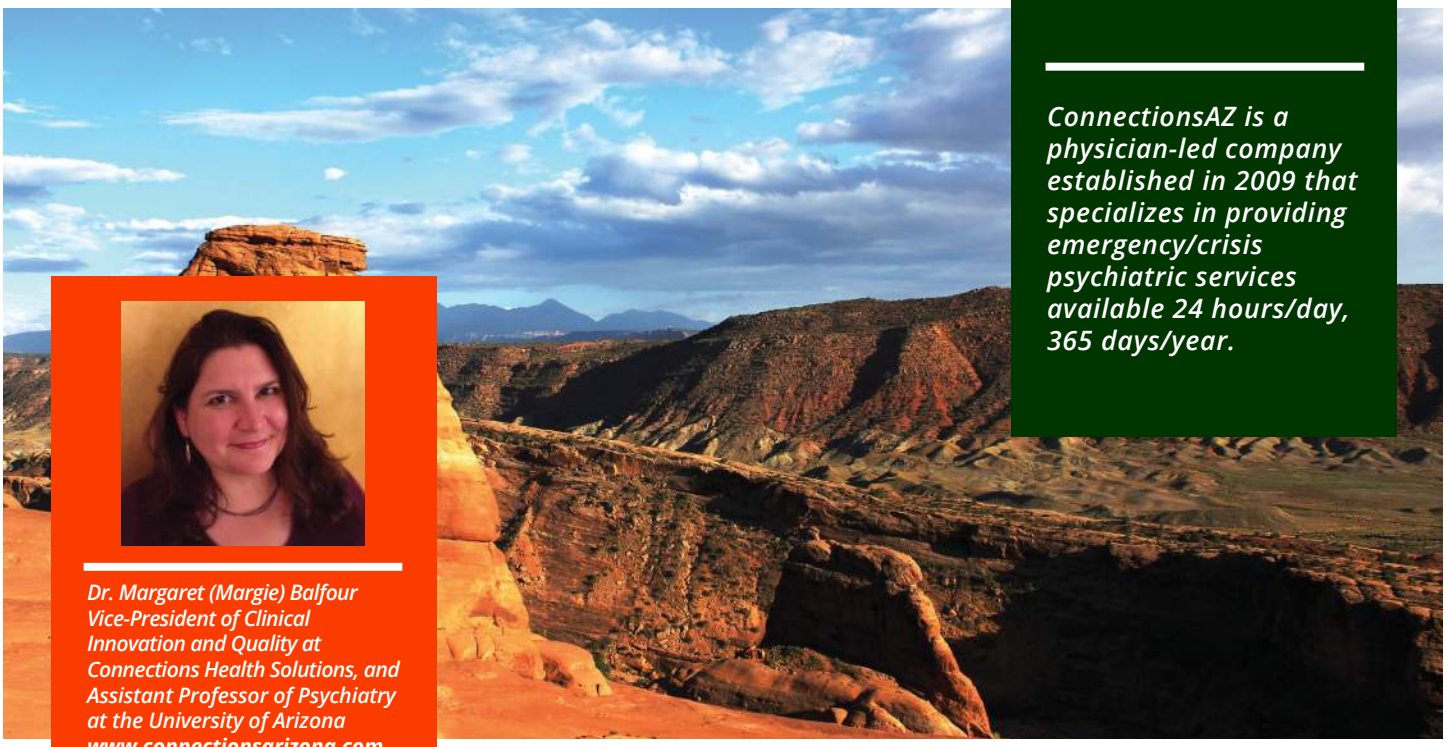
PODCAST 284: LEAN IN CRISIS PSYCHIATRIC CARE

By Mark Graban



Dr. Margaret (Margie) Balfour Vice-President of Clinical Innovation and Quality at Connections Health Solutions, and Assistant Professor of Psychiatry at the University of Arizona
www.connectionsarizona.com

ConnectionsAZ is a physician-led company established in 2009 that specializes in providing emergency/crisis psychiatric services available 24 hours/day, 365 days/year.

My guest for episode 284 of the Lean Blog Podcast, Dr. Margaret (Margie) Balfour, is the VP for Clinical Innovation and Quality at Connections AZ, one of the largest providers of crisis and emergency psychiatric care in Arizona.

