Telemedicine Tackles Mental Health Treatment

Dignity Health Telemedicine Network

Your Direct Connection to Specialized Care

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Dignity Health
Mercy Medical Center Redding/NSSA

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CONFLICT of INTEREST

Jim Roxburgh, Deborah Wedick and Dignity Health have reported no relevant financial interest/relationship with any commercial entities that may have ties to this presentation.

OBJECTIVES

- Provide an overview of the DHTN
- Detail aspects of telemental health workflow
- Identify the clinical and financial benefits of a telemental health program
- Detail the success of the Mercy Medical Center Redding Telemental Health program

Your Direct Connection to Specialized Care

Overview

Dignity Health™

DHTN PROGRAM GOAL

Provide timely access to high quality specialized healthcare services that are not readily available

DHTN计划目标

让人及时获得难以获得的高品质专业健康护理服务

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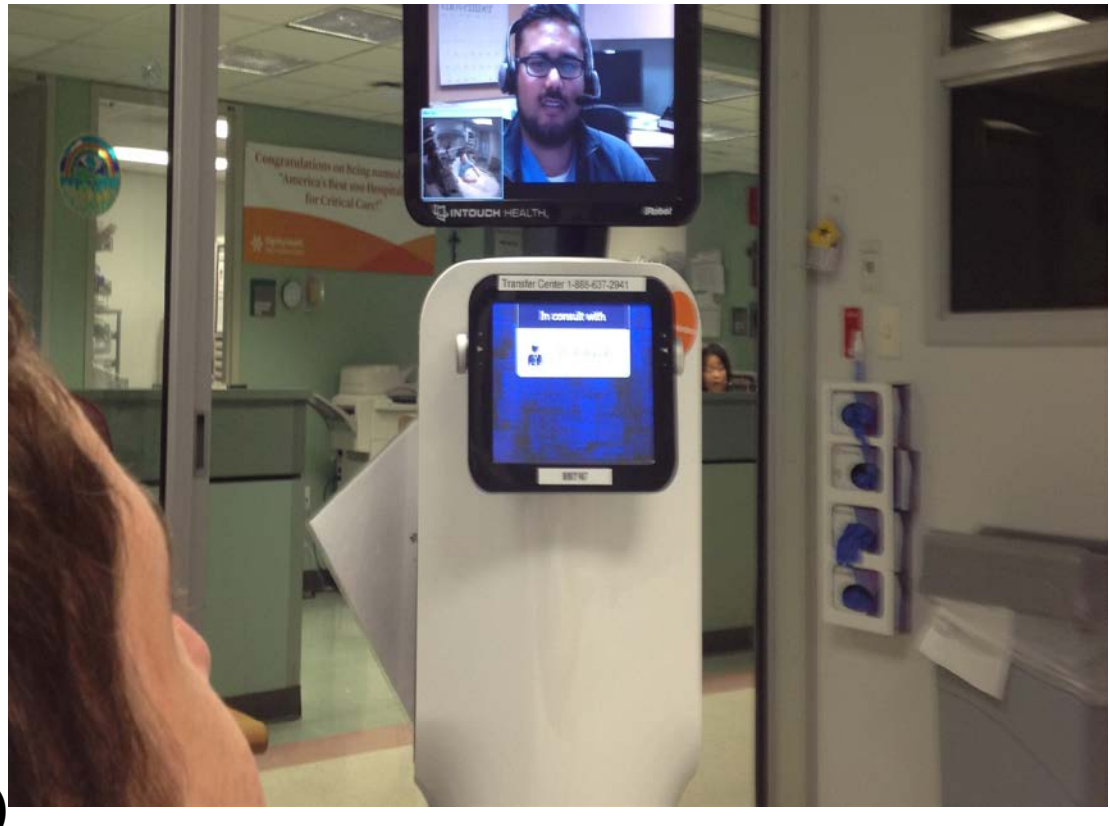
DHTN The Facts…

- ✓ The Mercy Telehealth Network Founded (2008)
- ✓ Recognized as the Dignity Health Telemedicine Network (2014)
- ✓ 80 End Points
- ✓ 52 Specialists
- ✓ 11 Different Services
- ✓ 48 Partner Sites
- ✓ 22,401 TOTAL Consults (last 12 months ending March 2016)



