Emerging Patient and Family Engagement (PFE) Story

RI International

In what way were persons, family, and community members involved in the implementation of this PFE intervention/program?
- Surveyed
- Informal interviews/ad hoc feedback
- Patient/Family member suggestions

When were patients involved in the implementation of this PFE intervention/program?
- During the planning stages of the intervention
- Patients were involved from design through evaluation
- Peers (people with lived experience defined as having received prior mental health or behavioral health treatment) were members of the design team.

PFE Metrics and Concepts that were integrated into Plan-Do-Study-Act (PDSA) effort:
- Metric 1. Person & Family Voices in Governance & Operational Decision-Making
- Metric 2. Shared Decision-Making

Patient and Family Engagement Concepts:
- Listen to Person and Family Voice
- Respect Values and Preferences
- Collaborate with Persons and Families

PLAN

RI International is an organization that offers services in crisis, health, recovery and consulting. The crisis program in Peoria, AZ is a Recovery Response Center (RRC) and is a Crisis Stabilization Program. The program served 5,300 individuals in 2017 with 81% of those served in the facility arriving in the back of a police car. The practice identified having a problem with the intake of patients who were in crisis brought in by the police and developed a project to address.

Fundamental to this project was the input from peers. Peers bring lived experience to the workplace and the members they interact with. RI International has employed persons with lived experience at all levels of the organization for many years. Additionally, RI International has 116 team members on the RRC units and 35% are in peer roles. As a company, approximately half of the employees have lived experience.

This performance improvement project was initially started in 2014 and has been conducted in phases.

Phase 1: The first phase, that began in 2014, was largely focused on becoming better partners with law enforcement through a process that started with accepting all law enforcement drop-offs without a screening process. The practice delivered crisis stabilization care and patients who were brought in by law enforcement officers had higher rates of emergency department (ED) visits and incarceration.
This initial step contributed to increasing the number of individuals served and provided diversion from EDs and (2) incarceration.

The practice then worked with staff, clinicians and peers to understand the processes and determined a need to display information. The dashboard design that followed in 2016 then supported improvements in throughput; creating a more efficient resource that lowers cost of care in the behavioral health system by continuously evaluating performance in terms of length of stay, readmission rates, diversion success and metrics viewed as essential to increasing referral volume (which again contributed to diversion from EDs, jails and acute inpatient admissions).

**Phase 2:** In 2018, based on peer and patient feedback, there was increasing awareness that the facility design was not optimal for patient flow and throughput. There was a greater emphasis on the physical environment in a manner that improved the experience of those served in the program in a manner that increases satisfaction, enhances diversion numbers, lowers use of seclusion/restraint, shortens time to stabilization and strengthens relationships in a manner that enhances the connection to ongoing care with outpatient providers (achieved through peer connections). The 2018 project phase was initiated by patient feedback to improve their ability to address the experience of those they serve in their crisis observation /stabilization unit. The practice had high volume demands, high rates of seclusion and restraint incidents, high average lengths of stay and readmission rates and sought to increase the number of individuals served, guest satisfaction and conversion rates of involuntary commitments to voluntary treatment. See table 1 for baseline and post data.

To summarize, the intervention was a two phase plan: 1) design and implementation of the practice that included CrisisTeach360 dashboard that provides data to the practice and 2) facility redesign based on feedback from peers, patients and the clinical teams, as well as re-design the facility by getting input from peers (workforce of Peer Support Specialists who transform their past experiences into healing for others).

Phase 1 was informed member and stakeholder feedback that drove a collaboration with Behavioral Health Link to design the dashboards. Phase 2 was largely designed by feedback received from those directly receiving services at the site, their family members and RI team members, including peers with lived experience.

**DO**

RI International partnered in the design of the CrisisTech360 Dashboard that offers real-time and monthly data views to support the evaluation of progress in addressing these metrics. Additionally, facility redesign efforts were informed by peers on the service delivery team (approximately 1/4 of those working in the program) and those who were actually receiving services at the facility.

**How was the change managed internally? (staffing, training, etc.)**

RI’s planning team is comprised of leadership, the direct care team, individuals receiving services and peers working for RI that fall into all these categories. RI’s planning team reviewed baseline data of care
delivered to individuals who are in a mental health crisis and typically brought in via law enforcement drop off. The baseline included longer lengths of stay, fewer law enforcement diversions that resulted in incarcerations and emergency room boarding, and higher rates of seclusion and restraint.

The team identified opportunities to improve throughput and the patient experience by engaging in the two phased approach to quality improvement.