Margie is also one of the authors of a recent article published in the *Joint Commission Journal on Patient Safety Journal on Quality and Patient Safety* titled "Using Lean to Rapidly and Sustainably Transform a Behavioral Health Crisis Program: Impact on Throughput and Safety," which we discussed in this interview.

Margie started off as a researcher, having an MD and a PhD in neuroscience. But, instead of wanting to spend time in a lab doing research, she had an increasing interest in delivering good care.

"I learned about Lean when I was at my previous position, at Parkland [Memorial] Hospital in Dallas, which is a large, level one trauma center. And, they had actually gotten into some regulatory trouble, a lot of it around overcrowding in the ER, a lot of it around the psychiatric patients in the ER. So, during that time, I, and one of my colleagues, we went and did our Lean Six Sigma green belt training. Our project was really around all of those psych patients who were scattered throughout this huge emergency room," Margie said. "And really trying to identify them quickly, get them seen quickly, and really tighten up the process for them."

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Margie completed her Lean training at the University of Texas in Dallas, and said that, luckily, the course emphasised that Lean is a philosophy and a management style, not just a toolbox.

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"In healthcare, I think Lean is very attractive, especially in emergency room settings, because it does focus so much on waste and in healthcare that's waiting," Margie said. "Sometimes, I think [Lean] seems [to be] a tool to increase throughput, but it's so much more than that. And, if you think about why do we have all these throughput measures? Well, it's because we assume that if your door-to-doctor time is short, then people will get treatment quicker and they'll have better outcomes."

As she explained, as someone is in a hospital longer, there are more opportunities for an adverse event or outcome to happen. Health care providers want to get people seen quickly because that's good patient care, but also, if you start treatment earlier, then you should see better outcomes as well.

This is what Margie has seen at Connections AZ, which runs mental health crisis centers that were developed as an alternative for people in mental health crisis so they don't have to go to jail or wait a long time in emergency rooms.

"It's sort of like a big psych emergency room. About half of our volume comes directly from the police, dropping people off and bringing them for treatment instead of to jail, we get people who were transferred from emergency rooms, people who walk in."

Margie currently works within a county-built crisis response center that opened 2011 in Tucson. Her organization was asked to come and take over its management because of the success it had in with the urgent psychiatric care center in Phoenix.

"The problem was we had this wonderful crisis center, we had wonderful staff, but the processes were such that there was a lot of concerns about the quality of care, the safety, and the waits and the inefficiency in the process was a large part of the issues," Margie said.

While the staff had a high level of training and were caring and compassionate, a culture shift was also necessary due to the longstanding process issues.

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"They knew that they were working in a system that was not doing the best that it could for the patients and that had been hard for them. That was kind of traumatizing to them and they needed to be able to work through that. And, there was a lot of distrust as well, like this new company is coming in and taking over, what's going to happen. And so, we did a lot of town halls and for the first month just listened."

In addition to a lot of trust building and listening for that first month, Margie explained that she and other leaders were also working on the floor, experiencing what's going on and learning about what the issues were. Not only did that help them understand what the problems were, but also helped get buy in from the staff that we were serious, she explained.

"In crisis, I mean the whole thing, that's why I like it is it's so unpredictable, so you think you've seen everything and then tomorrow happens and you see something else. And so, you can't have a rule for every scenario," Margie explained. "But, our staff had been kind of conditioned to be very afraid of breaking a rule and getting in trouble sometimes, almost like the United Airlines thing, to the point of absurdity, where they couldn't really use their creativity. And so, a lot of what we did too, is really instil that we support values-based decision making," Margie said. "I mean, we have really great clinicians, and you want them to use their clinical brains and explain their decision making. Telling people that we trust them to make the right decision, going back to the psychological safety, if you trust your staff then it's not rule breaking, it's articulating your clinical judgement."

To empower staff to make values-based decisions, the organization, of course, needed to get clear on

what those values are. The center is divided into two areas, a 24/7 walk-in clinic, and an observation unit,. When defining their mission, vision, and values, the center also created a mission and vision for each area, in addition to its core values.

After getting clear about what the clinic and the observation unit are supposed to be and do, frontline staff and management came together in one room and mapped out processes, challenging staff to come up with the ideal process.

