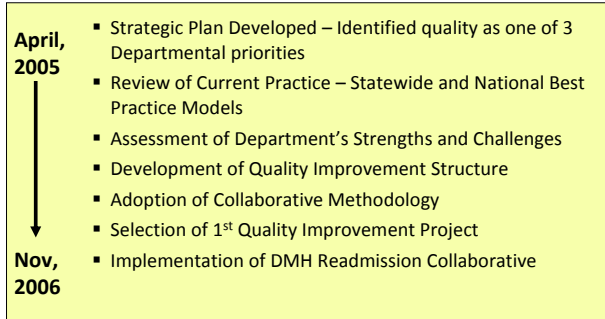




PLANNING FOR CHANGE

Timeline



QI Project Team
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A Statewide “Learning Collaborative”

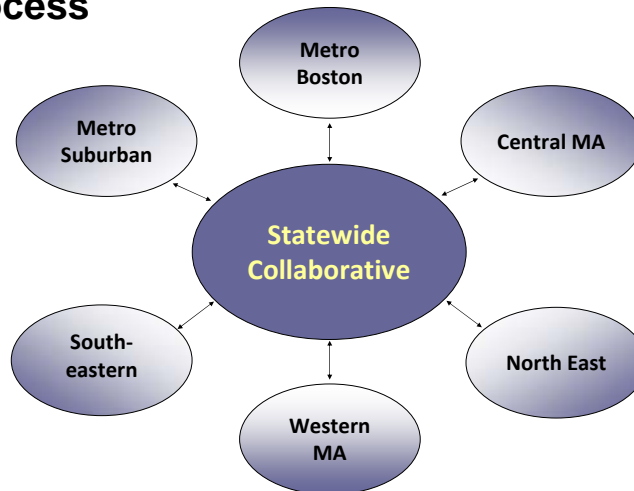
- Utilizes “real time” training and process improvement methods to improve a clearly defined systems problem
- Solutions are generated and implemented at local (Area) level; learning is shared throughout system
- An innovative approach to Quality Improvement and to reach management goals
 - Emphasizes the adult learning model
 - Values many creative solutions for learning
 - Successful in large, complex systems and public-private partnerships
 - Uses Plan-Do-Study-Act cycles to create change
- Projects are informed and successes determined by data

The DMH Readmission Collaborative was the first state-wide behavioral health collaborative in the nation

Change Process

Problem Statement:

Approximately 30% of inpatient psychiatric admissions for DMH consumers covered by the Massachusetts Behavioral Health Partnership (BH carve-out) result in re-admissions to MBHP inpatient psychiatric facilities within 30 days post discharge



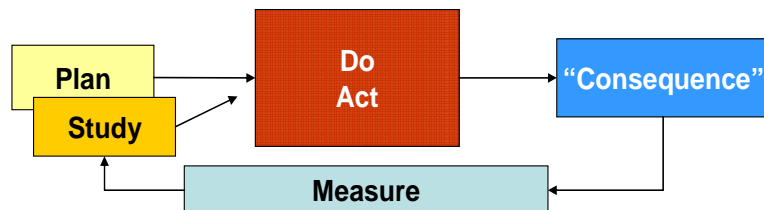
Goals:

- Reduce readmissions
- Increase linkages between levels of care
- Increase integration within & between systems
- Implement quick, “real-time” solutions
- Training in quality improvement methods
- Develop culture of quality from “ground up”

Change Process:

- Statewide Collaborative format
- Each DMA Area form local change team
- Meeting held every other month
- Membership includes MA-DMH Central Office and Area staff, MBHP, consumers and providers
- Phone support