The program has two phases:

Phase 1: Dashboard development and training to improve throughput and crisis stabilization

The initial dashboard design was geared towards effort to increase efficiency in a manner that lowers cost of care. Metrics such as law enforcement drop-off time and % referred by law enforcement were put in place to measure how successful efforts were to partner in a manner that increases diversion from EDs and jail in a manner that also translates into serving more individuals with the existing resource, therefore lowering cost of care. Length of stay, readmission rates and diversion from higher levels of care were also important to efforts to truly lower the cost of care while also pointing towards better health outcomes. The inclusion of seclusion and restraint numbers and total number served have furthered that effort. Although the initial design did not include a formal process of gather input from individuals served in the crisis facility, it was informed by peers on the team with 50% of RI’s team reporting their own lived experience. Dashboard redesign efforts are currently underway to incorporate satisfaction data and a balanced facility performance metric based on feedback received during the 2018 quality improvement efforts that have been informed by those served by the program.

Using member and stakeholder feedback, RI designed a dashboard to measure and drive performance and improvement around law enforcement engagement, lengths of stay, utilization, the use of seclusion and restraint and readmission rates.

The dashboard provides a view of real time occupancy, length of stay, percentage referred by law enforcement, and high acuity members. The dashboard also offers monthly views of readmission rates, census count, and diversion from acute inpatient, seclusion and restraint and hand off time. The CT360 dashboard view that follows represents the 30 day look back at (1) occupancy rate, (2) performance related to target length of stay for the program, (3) number served, (4) % of individuals served that were discretionary law enforcement referrals, (5) % of individuals who escalated to a higher level of care, (6) readmission rate, (7) seclusion and restraint volume and (8) average time for law enforcement drop-off in minutes.

Staff and peers underwent training on the use of the dashboards to help facilitate the disposition of patients who were in crisis. Staff and peers collected patient feedback and measured performance in defined metrics while also evaluating alternative metrics for inclusion in future dashboard designs.
Phase 2: Facility Design - to enhance the patient experience

RI International engaged in a comprehensive campaign to change the way services were delivered on the unit; emphasizing an engaging approach to meet the unique needs of individuals in a mental health crisis who typically arrive via law enforcement drop-off. Every employee, including peers (those with lived experience), attended a live training and monthly meetings around progress continue. Employee safety surveys have been taken and staffing ratios were increased to address the need for higher flow with the limited number of chairs/beds.

Facility redesign activities that have already been completed include: changing colors on the unit, moving observation chairs into conversational layouts, added tables and chairs throughout the facility, offered on-going group services, incorporated murals throughout the facility and redesigned space to offer additional private space for members.

Efforts are underway to expand the space based on additional feedback from those served in the program as well as the staff and peers. Expansion will include a smaller separate six chair space for individuals with high acuity needs; reducing disruption to others and supporting more focused care for those with needs for this alternative environment. RI International has not asked for any capital support in making these programmatic changes designed to improve care while lowering overall health care costs.

The design of the existing space is largely completed with the last phase of construction is scheduled to begin in October 2018, leading to the addition of a high acuity area with 5 crisis stabilization chairs and an additional seclusion and restraint room. The program is adding a direct door from the law enforcement drop-off area to the existing seclusion and restraint room to minimize unit disruption during drop-offs that require these types of interventions. Construction is scheduled for completion in December 2018.
What barriers did the staff identify and how did they address them?

The physical environment met licensure expectations for space demands but was not necessarily conducive to delivering care that aligns with the exceptional practice standard of retreat or living room “home-like” environments. RI did have to lower the total number of chairs to create the desired environment and to also align with Joint Commission expectations that there be no more than 8 people in an environment in which the person might sleep as part of their 23-hour service delivery period. Length of stay was impacted by duration of time needed to engage and the modified environment immediately influenced outcomes in that area, but the current lack of a separate high acuity area does mean that an escalated guest may adversely impact the experience of others on the unit. Expansion of the facility is pending approval by the city and then licensure.

STUDY

Early returns from the implementation of the dashboard resulted in decreases in length of stay which escalated program capacity to serve more individuals in the program. These higher numbers were able to be served despite escalation in the acuity of those served by the facility that has been quantified by the percentage and overall number of individuals arriving via law enforcement drop-off.

