (PES) visit rates for pediatric clients receiving mental health services through the ambulatory clinic. The specific aim of this process improvement idea is to achieve the triage of 100% of pediatric patients who are being referred to mental health services by August 5, 2016. The purpose of this improvement intervention is to implement a change to decrease emergency department visits or psychiatric emergency services visit rates for pediatric clients receiving mental health services through the ambulatory clinic to increase client safety and quality of care provided.

The problem identified in the microsystem, the ambulatory pediatric clinic in San Mateo Medical Center, is the lack of timely nursing triage for calls received regarding mental health concerns. The issue became apparent when we received 3 notifications from the emergency department that pediatric clients were seen for mental health issues.
When we examined the patients’ charts, we were surprised to find telephone encounters addressed to the mental health therapist that were pending in her inbox. This means that the patients’ parents reached out to the clinic for assistance and were not contacted in a timely manner, or the call was not escalated and sent to nursing triage therefore they had to seek care in the emergency department.

The client population consists of pediatric clients who are seventeen years or younger and under with mental health concerns who call the clinic requesting services. The client population consists of families who are of low socioeconomic status, many of which are immigrants. The intervention statement was to forward these calls to the registered nurses for triage. The comparison statement was if no forwarding of these calls to the registered nurses and the clients wait for outreach from the therapist. The outcome statement was a decrease of emergency department/psychiatric emergency services visits and prevent missed opportunities for outreach to patients with emergent/urgent mental health concerns. As deinstitutionalization and the establishment of crisis assessment teams and “mental health triage services in the late 1990s, this responsibility has predominantly shifted to nursing and allied mental health professional” (Elsom et al., 2013). In the pediatric population, this can provide an environment that is comfortable and familiar. Especially since “depression can be more common than asthma and other chronic medical problems in the pediatric population [therefore] assessment and treatment of major depressive disorder (MDD) in children and adolescents is critical in the primary care setting” (Hamrin et al., 2012).

As this is a safety concern and lack of call classification and follow up regarding mental health issues can lead to patient injury, the clinic decided this is an opportunity for
the development of an improvement idea. There is one family therapist in the clinic that is not a full time employee, therefore it is expected that calls may not be addressed for days from when they are received. On the other hand, we are fully staffed in the pediatric clinic—at least at the moment—and can assist in triaging patients to ensure they do not have an emergent or urgent need. The need for call classification by the call center is important as this assists the nurses in quickly identifying the subject and reason for the phone call. This arose the need for a work process that is within the scope of the non-licensed medical staff. Thus, the implementation of a workflow to have the call center staff forward calls regarding certain mental health concerns to the nurse for triaging is an evidence-based activity.

A barrier I encountered for the improvement project was the distribution of the flow chart. I expected the flow chart to be distributed on Monday or Tuesday the week of July 3rd, but it did not get distributed until Wednesday as the person assigned to the task called in sick. Although it did not threaten the project, it delayed my official implementation date. After the implementation date, I noted there was an increase in telephone encounters for the nurses to triage. I expected there would be some push back from the nurses, but due to the increase in pediatric patients receiving mental health services they understood the importance of triaging these clients.

Another barrier I had not considered was how to best triage and provide care for patients that require a higher acuity of mental health services than can be provided in the ambulatory clinic. For example, we had a patient that was triaged because the mother noted patient was sleeping more than usual and seemed fatigued at all times. This client’s history included eating disorders and was receiving mental health services
through another county mental health facility. Summer is considered to be less busy than the winter or fall season as the pediatric clients are on summer vacation from school therefore demand for services from the clinic is decreased. We expect that the fall and winter season will increase the telephone calls for pediatric mental health services when the clients return from their summer trips and return to school.

The increase in telephone encounters and phone calls transferred to the nurses for triage were evident the first week. There was a daily increase of an average of 7 telephone encounters sent to the nurses’ pediatric triage pool. Please see Appendix G and Appendix H for a further breakdown of telephone encounters. Although there were still pediatric clients seen in the emergency department, we found the algorithm to be a success as the clients who were seen in the emergency department were either not clients of the pediatric clinic due to receiving higher acuity mental health services elsewhere or were instructed to go to the emergency department after being triaged by a nurse.

Fleiszer, Semenic, Ritchie, Richer, and Denis (2015) note healthcare innovation sustainability “remains a multi-dimensional, multi-factorial notion that is used inconsistently or ambiguously and takes on different meanings at different times in different contexts.” They propose a broad conceptualization that consists of three characteristics: “benefits, routinization or institutionalization, and development.” Another suggestion is that sustained innovations are influenced by a variety of factors: innovation, context, leadership, and process related. The resources needed to sustain innovation are employee time, managerial time, and project and program tools. Planning for dissemination begins at the same time projects are being developed. After a few PDSA cycles, I still believe there will be changes to the improvement idea as patient
needs change. The improvement opportunity for the problem of missed opportunities to triage pediatric patients who are being referred to mental health services can lead to changes in the process of handling telephone calls or referrals.