PDSA Cycles

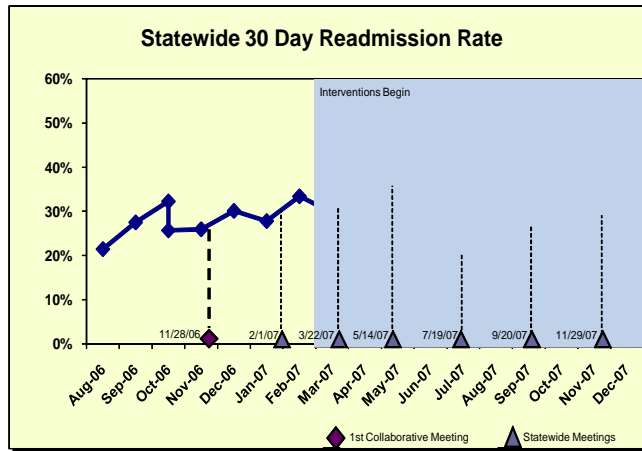
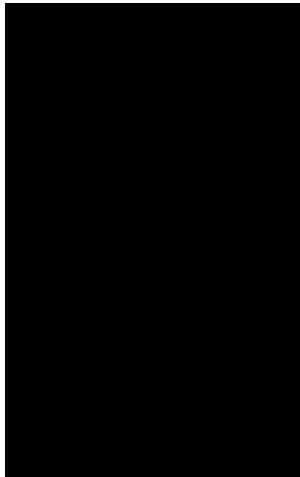




IMPLEMENTING CHANGE

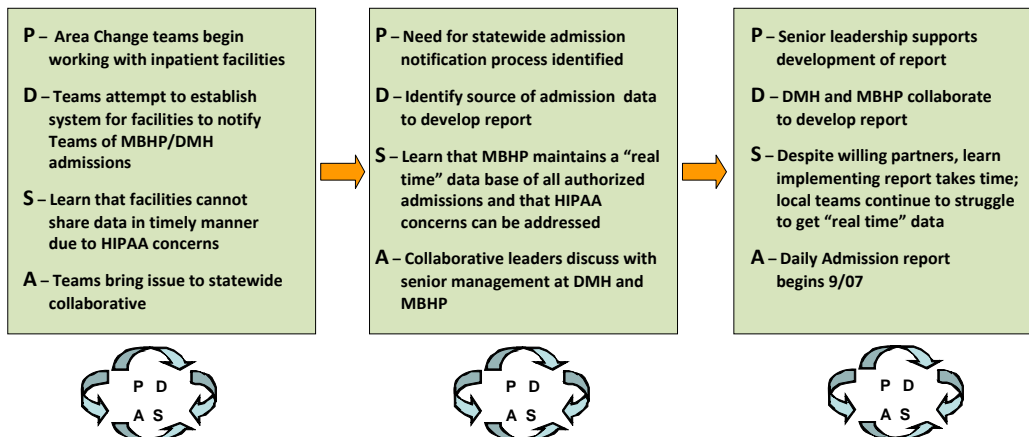
Aim, Measures and Interventions

Area	Aim Statement
Southeastern	The Southeastern Area will reduce hospital readmission rates by 25% for adults served by DMH and MBHP by identifying potential causes of rehospitalization and developing interventions with Pembroke Hospital and MBHP.
Western	Western MA Area seeks to reduce readmission rates for DMH clients enrolled in MBHP by 5% through better coordination of DMH case management services, MBHP Intensive Case Management and hospital psychiatric units.
North East	Increase communication between inpatient and outpatient providers by 25% when complex history presents or other identified criteria are met. Increase attendance rate to first scheduled psychopharmacology appointment after inpatient stay within two weeks of discharge.
Central Mass	Reduce readmission rates for DMH/MBHP adult clients by 30% in six months by enhancing continuity of care through increasing appropriate service linkage early in admission and cross coordination to plan and implement the necessary transition back to the community.
Metro Suburban	To reduce readmissions for DMH/MBHP adult clients by 25% through timely notification of admissions; early contact between DMH staff and hospital and improved discharge planning.
Metro Boston	To identify Boston Area DMH/MBHP members who are admitted to any inpatient facility their first day of admission in order to facilitate coordination of discharge planning in the early stages of hospitalization and reduce readmissions by 3% in the pilot project.