The table below represents the programs increased ability to serve more individuals and a significant escalation of in the numbers of individuals being diverted from law enforcement alternatives of emergency department drop off or incarceration. Law enforcement has been able to drop off an additional 2,050 individuals, which is a 91% increase over a 3-year period. RI has increased the number of members served by 35% over this same period.
In addition to supporting RI’s ability to measure and evaluate performance through the dashboard, as a funder, Mercy Care has access to this data as well. Phase 2 activities resulted in the following:

1. Reducing the number of observation chairs in the open area of the facility from 15 to 8 (17 additional chairs are located in rooms that contain no more than 2 chairs each);
2. Rearranged chairs from rows facing a single direction to conversational style arrangements;
3. Added more tables and chairs to support interaction / engagement;
4. Painted the walls based on colors recommended by peers;
5. Added murals with themes identified by those receiving services on the unit at the time that were painted by peers; and
6. Offer interactive group support opportunities throughout the day.

What key goals or measures did the practice meet?
Increased the number of law enforcement drop-offs at the facility by 91% from 2014 to 2017;

Increased the number of individuals in mental health crisis served in the facility by 35% from 2014 to 2017;

Following changes to the facility that began on February 1st, 2018 and continue today, there has been a 29% decrease in the average number of monthly seclusion and restraint incidents with only one month out of the previous seven having 35 or fewer incidents while five of the six months since the change have been below this threshold; and

Dramatically improved Joint Commission safety and quality review performance with only one finding during the last one site review that was resolved before the reviewer left the facility.

ACT

RI international is also focused on achieving additional outcomes that are more difficult to quantify but important to monitor with the best available resources. These include diversion success. 50% of those who arrived by law enforcement arrive as discretionary drop-offs, representing individuals who would otherwise be referred to emergency departments or incarcerated for misdemeanor offenses. Over the past four years, RI International has accepted approximately 12,000 law enforcement referrals without a refusal. This translates into true cost savings to the healthcare system, particularly when one considers the two day average length of stay in the adjacent subacute facility that has a lower per diem rate than the AZ Medicaid published rate for a psychiatric hospital bed. Therefore, cost savings can be calculated within the following factors:

- No cost on healthcare system for transport by law enforcement ($316 Medicaid transport rate);
- Low demand on law enforcement with average drop-off time under three minutes (justice system savings);
- 96% of individuals served did not require referral to ED for medical clearance (average cost estimated at $1,233);
- Lower per diem rate in subacute than psychiatric hospital; and
- Lower average length of stay (two days) than typical psychiatric hospital which is estimated to be at nine days despite high acuity served by RI International (81% were law enforcement transported).

**How did Pii support the successful outcome?**

The Pii team continues to be a source of support for the RI International team. Regular discussions are held to review approaches to better using data and alternative ways of evaluating success around larger system outcomes when data may not be readily available. Pii has also helped by informing future service delivery design in our Peoria campus of care that will soon add a non-IMD 16 bed unit and an integrated outpatient program. The driving force behind this addition has been data showing that RI International serves approximately 150 Medicaid enrolled members each month who are not currently engaged by an
outpatient treatment provider and often have co-morbid physical health conditions that are not being addressed.

**How/Can the workflows, project plans, etc. be scaled up, utilized by other practices or otherwise drive further change – in the same practice and among others?**

RI international continues its development of tools to support crisis system design and evaluation to better serve members and makes information broadly available through posting in NASMHPD’s [www.crisisnow.com](http://www.crisisnow.com) website. RI International has published documents, presented with Arizona’s Medicaid Director on two occasions nationally, posted business case videos and shared system analytic tools that support efficient design of crisis services based on community specific data (example below of RI International-developed tools from the Crisis Resource Needs calculator as well as self-assessment resources).

RI International has a continuous improvement process related to infuse patient and family voice into all operations of the organization. For instance, RI Internal employees peer with lived experience in all settings and at all levels of the organization including leadership. Additionally, surveys are conducted to infuse personal preference and choice into all areas of operation. Survey’s responses are tracked and trends are identified.

**PFE Intervention Positively Affected a TCPI Aim - Which of the TCPI Aims were positively affected**

- Practice Transformation
- Effective Solutions Moving to Scale
- Reduced Avoidable Hospitalization or Emergency Room Usage
- Reduced Costs
- Documented Value

**PTN Assistance:**
RI International has been commitment to Patient and Family Engagement initiatives for many years. They pioneered the value of employing members with lived experience. The TCPI PFE milestones around PFE reiterated the great work already going on with peers and families however, RI International is always ready to raise the bar again. TCPI’s influence was to continue the already on-going conversation at RI International

**Through what means did the PTN prompt your practice to strengthen the PFE effort?**

- One-on-one coaching
- Peer-to-peer engagement