If the level of acuity changes, then the algorithm or policy will have to evolve along with the changes occurring in the clinic. The improvement project was met with enthusiasm as the county ambulatory clinics have been revamping their services under the Patient-Centered Medical Home (PCMH) model. This model focuses on standardizing all processes. The discussion is ongoing of how to best address mental health calls. The CNL competency this topic relates to is Essential 2: Organizational and Systems Leadership, “collaborate with healthcare professionals, including physicians, advanced practice nurses, nurse managers and others, to plan, implement and evaluate an improvement opportunity” (AACN, 2013). The goal of improving patient safety and providing timely nursing triage for calls received regarding mental health concerns while reducing emergency department visits for these concerns was met as all telephone encounters regarding mental health concerns were sent to the nursing pediatric triage pool.
References


Appendix A

60 Day Emergency Department Pediatric Visits

![Bar chart showing May and June Emergency Department Visits with categories for Mental Health Concerns and Other Medical Concerns]
Appendix B

SWOT Analysis

**S**
- Support from administration
- Support from nurses and call center
- Adequate staff to implement improvement ideas

**W**
- Call center with minimal medical terminology knowledge
- Poor definition of the call process

**O**
- Improving communication between the patients and staff
- Improving communication between members of the care team
- Empowering the team members
- Encouraging teamwork

**T**
- Therapist not available to provide crisis intervention
- Clients calling during hours the clinic is closed
- Hesitancy of parents/clients to seek help regarding mental health concerns
Appendix C

Flow chart for Telephone regarding Mental Health Concerns

**Keywords:**
Anxiety
Hallucinations
Paranoia
Confusion
Suicidal Threats
Intent to harm others or oneself
Increased stress
Increased/decreased
Sleep
Drug/Alcohol Problems
Appetite loss
Binging/purging
Dangerous behaviors (cutting, head banging, running into streets)

- Parent/client states situation is emergent/urgent
  - No, calling for non-emergent matters (ie counseling, f/u counseling)
  - Yes
    - If there is an immediate crisis, such as actively attempting suicide, threats to harm others, or suffered some sore of abuse, call 911 or if it safe then bring the Emergency Department
    - Create TE and call nurse with urgent update for further evaluation
  - Create TE and make a warm transfer to nurse for further evaluation
Appendix D

Root Cause Analysis – Fishbone Diagram

People
- Nonlicensed staff
- Little medical terminology
- Lack of mental health education
- Addition of work for nursing staff

Process
- Poor definition of call process
- Lack of call classification
- Lack of process map

Materials
- Lack of process map
- Lack of designed workflow

Environment
- The therapist may not be available in the clinic when a client calls to provide crisis intervention
- The clinic may not be open when a client calls regarding mental health concerns

Lack of timely nursing triage for calls received regarding mental health concerns
Appendix E

Savings Per Client Who is Not Readmitted Due to Care Transition Program Service

<table>
<thead>
<tr>
<th>Costs of Emergency Department Visit</th>
<th>Average Cost</th>
<th>Savings by Preventing ED Visit (3 clients/month)</th>
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<tr>
<td>Emergency room Visit</td>
<td>$1,233</td>
<td>$14,796</td>
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<tr>
<td>Cost of Triaging Client</td>
<td>[20min x average RN hourly rate ($50)] = $16.67</td>
<td>$200.04</td>
</tr>
<tr>
<td>Savings Per Client</td>
<td></td>
<td>$14,595.96/month</td>
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Appendix F

Timeline

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<th>May</th>
<th>June</th>
<th>July</th>
<th>August</th>
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<td>5</td>
<td>7</td>
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<tr>
<td>Nurses</td>
<td>1</td>
<td>3</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Administration</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
Appendix G

Total Pediatric Emergency Department Visits compared to Clients who have/have not reached out for Mental Health Services

<table>
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<tr>
<th>Date</th>
<th>Visits</th>
<th>Did not call clinic regarding Mental Health concern</th>
<th>Called clinic regarding Mental Health concerns</th>
<th>Total Pediatric ED Visits</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
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<tr>
<td>July 10th</td>
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<td>22</td>
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<td>July 17th</td>
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<tr>
<td>July 24th</td>
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<td>July 31st</td>
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<td></td>
<td>5</td>
</tr>
</tbody>
</table>

Legend:
- Did not call clinic regarding Mental Health concern
- Called clinic regarding Mental Health concerns
- Total Pediatric ED Visits
Appendix H

Telephone Encounters forwarded to nursing Pediatric Triage pool regarding Mental Health services by week

![Bar chart showing Telephone encounters and ED visits by week.]

- ED visits
- Telephone encounters

July 3rd, July 10th, July 17th, July 24th, July 31st
Appendix I

Likelihood to Recommend Scores