Change Team Interventions	
Written/Electronic Communication	<ul style="list-style-type: none"> - Notify DMH of admissions within 24 hours - Develop communication tool for DMH offices to use with providers - Fax hospital discharge summary to DMH offices office, including appointments - Pharmacy provides medication history to inpatient unit on admission - Case managers/supervisors enter note in electronic health record
Care Coordination	<ul style="list-style-type: none"> - DMH case manager/providers visits hospital & attends team meetings - Expectation for inpt/outpt prescriber communication - Contact between DMH CM and hospital SW within 24 hours - DMH staff facilitates attendance at first psychopharm appointment
Treatment/ Discharge Planning	<ul style="list-style-type: none"> - Develop community transition plan, including day passes - Develop/review/revise crisis and/or relapse plans - Refer to MICA coordinator (substance abuse) - Schedule therapy appt within 7 days/psychopharm appt within 19 days

Creating Systemic Communication: PDSA in Action





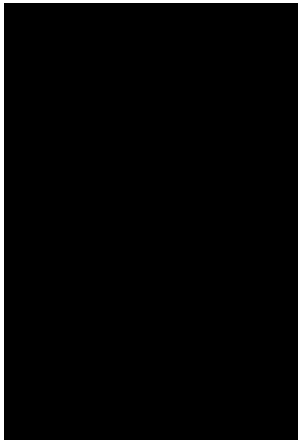
CHANGE TEAM IN ACTION

Southeastern Massachusetts

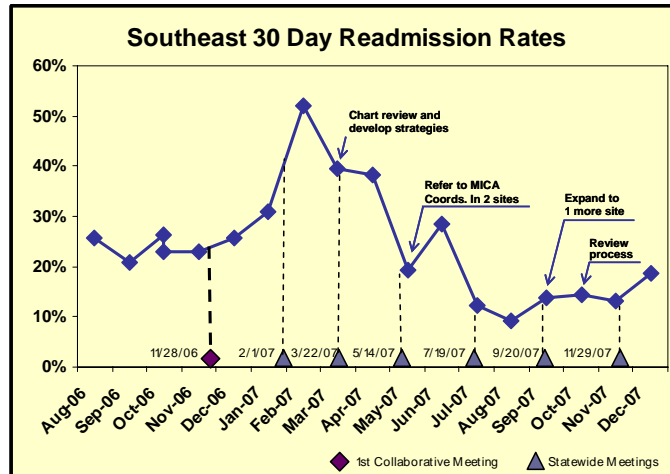
Aim: To reduce readmission rates by 25% of DMH/MBHP clients through identification of causal factors of readmission; substance abuse consultation following discharge as indicated; and revision of crisis plans

Intervention	% Achieved
1. Create a chart review tool, review records, identify causal factors to readmission, and develop change strategies.	100%
2. DMH Crisis Directors refer adults hospitalized with substance abuse as a contributing factor to MICA coordinator (substance abuse clinician) to review and consult on treatment plan.	80-90%
3. DMH Crisis Director reviews/develops crisis plan with DMH providers and admitting hospital for all clients with 2 admission within 90 days.	67%

Readmission Rates



DMH Monthly Data 12/28/07



Success Factors

- Active engagement by Senior Leadership, including Area Director and Area Medical Director
- Consistent oversight and documentation of the interventions by the Quality Management Director
- Interventions were well-defined and within the control of the Change Team to implement
- Positive collaboration between DMH, MBHP and providers
- Effective use of PDSA cycles – interventions were revised and then expanded to new sites

Summary

Lessons Learned

On Readmissions:

- Readmission rates can be decreased through collaboration among providers
- Evidence exists regarding effective strategies
- Addressing barriers to systemic communication is critical
- Lack of systemic communication can result in misperceptions, gaps and duplicative work

On Learning Collaborative Model:

- Small “pilot” projects make complex problems manageable
- Rapid PDSA cycles are an effective method of testing change
- Model allows system barriers to be identified and addressed
- Consumer and family input throughout effort is essential and needs to be supported
- Spread and sustainability need to be considered throughout process
- Collaborative members appreciate the opportunity to work across systems and address a clearly defined problem

Sustaining Change

- Maintain sense of urgency
- Keep data visible
- Spread change systematically with ongoing use of PDSA

Change is a bumpy road...

