Emergency Involuntary Procedures (EIP) Work Group
Department of Mental Health
280 State Drive, NOB 2 North
Waterbury, VT 05671-2010
March 12, 2021 ~ 10:30am – 12:00am

Attendance [phone]: DMH Staff: Jennifer Rowell, Frank Reed, David Horton, Mourning Fox, Karen Barber, Tom Weigel, Laure Omland; CVMC: Kimberly Cookson, RRMC: Lesa Cathcart, NAMI: Laurie Emerson, VPCH; Sarah Sherbrook, Jeremy Smith, UVMMC; Jessica Charbonneau, BR: Lauren Shockley, Louis Josephson, Kayte Bak, Dr, Chawla; DAIL, Suzanne Leavitt

Dr. Kevin Huckshorn, Alex Lehning, Dr. Janice Lebel, Malaika Puffer, AJ Ruben, Merry Postemski

Meeting minutes are intended to capture the substantive business of the meeting and should not be construed as an explicit transcript of all meeting commentary

Welcome and Introduction: Thank you to all on this call today, and a thank you for last meeting, felt like it was a very productive meeting.

UVMMC Presentation: Jessica Charbonneau

Jessica started in October in an interim role and is applying for permanent nurse manager position. Overview: How are we utilizing 6CS? Data inform practice – There is a lot of unit-based council, psychiatric and quality council, which includes medical director and quality, along with different staff members [i.e. when an EIP happens, often mental health tech sitting observing the individuals and see the triggers happening, they are one of the most valuable to be present]. Going to have a standing agenda item to look at deep dives of the EIPS, will look at the date for a month, but would give an opportunity to see if there are specifics within the event that could have been improved.

Workforce development – from the time of interview, we are implementing 6CS, interview question is to describe an instance where a patient was being verbal, aggressive, violent and how they handled that, so I know what their personal philosophy is going in. I make sure it is expressed the least restrictive philosophy from the moment of the interview.

2 nurse educators, each staff member receives training on ProACT and MOAB. Provide additional hands-on training for seclusion/restraint when we have staff members who are new and additionally yearly, or whatever timeframe we are looking at.

Inclusion of family and peer – they are included in care plan at creation and d/c planning. Have a camera that goes around the room so they can see a family member, nurse, etc. that was implemented with COVID. It is part of our process to offer to inform your family after an event, so they can be an additional support.

Risk assessment/Prevention for EIP – we have a coping tool assessment, ask individuals about triggers and any coping mechanisms they use, which is the first page of the face sheet when we log-in. Violence risk assessment is completed when they first arrive and can be updated throughout their stay. Has there been violence in the past, being able to look at that? Do a debrief process immediately after any EIP [what went well, what could have gone better].

What quality measure do we look at – infection rates, injury – main groups of data are the EIP data, a lot of work in our safe reporting system, anything unsafe, broken in the system, the leadership team looks at that. Develop a plan together to address those situations. Put a bulletin out to staff with this information, anything

that was changed or educational reminders, has been done in the last year. Also look at focus group data from patients and everyone is asked to fill it out, rating system and a place to fill out comments.

G&C as an organization. There is quite a leadership presence, if there is ever an instance where someone is unhappy, one of us is always available to go out and address that concern, sits and listens to the individual, provides further resources or address the concern directly. Internal patient advocate that we can call i.e., specific concern or item they brought in and are not able to find, this internal group will investigate so it is not the person they told.

Question: Do you have the instance of S/R over the last month? Answer: It really depends on the group of individuals that are present, I found that often when we have a month where there is a high instance of S/R it tends to be the same few individuals who are continuing to struggle. For the month of March, only had 2 emergency events, February there were 4, January was a tough month, individual had a few events.

Question: Database where you capture the reason for the EIP from the staff's perspective and the persons served? Answer: Not a database in the sense it is an electronic version, when we do the debriefing there is the staff and patient debrief within 24 hours, on that there is a place for each group to say what do you think was the trigger. We don't log and track it anywhere. Comment: Should probably have it in a database to be able to have a granular look. Kevin and Janice will drill down going forward to get that information.

