

Adapting and Implementing New Strategies for
Patient Centered Care – Transforming Care where
we meet our clients in Behavioral Health

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Patients and Families as Care Partners
April 20, 2011

Little about us...

- Contra Costa Regional Medical Center (CCRMC) is a 166 acute-care public hospital in the SF Bay area
- Receiving center for all psychiatric emergencies (adult and child) throughout the county including involuntary holds (5150) and voluntary presentations
- Approximately 20 beds in Psychiatric Emergency
- 15 bed adult inpatient unit



Patients came to us in crisis, but did not stay....

- Prior to May 2010
 - Patients with a behavioral health crisis were brought to the medical emergency room via walk-in, ambulance or police,
 - Patients waited for an average of six hours to be seen for a medical clearance then were sent to the Crisis Stabilization Unit
 - Patients frequently left without being seen or AWOL'd

Rapid Quality Improvement Events

- 2009-10 Kaizen Events began to improve CHF care
- Grant funding demanded we include patients in improvement process

What is a Kaizen event?

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- Modeled after the Toyota production model
- Focus on concentrated time (one week) of stakeholders (staff, consumers, family members)
- To look at current state and remodel into a future state
- Equals about 400-800 hours of improvement time

Establishing the HCP

- After the first Kaizen event, the Healthcare Partnership was initiated
- Primarily of mental health consumers and family members
- Poised to make big changes in quality of all care

What about us?

- Patients/Consumers of psychiatric emergency care wanted in on the action
- Passionately wanted to change the current state for psychiatric consumers
- Wanted access to psychiatric emergency services through their OWN door
- Asked us to perform a Kaizen event for psychiatric emergency services

Framing the problem

Gathered the stakeholders

- Patients
- Family members
- Physicians (psychiatrists and emergency room MD's)
- Nurses & therapists
- EMS staff
- Police departments
- Fire and rescue
- Detention (jail) staff

Told their stories

- What is it like to “go crazy” ?
- Equipment “show and tell”
- Understanding each other outside of an emergency
- What can be changed and what must remain in policy

Open the Door!

- These were the needed changes identified by ALL stakeholders:
 - Quicker access to care
 - No medical emergency room waits
 - Make access friendly and inviting
 - Change the name of the Unit from Crisis Stabilization Unit to Psychiatric Emergency Services