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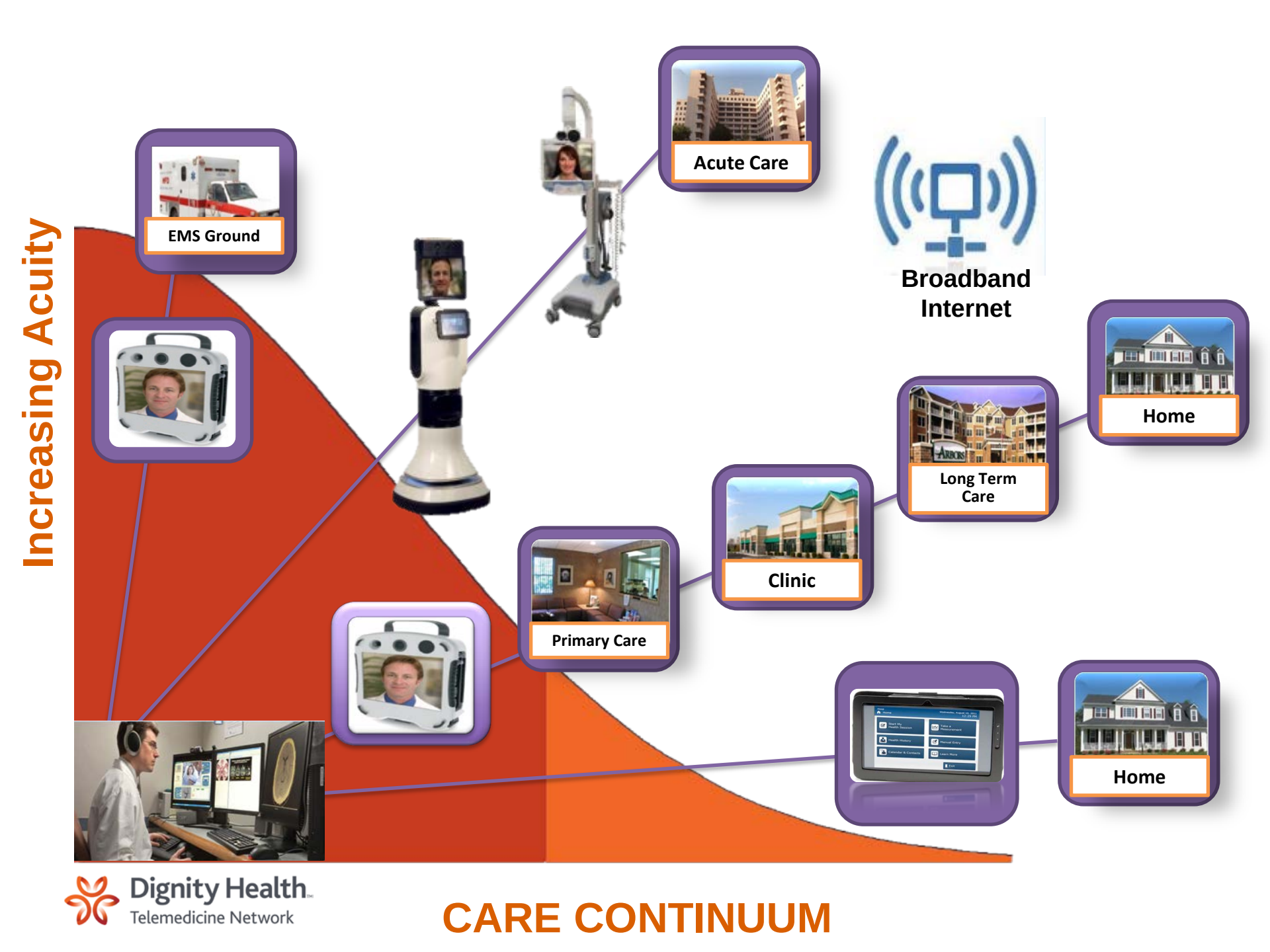
Increasing Acuity
EMS Ground
Acute Care
Broadband Internet
Home
Long Term Care
Clinic
Primary Care
Home
Dignity Health
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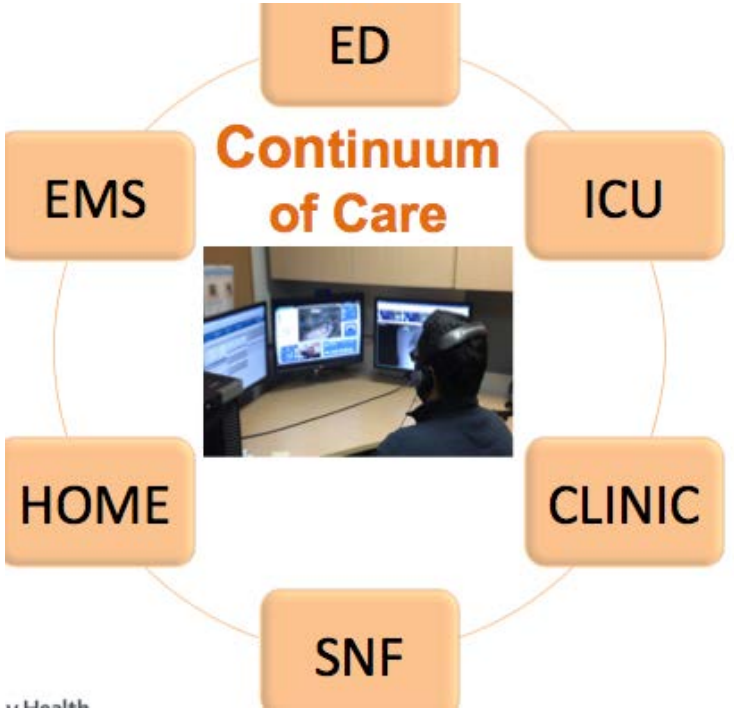
CARE CONTINUUM