Kevin and Janice

Thank you for inviting us. In most cases, the most effective or successful use of a committee of a statewide EIP committee is that the stakeholders are at the table, and everyone feels comfortable about speaking, everyone understands the purpose of the meeting is to gather and drill down on information. One of the most core pieces of EIP meeting is a safe place to discuss both their successes and their struggles. When the data demonstrate the unit has an issue, you might want to focus on your problem areas and talk a bit about how 6CS are being used, what is the input coming in from staff, peer, family members. First off, there is a million ways to collect data on EIPS, the one right way has to be targeted and individualized to your system of care. You do not want to aggregate data for apples and oranges. That complicates the data and makes it murky. We want to talk with some of the state gurus about apples to apples to data, stop reporting aggregate because it is very meaningless. We also really want to focus not just on the number of EIPs by type, but we also want to look at the duration of each one of those events. It is important to run your data across the state system with the same denominator. Debriefing – possibly might be the hardest one to do well. CMS and Joint Commission possibly don't understand what it might be, the bottom line is if you don't figure out the triggers that caused the EIP, you have missed the boat. Encourage everyone from this committee is to give us your suggestions and concerns, thoughts going forward to make this time as important as we can make it and as useful as we can make it.

At the end of the day, it is about translation of the data and about quality of care for those who are served. The data tells us something but doesn't get to the essence. Jessica's presentation did a nice job of some of the translation of the 6CS to their practice. We need to teach and work with staff to heal the breach i.e., reparation, teaching, getting back on track.

Interested in direct care staff and advocacy on the use of EIPs – getting really important info that a patient or person might not feel comfortable telling staff. People are not particularly comfortable telling staff what they think, gathering that info from advocacy/family members/direct care staff is a really valvulae source of information. Frank can provide our contact info for you to provide feedback to us confidentially.

Kevin Huckshorn: kevin@kahassociates.com Janice Lebel: Jlebel@comcast.net

Comment/Questions:

Appreciate the discussion. Working for DRVT, bringing that discussion to the forefront, thank you. When you talk about real meaningful debriefing and looking at it, part of performance improvement, make it a safe place for staff to speak about prevention, etc. Have you worked with a facility who has successfully incorporated advocate roles in performance improvement? Answer – Yes, in a number of facilities. It has to be based on trust. It can be tricky. Advocacy staff have very different goals then an actual group of hospital staff, so it needs to be rolled out carefully. Try to avoid PHI on the level of the individual patient, except when that can be done in a controlled situation. Massachusetts DRVT had offices right in the hospital and looked at the EIPs asap to go over events. We do have advocacy participation and as Kevin said, it has to be done with care and trust. Where it works well, it is a really powerful intervention that helps people. Also have done this in our youth program. The other point of difficulty is sometimes we get family members who want to participate but don't want advocacy in the role.

Kayte at Brattleboro Retreat has worked hard with all of her staff to start at square one, going through 3-hour trainings until it is done and creating a new strategic plan for the troubled areas that all of us have.

NAMI – I wanted to mention that last year the VCPI had an online training and I participated and wanted to thank you for being here to help with these meetings. I found the training very helpful as a committee member. I know that VCPI is hosting another training soon, and also wondering about the availability of other advocates for making sure people who are interested in this, can have access to that training, it would be very helpful. Alex Lehning is the new executive director at VCPI. Answer: Thank you, and glad you mentioned VCPI as we have been partners for almost 15 years. When we started rolling it out in 2002, part of the expectation was the teams that came to the training was that they invited their local advocacy groups. We always love to have advocates in the group. Thank you for saying that.

Data Reports

David went over the first report, which is the standard report on involuntary EIPs. The second report is a new report on voluntary patients, both reports are for the same time period, October through December 2020. Takeaways

1. So few administered EIPs to youth, the data in adult patients is what we are seeing, when both populations are combined in the chart
2. Trend data – pretty erratic, volatile and hard to trend, one thing that jumps out is there was a decrease in manual restraints and increase in manual restraints.
3. Units by type of procedure across all units – 2 youth units on left, then standard units, then Level 1, more EIPs are administered to the Level 1 units, little more than 186 being admitted on T4 at BR and fewer RRMC and VPCH.

Question: Frequency data? Adjusted for census? Hard to make sense of the data without knowing what we are looking at. Answer: Census comes later in the report and calculated for direct comparisons can be made. One thing that is not included but is listed down below the chart, but you can see the duration time of all EIPs summed up for all units.