Kaizen Event

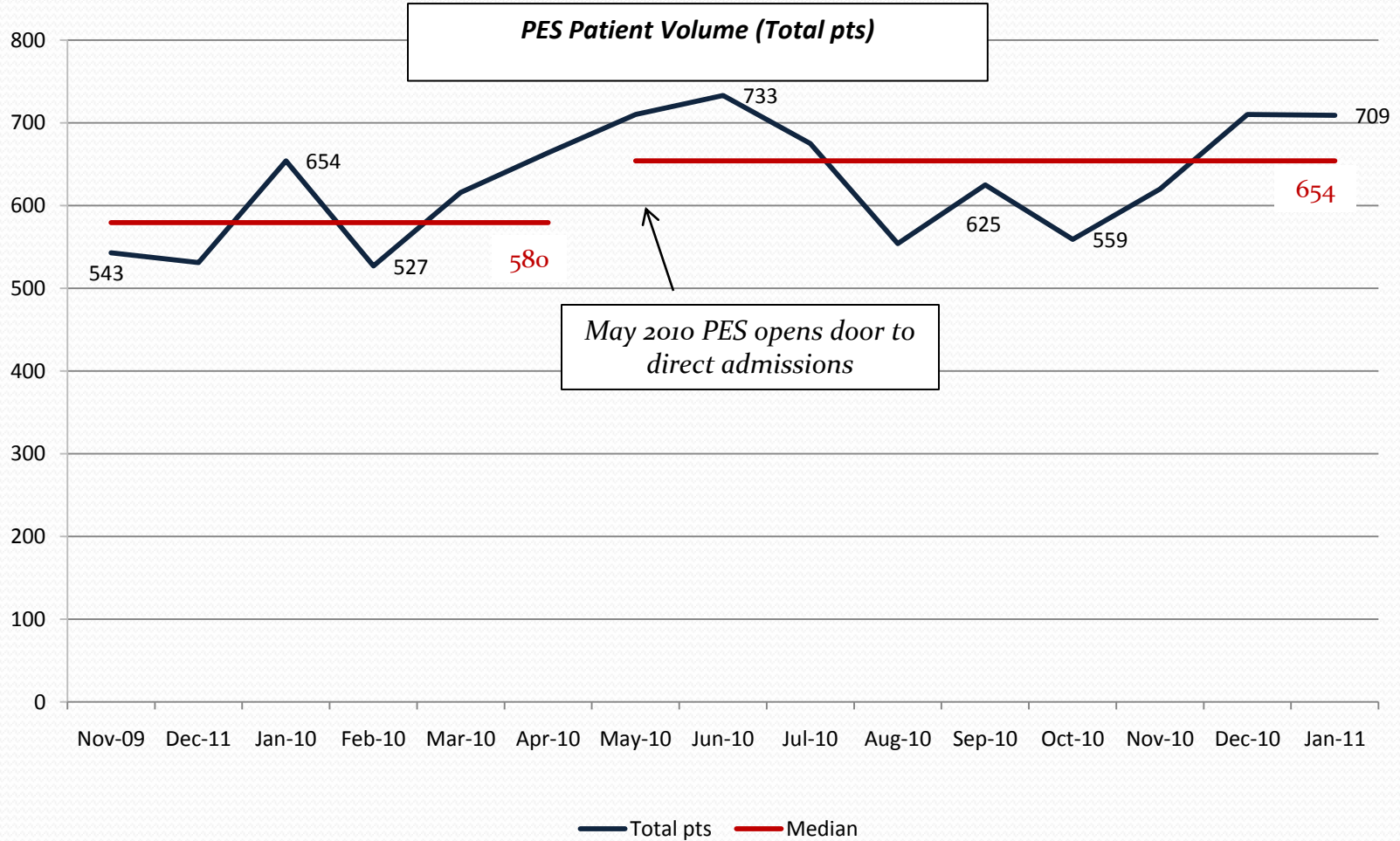
- Invited patients and families with staff and law enforcement into the psychiatric crisis unit to look at current state
- Redesigned forms
- Developed a multidisciplinary “welcoming policy”
- Standardized “safety check”
- Redesigned psychiatrist work flow to include a Medical Screening Exam (required by law)
- Brought in a television for patients to watch while waiting

Prepare to be Welcomed!



