Emergency Involuntary Procedures (EIP) Work Group
Department of Mental Health
280 State Drive, NOB 2 North
Waterbury, VT 05671-2010
June 11, 2021 ~ 10:30am – 12:00am

Attendance [phone]: DMH Staff: Jennifer Rowell, David Horton, Dr. Tom Weigel, Laure Omland, Samantha Sweet, Sarah Sherbrook, Dr. David Rettew; VCPI: Alex Lehning, Amy Stonha; VAHHS: Emma Harrigan; DAIL, Suzanne Leavitt; RRMC: Lesa Cathcart; BR: Alix Goldschmidt, Kayte Bak, Bonnie M., Dr, Chawla, DRVT: Merry Postemski; UVMMC; Jessica Charbonneau

Michael Sabourin, Dr. Kevin Huckshorn, Dr. Janice Lebel, Alex DelMarco, Malaika Puffer, Ward Nial

***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:** Introductions took place. Review of what the purpose of the Committee is and what it does.

Have each member as defined by the membership roster, what you want for the yearly report, how can we think about your chartered purpose, how can we fulfill that? What is going well and what is going better.

There is a new comment form, which can be sent to Alex at any time.

**Annual Report Discussion**:

BR: Looking at data as a whole. Compared last quarter of 2020 with the first quarter of 2021 – we saw a dramatic decrease; the child unit saw the most decrease. Minutes of seclusion, 6,115 and first quarter dropped to 3,438. Restraints 9,364 down to 5,242. There was a slight increase in T2, one individual was some of that trend. We know we have work to do, but we have started the rollout of 6CS and there is a lot of buy in hospital wide.

CVMC: 14 bed unit but maxed at 10 patients right now due to being down a psychiatrist. Did a unit refresh, got some new furniture, wall hangings and the sensory room has been completed and patients are loving it. Working on transitioning to a new EHR Epic. Use ProAct and MOAB for staff training. New program being implemented to move away from MOAB. Start doing COVID immunizations for anyone that wants them. Boarding continues to be an issue. 11 year old has been there for 400 hours.

DA: No representation

DAIL: Nothing unique to see in the report

DMH: Submit additional information in writing, want to increase the rigor of the CON process, working with VAHHS and the hospitals to try to add in race and ethnicity data. Working closely on 6CS implementation at different hospitals, get voluntary EIP information in the report as well.

Peer: How people attempt to implement the 6CS, how you monitor the hospital/facility for fidelity. How do you move forward with 6CS once you eliminate EIP's? If all we are looking at is numbers, how do we get the whole picture?

Comments/questions: BR - Glad you brought this up and glad you took a few minutes to expand what you are looking for. We just started 6CS and did a lot of research on culture of our organization, we decided to take

this on at the beginning of the year. They are using the New Zealand checklist as our NorthStar. We have a very energized group of staff and leaders who meet on a regular basis. We are starting with 3 of the strategies and doing work on that regularly. There is a shift and staff are noticing it, not as much S/R. In terms of holding fidelity, as this gets imbedded in our work, that they will know it is a trauma informed organization and to use S/R as a last resort. We are very committed to this work. Workplace injuries have gone down by half.

Kevin H. – you have identified an extremely important issue. It is not just about eliminating EIPs but that is the first and most important step. Looking at that type of data, in the future we will want to measure patient satisfaction, would I as a patient, chose to go back there if needed? A great topic for a further discussion.

RRMC: Certainly, the pandemic had a pretty big effect on the work we do at the organization, a lot of attention went to managing the pandemic, we still had a lot of the 6CS pieces hardwired in the work that we do. In April, we wanted to kick things off again for 6CS with a lot of new employees. We did an extravaganza. All of the leaders did a storyboard, highlighted some of the successes we have had with the work in 6CS. Trying to engage staff again in the committees and it was a huge success. All of our CONs are on paper, and we are looking at going at electronic documents and still trying to figure that out. Construction has been going on - All of our patients will have individual rooms, new artwork for the walls, more community spaces for patients, there will be a brand-new nursing station to allow for better access to all of the wings in the unit.

Springfield – No participation

UVMMC: working on a lot of things this year, important to acknowledge the impact of COVID. It would be beneficial to talk about the impacts the state has had and nationally around staffing shortages, the specialty of psychiatry and closures of the beds around all of the organizations. Some of these previous EIP meetings, we have an in the moment debrief process, but we have started to incorporate different educations/debriefings, deeper dives into events/situations. We are going to be doing more of an EIP review and documenting more closely, looking for trends. ProAct debrief is going to happen possibly every three months. We are in the middle of a technology upgrade project.

VA: One of the main ways we were affected by COVID, the inability to do PMBD trainings. We are catching up, trying to get staff trained.

VPCH: We feel like we are also in some recovery stages from COVID. Our educational and training team is developing a training for nursing and MH specialists. High quality and high caliber training is important. We are looking at our EHR. Getting a selection of furniture for the common area. Looking at debriefing as well.

Comment: RRMC is replacing their crisis de-escalation model, going to ProAct. That is something to be commended. At BR that has been mentioned and well deserving, the Peer Specialist position is back under recruitment.