Question: Chart – other units' data – the other level 1 facilities reporting, do they accept level 1 patients, comparable to T4 which are 100% level 1 for the most part? Answer: VPCH – all 25 beds are level 1. RRMC South is also all level 1.

Comment: Wanted to point out a clarification. VPCH a good chunk of the beds had been turned over to MTCR, so not sure if it was the same acuity when the care centner was more acute level 1 patients. I know that on T4, we had a slightly older patient with cognitive impairments that needs a lot of direction in toileting and

showering. I believe our staff were recording this as a restraint/intervention when we have to put hands on for showering. We were concerned the patient couldn't safely do those ADLs without support.

Question: Wondering, in terms of how treatment time is calculated, in relation to forced drugging incidences, if there is sort of manual restraint during the course of giving involuntary meds, does that get counted separately as restraint, or categorized as part of the involuntary meds? Answer: if more than one EIP type is used, they are each counted as an episode.

Question: Involuntary meds, I do wonder if facilities are reporting consistently, or in the same way. In looking at overall data, we at DRVT receive a lot of info from patients in situations where staff members are holding the needle, stating you will get this if you don't take PO meds. They often accept the PO meds – are those being recorded as involuntary medications? Answer: What the definition is on page 2 of the report is what we use: *A restraint is also defined as a drug or medicine used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not standard treatment or dosage for the patient's condition (CMS 482.13(e)(1)(i)(B)).*

Question: I was wondering if there is a way to collect a little more drill down data on which point of hospitalizations are these EIPs occurring? How are our crisis interventions impacting this? Answer: Most of the reporting gets rolled up a high level and not able to distill more purely. Facilities can do their own data drilldown though.

Brattleboro Retreat

Thank you for having us. If there is a medication order, any time we have an emergency medication, we still want to give them choice, but still very much an emergency medication. We record those as emergency interventions, and part of our EIP data.

Osgood 1 - Pediatric Unit. Nearly 50 instances that happened were all attributed to 1 patient. That can have a lot to do with driving up numbers. Some kids don't want to go home and want to be here so they are acting out so they don't have to leave.

Osgood 2 – 1 patient within 2 weeks of hospitalization was experiencing a lot of EIPs, once we could drill into triggers, they began to come down with therapeutic interventions. We also looked at what spiked the other units as well.

How we are addressing these issues:

- Daily meetings to assess progress and plan for d/c
- Consultation with Occupation Therapy for individuals coping strategies.
- Coordination with community stakeholders and state agencies to plan safe and appropriate d/c
- 6CS – the administration team is fully committed to this implementation.
- There are significant steps to improve data collection.
- Improving real-time meaningful use of data for recognition of clinical goals

We are committed holey to this work and learning all the time related to some of the things that drive our numbers up. We had a patient on T4, limiting their movement to provide ADL care so this drove up the numbers. What constitutes a restraint and what is the provision of medical care – we went over this with staff. We have started to see a decrease in our numbers and really identify individual areas where we can make a real difference when one of our patients are needing more acute care related to EIPs. We understand the risks and we want to head that off much earlier and through some of our initial training that we started here around 6CS, we are really starting to get momentum and excitement around this work. We have subgroups and committees forming and we have committed the initial leadership launch off training. Exciting time for BR.

We have a committed team and appreciate your time in having us explain that.

Comments/Questions:

This is a perfect opportunity call out the work that was done with that young person at BR who as being involved in EIPs at the beginning of stay, and the fact that the BR staff were able to figure out what was going on with that young person and implement the corrective measures within 14 days is not something you see a lot.

Comment: There is a pattern I have observed in these meetings, there is a lot of talk about the retreat numbers, reasons why they are and going to change, that is fine to talk about and fine to appreciate the positive, but the goal of this whole process is to reduce harm, then we need acknowledgement of harm. I have never heard this from this committee. Follow up about process requests with me.

Comment: I do believe we talked about this before, but we consider it a failure when we have to use EIPs, not something we want. We want it zero if humanly possible. That is why we are working so hard. We are doing our best, trying to learn, struggling ourselves to help at times, it is a process and a failure if we continue to do that.

Comment: Thank you for that.