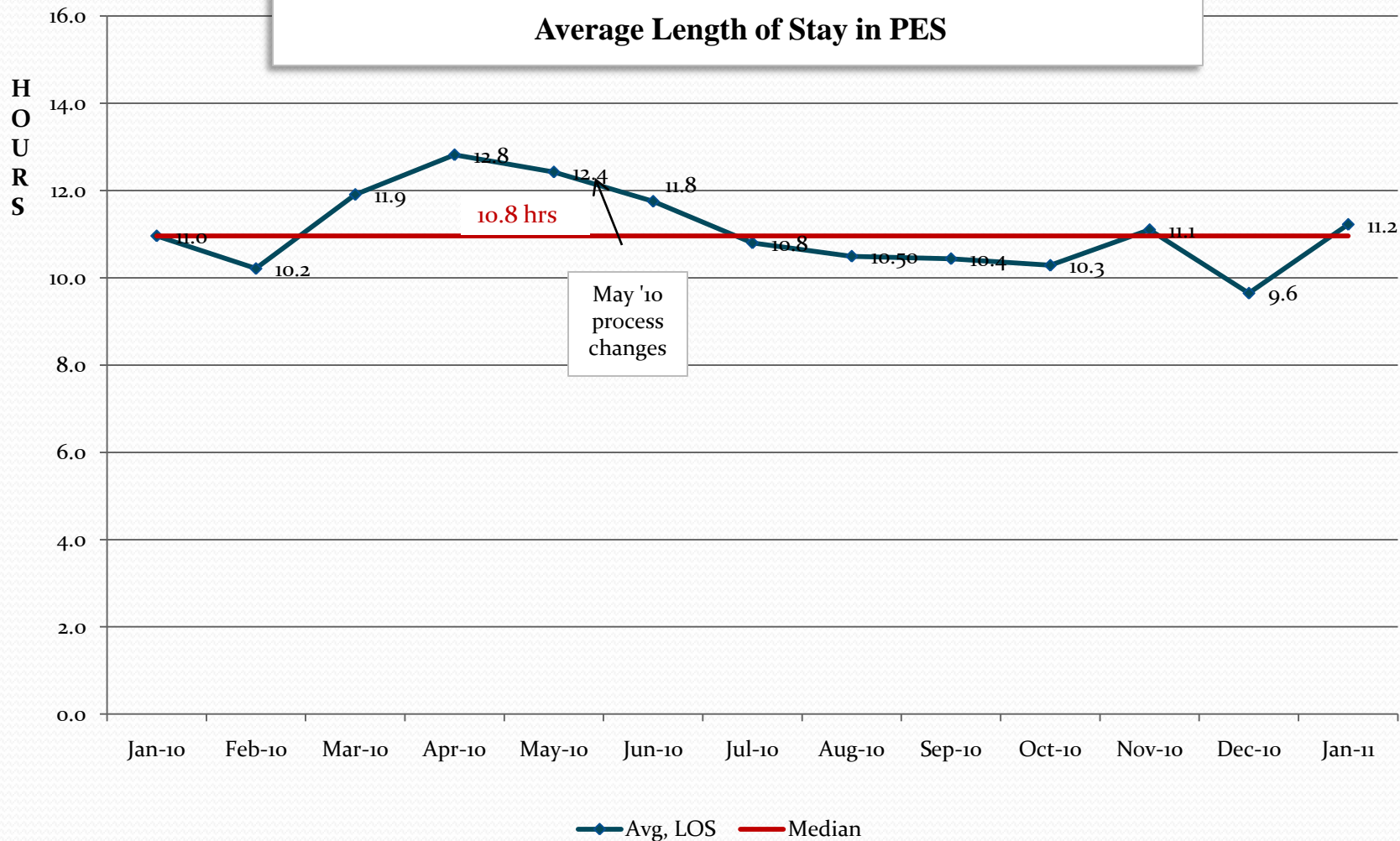
May 17, 2010

- External door to Psychiatric Emergency Services was open to direct admissions
- No more waiting in the Emergency Department to be seen!
- WE GOT NUMBERS.....