DHTN Services

ACUTE	CLINIC/SNF	TRANSITIONAL	HOME
• Stroke/Neurology • Mental Health • Critical Care • Nephrology • Pediatrics • Newborn Care • Cardiology • Infectious Disease	• Geriatrics • Neurology • Endocrinology • Pulmonology • Thoracic Surgery • Oncology	• CHF • COPD • Diabetes • Post Surgery • Wound Care	• CHF • COPD • Diabetes • Post Surgery • Wound Care



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Dignity Health Telemedicine Network

1. Mercy General Hospital
2. Mercy San Juan Medical Center
3. Mercy Hospital of Folsom
4. Sierra Nevada Memorial Hospital
5. Sierra Nevada Medical Group Clinic
6. NorthBay Medical Center
7. NorthBay VacaValley Hospital
8. Woodland Healthcare
9. Methodist Hospital of Sacramento
10. St. Joseph's Medical Center
11. Mercy Medical Center—Mt. Shasta
12. Mercy Medical Center Redding
13. Redding Medical Group Clinic
14. St. Elizabeth Community Hospital
15. Mercy Medical Center Merced
16. Mark Twain Medical Center
17. Mark Twain Medical Center Clinic
18. Bakersfield Memorial Hospital
19. Kern Valley Healthcare District
20. California Hospital Medical Center
21. St. Bernardine Medical Center
22. Community Hospital of San Bernardino
23. St. John's Regional Medical Center
24. St. John's Pleasant Valley Hospital
25. Marian Regional Medical Center
26. French Hospital Medical Center
27. Arroyo Grande Community Hospital
28. Sequoia Hospital
29. Oak Valley Hospital
30. St. Joseph Hospital Eureka
31. Tehachapi Valley HealthCare District
32. Mercy Downtown Hospital
33. St. Mary Medical Center
34. St. Rose Dominican Hospital—Rose de Lima
35. St. Rose Dominican Hospital—San Martin
36. St. Rose Dominican Hospital—Siena
37. Oroville Hospital
38. Madera Community Hospital
39. Kona Community Hospital
40. Santa Rosa Memorial Hospital
41. Folsom Fire Department
42. Mercy Community Clinic, Mt. Shasta
43. Lady of Lourdes Life Center, Auburn
44. Northridge Hospital Medical Center
45. Rideout Memorial Hospital, Marysville
46. Bruceville Terrace Nursing, Sacramento
47. Petaluma Valley Hospital
48. St. Elizabeth Community Hospital Clinic

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CHECKLISTS

Partner Site

Transfer Center

DHTN Team

DHTN Physician

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TELEMENTAL HEATH CHECKLIST
Partner Site

- ❑ Patient is identified; it is determined patient needs a TeleMental Health Consult
- ❑ Call **Dignity Health Transfer Center (DHTxC): 1(888) 637-2941**
  - (Target: door to call <10min)
- ❑ Place robot at the foot of the bed
- ❑ Make sure patient is consented for telemedicine (verbal consent)
- ❑ Be prepared to assist and/or provide patient history to the TelePsychiatrist during the consult
  - Patient Name
  - Clinical Presentation/Hx
  - Vital Signs/Labs
  - Chief Complaint
  - Current Medications and Allergies
  - Behaviors or language observed
  - Collateral information obtained and documented from family or conservator/guardian
  - If patient has involuntary hold 5150 or 1799 be prepared to read it to Telepsychiatrist
- ❑ TelePsychiatrist will make recommendations in Clinical Apps, and they will be faxed to ED or sent to the EMR (for Cerner Sites only)