Comment: Excited to see how this committee grows and changes with more participation that we have had in the past, figure out how to make it work for everyone.

**Quarterly EIP Report: Jan-Mar:**

- 3 EIPs administered to youths.
- January most EIPS with 157 total with 61 in February and 68 in March
- Manual restraints dropped from last month, similar drop in emergency medication, slight drop in seclusion and manual restraint.
- Most of the EIPs are administered on Level 1 units with the most acute patients.
- There were 2 EIPs administered by the VA [doesn't usually have any]

- T4 is where most o the EIPs were administered over the quarter, with RRMC and VPCH following.
- Per patient EIPs – most involuntary patients do not receive any EIPs, 11 patients had between 1-2 EIP's
- All units combined looking at the national average – trend is downward with all units combined.
- New slide - when the first EIPs occurred during the stay.

**Voluntary Report – from BR**

- There are more voluntary EIPs administered to youth than adults. 11 to 17, depending on the month, per month.
- There were 19 in Jan, 61 in Feb and 57 in March.
- The majority of them are administered on Osgood 1, T4 is included now in the report, but there were none this quarter. We can calculate the total hours of EIPs.

Comment: Looking at the chart quickly, just reminding that there is a larger number of voluntary patients, then involuntary. Looking at how hospital changes improve things, hoping we can come up with a suggestion on what a future report could look like to show this.

Comment/Question Period:

Comment: Thank you Alex for being the lead on this. There were a lot of great ideas talked about today.

Comment: Suggestion – one of our concerns around the CONS documentation is that it typically does not reflect or have a requirement to document the patient preference that is part of the EIP statewide standards. How to look towards better documents, how is patient preference being obtained, being operationalized?

Comment: Echo the chat comments for the Retreat doing really good well, RRMC as well. What I heard in the presentation is not just the facts of the data, but a positive energy and spirit that goes with it. It is very hard work to do this, but especially during COVID. Love the great tone of this EIP meeting.

Comment: Great comments, just want to second the really robust participation on the part of all the members. Part of being high quality health care system is honesty, being encouraged to put out thoughts and challenges to each other.

## Chat Transcript Notes

*From Ward Nial (he/him) to Everyone:* At one of the meetings that Kevin Huckshorn spoke at she stressed the importance of following the strategies with what she called fidelity. I was wondering how we plan or are evaluating the fidelity that each hospital is achieving.

*From kevin Huckshorn to Everyone:* Just a note about comparing facilities. It is extremely difficult to compare one facility to another facility as each one has a number of different variables that impact the use of EIPs including staffing ratios, line of sight, internal practices, staff competencies/roles, staff supervision issues, staff turnover rates, presence of peer staff, definitions of imminent danger; the list goes on. Comparing facilities is somewhat similar to comparing individual humans. That said, it is why the facilities baseline is the most important factor to compare to. Hope that makes sense.

*From Ward Nial (he/him) to Everyone:* … Currently it seems that DMH tracks progress on EIPs by looking at the absolute number of EIPs or the trend over time. This is interesting but not overly useful based on my understanding of the six core strategies. Six Core strategies is a quality improvement approach that has a goal of driving the EIPs to zero in each facility. Six core strategies is still applicable and needed when EIPs have been reduced to zero or near zero. When EIPs become near zero it seems evident that something else needs to be observed. And that becomes fidelity to the process and the culture that achieves zero EIPs. The process assumption is that zero EIPs will be reached when the underlying physical space, processes and culture in each facility removes the conditions that cause someone to escalate. My question is… What is the process that DMH is using to assure that each hospital is following the six core strategies with the greatest of fidelity?

*From Tom Weigel to Everyone:* DMH is adding a review of patient care experience surveys to their Designated Hospital re-designation quality reviews.

*From Tom Weigel to Everyone:* https://www.nri.blueunderground.com/ics-brochure All hospitals use this survey or something similar. It is required by the Joint Commission.

*From Michael Sabourin to Everyone:* one thing that has been discussed in past and has never surfaced to this committee is a root cause analysis for problematic situations

*From Michael Sabourin to Everyone:* regarding Kevin's comments - I want to agree to disagree - it's hard to address problems if we choose not to address them- discrepancies between facilities are usually indicative of something

*From Suzanne Leavitt to Everyone:* Does the data in the report specify restraint procedures in the emergency department?

*From Ward Nial (he/him) to Everyone:* Do I misunderstand the six core strategies? Aggregating data across facilities does not seem consistent with 6CS

*From Emma Harrigan, VAHHS (she/her) to Everyone:* Please make sure the y-axis for these charts match across the involuntary and voluntary reports

*From Ward Nial (he/him) to Everyone:* The Supplemental data looks interesting

*Laurie Emerson, NAMI Vermont to Everyone:* It is concerning that voluntary youth receive such a high # of EIPs.

*From Ward Nial (he/him) to Everyone:* I think the Hospitals should look at the type of data they need to manage their 6CS it doesn't seem like DMH should be dictating what the format is. Though consistency across hospitals would help us advocates

*From Emma Harrigan, VAHHS (she/her) to Everyone:* I agree Ward, I do think we can achieve something that is consistent and valuable