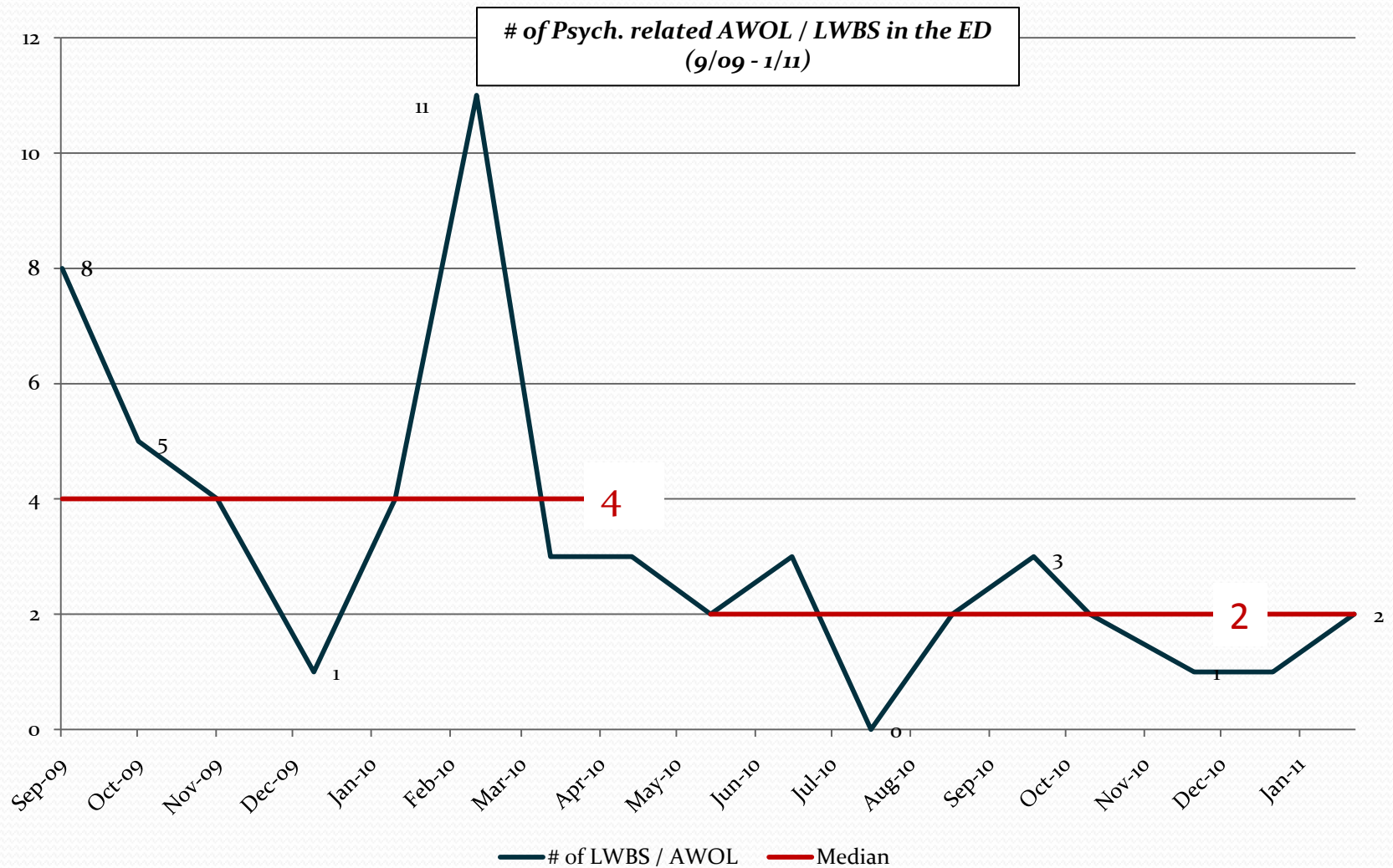


The number of patient's who seek PES services has jumped by an avg. of 66 pts per month since the 5/2010 process changes, indicating consumers are now more willing to seek PES services.