"Thinking back to that time, it was kind of stressful because midnight on April 1st we were responsible for this facility where knew there were safety issues (people had died in there before) and every minute that we didn't fix things when we knew the process was broken, it was like just waiting for the shoe to drop. So, we really wanted to move quickly, but we also had to be methodical about it. The first month, we were pretty much doing the town halls and listening. The second month, we were kind of doing our values and process mapping. Then, the third month, we were planning the implementation, and on July 1, just three months later, we did a big process change that had many, many, many changes," Margie explained. "So, we completely changed the way that we do the triage, we completely changed the flow, we changed all the documentation, and that was a very big, dramatic change. The outcomes of that were pretty positive. We saw the injuries go down, we saw the calls to security go down, we saw the throughput go down."

One measure that went up, however, was the percentage of patients required to see a doctor, due to the change in the triage process for appropriately identifying elevated risk people that needed to be seen by the physician. This also meant that the door-to-doctor time increased, unfortunately, and then the number of patients going back on the observation unit increased and the organization didn't have the doctor staffing to meet that demand.

"And so, that's what phase two was – we we looked at our physician staffing and the times that they were there, and we shifted around the time some and then we added a shift."

The journal article included a great control chart showing the increase from baseline in door-to-doctor time and then the decrease to be even better than baseline.

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"We didn't have a really good baseline door-to-doc time, we just knew that it was long at that time. And so, we kind of just said this is the right thing to do, we need to get the patients to the safest part of the building with the highest staff-to-patient ratio around them, they need to be seen by the docs. Then, we saw the effect of that and you know quality is an iterative process, we didn't plan phase one and then phase two. We did phase one and then realized we needed to do phase two, and then so forth. You just always do cycles of improvement on and on and on," Margie said.

While their door-to-doc time saw an initial increase of about three minutes, the journal article points out that there was a dramatic reduction in door-to-door, total time of almost four hours in the clinic area.

"We needed to really determine what is the purpose of that walk-in clinic area, a lot of times people were being held in there for hours to see if they got better, to see if they needed to go into the observation unit or not, sometimes even overnight, and that area's not ligature safe because, in psychiatric care, you have to worry about those sorts of things, really defining that this is a walk-in clinic, treatment doesn't happen in the clinic, you can get a medication refill, you can see a doctor. In here, if you're symptomatic or dangerous enough to the point where you need treatment or meds or some kind of intervention, then that needs to happen in the observation unit," Margie explained.

In terms of daily Lean management, one of the first things put into place were five-minute daily huddles to plan for the day. Their goal is to know what the problems were, start to fix problems in real-time, and empower management staff to be working on those problems.

"We just go over the shift report, who's in the building, where are the bottlenecks, and where are the hotspots. We have patients who get stuck sometimes because of discharge planning and, so, anyone who's been stuck here more than a certain amount of time, we discuss those patients individually, and any incidents or events that need following up on. So, we do that every morning. Our management structure, before there wasn't really like a defined

unit leader and our building, it's a beautiful building, but it's big and it's spread out. There's an adult unit and there's also a kid's unit, and there's an inpatient unit, and it was kind of like a house supervisor

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who kind of roved around, but there wasn't really like a leader of the unit or a leader of each discipline, so kind of building off of the Lean shift manager, or shift lead, concept is we created a lead for each discipline."

These leads are responsible for problem solving in the moment for their discipline, and if they can't resolve it, then they can bump it up. These leads are also given space to focus on their supervision duties.

"We try to not have them have a whole patient load, and that's been something that we've played with different ways to do that, and shifting the staff around so they can do that, but that is a constant challenge. Yes, having them free to do the problem solving is enormously important."

In the Joint Commission Journal on Patient Safety Journal on Quality and Patient Safety article, Margie and her colleagues really point out that Lean is really a mindset and approach for getting staff input and letting people be flexible when needed.

"These concepts around Lean they align nicely with the kind of care that we want to provide," Margie said. "It's like a sonnet. Your sonnet has to be in iambic pentameter, and the things have to be in rhyming couplets, and all that, and that's very structured. But then, how many sonnets are there, right? And there's beauty and there's art in all the sonnets. It's not like the structure of a sonnet limits your creativity, and so it's sort of the same in healthcare. There's a structure and there's a process, but then what you do with that individual patient within that structure and process, the art of medicine, is still there."

The article Using Lean to Rapidly and Sustainably Transform a Behavioral Health Crisis Program: Impact on Throughput and Safety is currently available online for free at http://dx.doi.org/10.1016/j.jcjq.2017.03.008.

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