Things to Remember:

- ❑ Return robot to the docking station and plug it in when consult is completed
- ❑ If patient is mod/high risk for harm RN, tech, or sitter ***must stay*** with the robot during the consult
- ❑ Partner Site RN's ***do not*** take verbal orders from TelePsychiatrist
- ❑ In the event that the Robot is being used for another less emergent case (such as a Telemental Health case); kindly notify the Tele-Specialist that the Robot is needed for a Telestroke case; call the Dignity Health Transfer Center once the Telestroke case is completed so the Tele-Specialist can complete their consult
- ❑ Robot ***must*** be returned its docking area and plugged in when not in use

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DIGNITY HEALTH TRANSFER CENTER
TELEMENTAL HEALTH CHECKLIST
(For calls received at the Transfer Center in which a TeleMental Health consult is requested)

1. TeleMedicine Specialist (TMS) #1 verifies this is a TeleMental Health request
2. TMS # 2 Secure Text (OnePass) Telepsychiatrist #1:
   a. If no response by minute 3, OnePass again and simultaneously call Cell Phone
   b. If no response by minute 6, OnePass again and simultaneously call Cell Phone
   c. If no response by minute 9, OnePass Telepsychiatrist #2 (when available)
   d. If no response by minute 12, CALL & TEXT Ellen Winckur @ 818 532-1297 *
   e. If no answer, immediately CALL & TEXT John Mackenzie @ 707 372-0577 *
   f. If no response by minute 15, OnePass Dr. Nie *
   g. If no response by minute 18, CALL & TEXT Vik Marla @ 818-292-2600 *
   h. If no response by minute 20, CALL & TEXT Jim Roxburgh @ 916-612-5278 *

* Generate an Unusual Occurrence Report

NOTE In the event the TMS cannot reach the Telepsychiatrist, continue to OnePass and call the Telepsychiatrist's cell-phone, every 10 minutes, while working through the above protocol.

3. TMS #1 obtains patient information and completes the sections of the *Patient Info* tab of the TeleMental Health document by logging into https://clinicalapps.intouchhcustomer.com

4. TMS verifies that the Partner Site has placed the robot at the patient's bedside
5. TMS verifies that the patient's nurse, physician, or social worker will be available to present the patient to the Telepsychiatrist
   a. TMS coordinates the report between the Telepsychiatrist and person presenting the patient, before and after the consult
6. Pending delays greater than 60 minutes: TMS notifies Partner Site of approximate *beam-in* time

Version 3.01

Your Direct Connection to Specialized Care

1

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box


smartsheet

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Telemental Health

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Telemental Health

21 Sites

8,437 Consults

3 Minute Response

12 Months

(Ending March 2016)