Average Length of Stay in PES

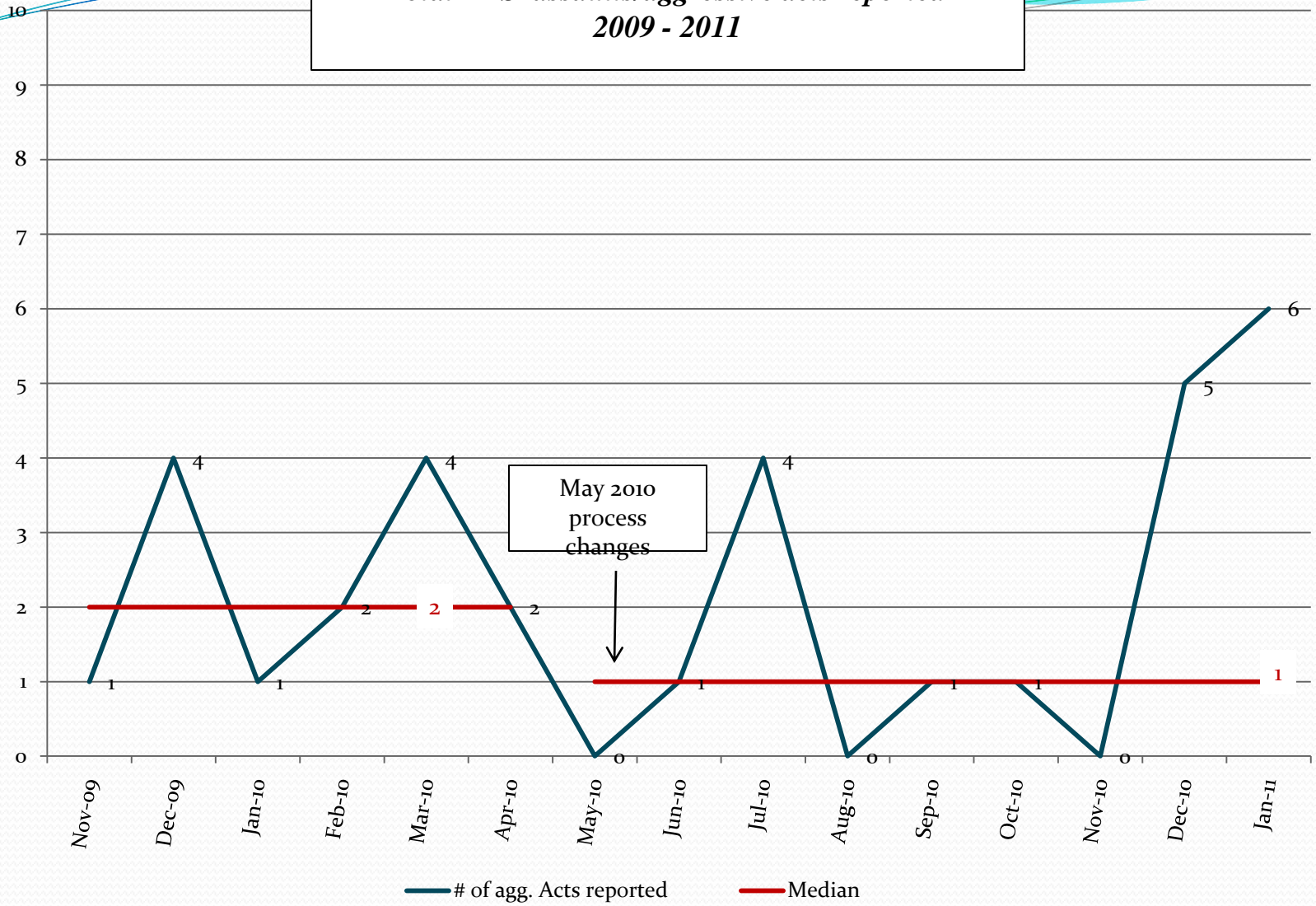


ALOS of patient's seen in PES does not reflect the additional avg. of 300 minutes per patient required for ED medical clearance prior to the May 2010 process changes.

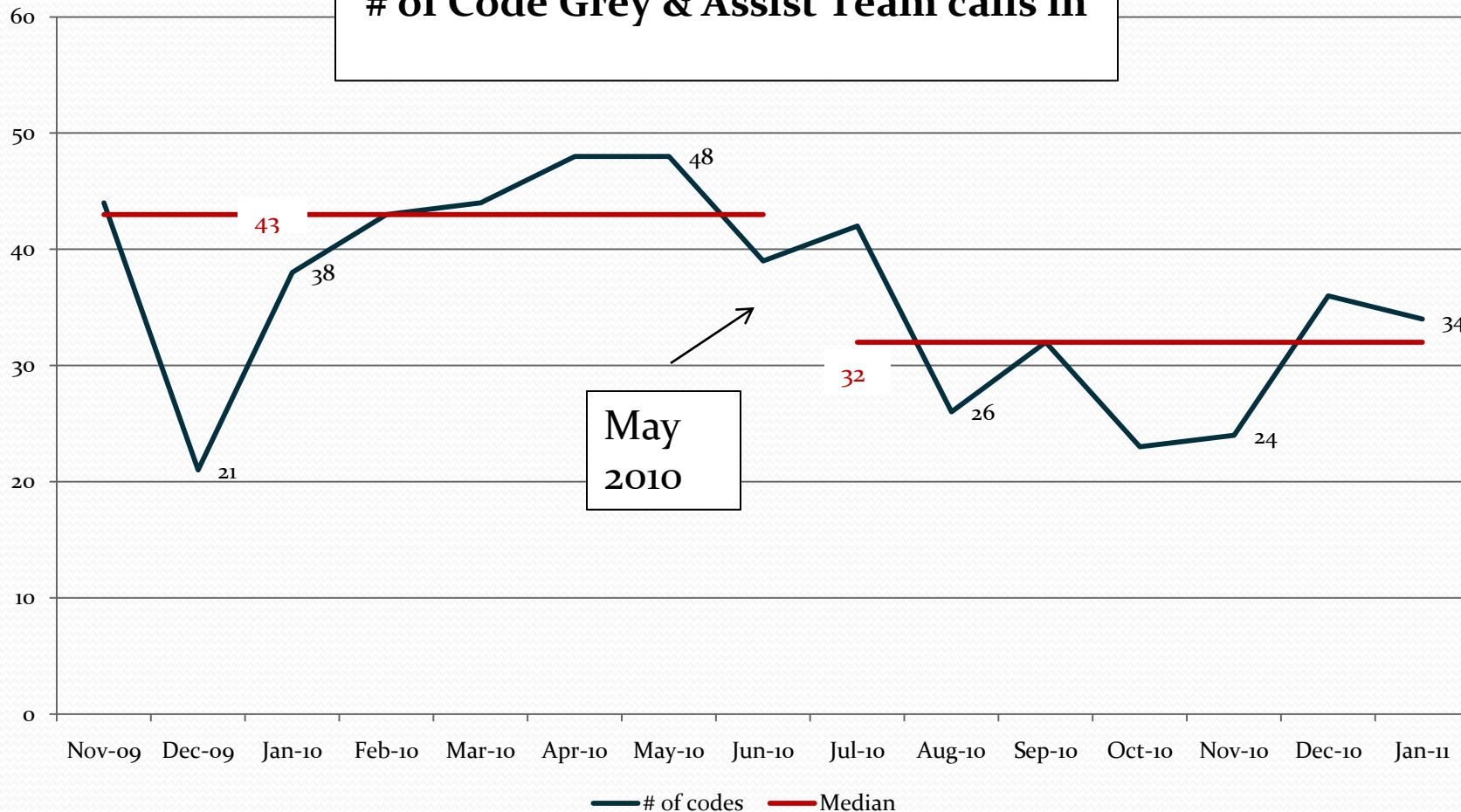


The avg. number of psychiatric patient's who AWOL'd from the ED prior to PES care dropped by half after the May 2010 process changes.

**Total PES assaults/aggressive acts reported
2009 - 2011**



of Code Grey & Assist Team calls in



More effective and patient centered care in the PES is demonstrated by a decrease in what is known at CCRMC as "Code Grey" and "Assist Team" calls. These are rapid response type teams which respond to acute behavioral emergencies modeled after Code Blue teams in other facilities. Since the May 2010 process changes, the unit has seen a significant decrease from a rate of 7% of patients to 4.9% of patient's whose behavior escalated to the point of requiring a multi-staff response to contain (a nearly 30% drop).

Partnership has just begun.

- Continue to meet weekly
- Currently working on a Welcoming project for inpatient psychiatric unit
- Monitor progress of improvements
- Formed, Normed, currently Storming...

Continued work

- Patient and family involvement is difficult, time consuming and fraught with pitfalls
- Finding the right fit for the partnership is important
- All “roles” are thrown aside during meetings
- Meetings have been contentious and intensely frustrating for all members

- It is the only effective manner to sustain lasting change..

Valuable lessons

Persevere through disagreements and frustrations,
Keep perspective – we are in this together for better
patient care,

Check your histories at the door – this is for the future
state of care, not the past,

All members must be committed to the outcome

Some members will not stay – it's ok,

Measure progress with data not just anecdotes.

Questions & Comments

- Questions, Comments and Feedback?
- To Contact Presenters or for further information:
 - Peter Brown, Executive Director - Peter@IBHI.net
 - (518) 732-7178 or
 - Alden (Joe) Doolittle, Co-Executive Director - Joe@IBHI.net

Announcing an IBHI Virtual Learning Collaborative on

Avoiding Unplanned Re-Admissions

- **Aim:** Assist participating hospitals and communities to reduce rate of behavioral health consumers unplanned returns to inpatient status within 30 days of discharge by 10 %
- **Method:** Build a learning community through an interactive web-based application of Institute for Healthcare Improvement (IHI) the Transforming Care methodology. The approach brings together Model for Improvement, Idealized Design concept and a concept of Innovation; to re-design processes of care for new standards of performance.
- **Schedule July, 2011 – March 20, 2012**
Initial Web-based Learning Sessions July 18 & September 26, 2011(2 half days)
- **October 3 , 2011— , March 20,2011 - Bi-Weekly** review of specific changes and results via conference call; expert –resourced conference calls, possibly one two day live meeting
- **December 12 &13, 2011 – Two half day** Webinars on areas of interest and initial results, including outside experts on specific issues – possible live session
- **March 19 & 20, 2012** Two half day Webinars Sharing results and celebrating success.
- **Cost Organizational Membership**

For More information contact either Peter Brown of Joe Doolittle at Peter@ibhi.net, or Joe@ibhi.net

IBHI Innovation Webinar Series Continues:

- **Hold the Dates: Innovation and Re-Design to more fully integrate Primary Care and Behavioral Health Series begins**

o May 25, 2011

o June 8, 2011

o July 6, 2011

All webinars begin at 3:00 PM EDST.

- **Completed Webinars in 2011 -see www.ibhi.net for PowerPoint Slides and related articles**