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Workflow

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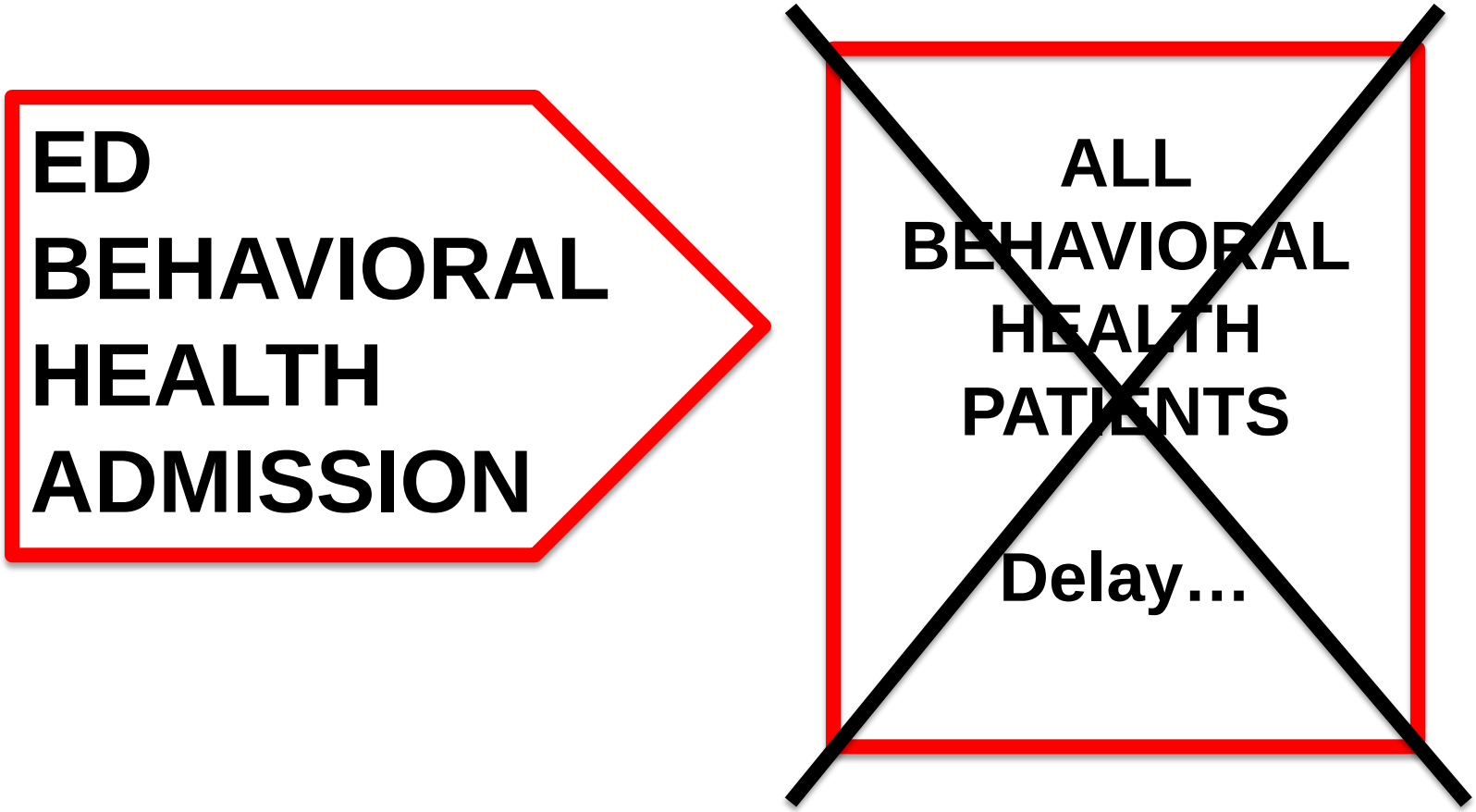
TELEMENTAL HEALTH WORKFLOW



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TELEMENTAL HEALTH WORKFLOW

Mild Risk

Moderate Risk

Severe Risk

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TELEMENTAL HEALTH ED WORKFLOW

ROUND & RESPOND

Telepsychiatrist **ROUNDS** at predetermined times am/pm

Telepsychiatrist **RESPONDS** to Partner Site requests 24/7

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TeleMental Health Consult Note

Patient Name	patient, Test
MRN	123456
Date of Birth	04/03/1954

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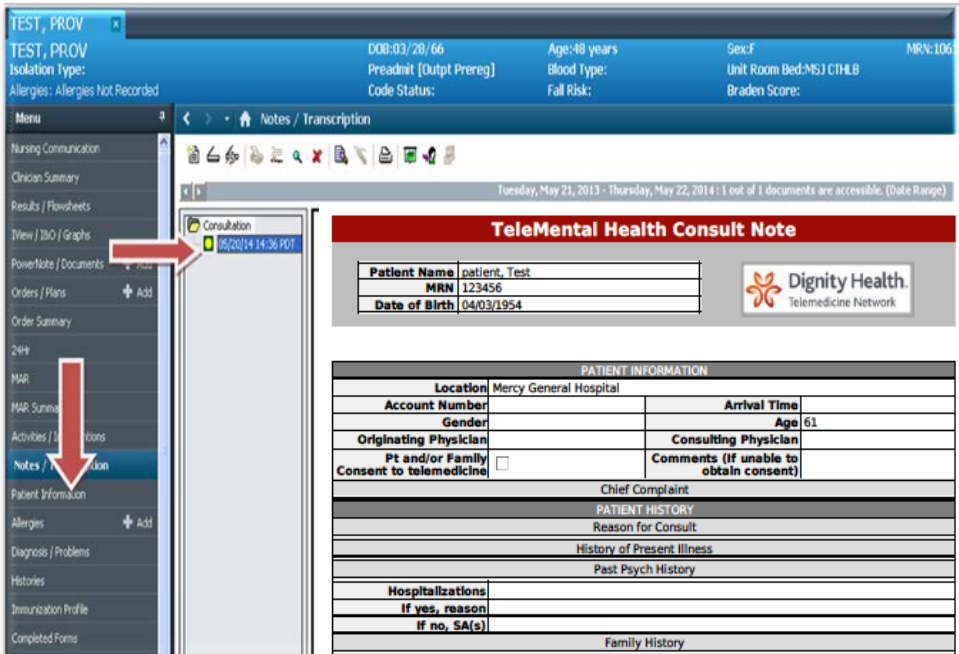
PATIENT INFORMATION			
Location	Mercy General Hospital		
Account Number		**Arrival Time**	
Gender		**Age**	61
Originating Physician		**Consulting Physician**	
Pt and/or Family Consent to telemedicine	☐	**Comments (If unable to obtain consent)**	
Chief Complaint			
PATIENT HISTORY			
Reason for Consult			
History of Present Illness			
Past Psych History			
Hospitalizations			
If yes, reason			
If no, SA(s)			
Family History			
Substance Use			
No known substance abuse	☐		
Substance abuse history		**If yes, substance(s)**	
Prior Substance abuse treatment		**If yes, substance(s)**	
Medical History			
Medical Hx			
Allergies			
Social History			
Marital Status		**DPA/Conservatorship**	
Level of Education		**Occupation/Retirement**	
Current Medications			
LABS			
Labs not available	☐		

CBC													
WBC		**Hgb**		**Hct**		**RBC**		**MCV**		**MCH**		**MCH C**		**Plt**	

CMP													
Na+		**Cl-**		**K+**		**Glu**		**Cr**		**BUN**		**Ca2+**		**Alb**	
T. Protein		**ALP**		**AST**		**ALT**		**T. Bili**							

Other Labs	
RUA	
Urine Drug Screen	
ICON	



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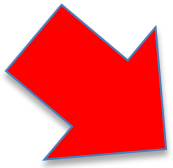
If yes, reason	
If no, SA(s)	
Family History	
Substance Use	
No known substance abuse	☐
Substance abuse history	☐ **If yes, substance(s)**
Prior Substance abuse treatment	☐ **If yes, substance(s)**
Medical History	
Medical Hx	
Allergies	
Social History	
Marital Status	**DPA/Conservatorship**
Level of Education	**Occupation/Retirement**
Current Medications	
LABS	
Labs not available	☐

CBC															
WBC		**Hgb**		**Hct**		**RBC**		**MCV**		**MCH**		**MCHC**		**Plt**	

CMP													
Na+		**Cl-**		**K+**		**Glu**		**Cr**		**BUN**		**Ca2+**		**Alb**	
T. Protein		**ALP**		**AST**		**ALT**		**T. Bili**							

Other Labs	
RUA	
Urine Drug Screen	
ICON	



Mental Health Evaluation Timeline

Originating Physician:_____ Psychiatrist:_____ Originating Time:_____

Patient Name:_____ Age:_____ Date:_____ Hospital:_____

DOOR → TREATMENT → DISCHARGE

	0 min	≤15 min	≤30 min	≤60 min	≤90 min	≤120 min	≤4 hrs	≤24 hrs
	Patient Arrives to the ED **Patient Discharged from ED**	**RN Triage** Chief complaint Initial safety plan Immediate bedding	**ED Physician Completes Order** Med (SMART) clearance Telemental health consult requested Psychiatric stratification • Mild (Green) • Moderate (Yellow) • Severe (Red)	**RN Completes Initial Assessment** Review demographics Medication reconciliation Patient registration	**Telepsychiatrist Consult** Recommendations provided to ED physician	**RN/LCSW Activate Treatment Plan** Discharge Transfer Observe	**RN/LCSW Initiates "TEAM" Assessment**	**Follow-up Assessment (if appropriate)** **Total Length of Stay**
Goal								
Actual								
Difference								
Comments:								

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Dignity Health Stroke Timeline Report

Patient Name: _____
MRN: _____
Date of Birth: _____

Hospital: _____
Onset Time: _____
Age: _____

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0 min	≤10 min	≤15 min	≤25 min	≤45 min	≤45 min	60 min	≤60 min
Suspected stroke patient arrives at ED	Initiate ED Rapid Medical Assessment (RMA) including patient history, last known well/time of symptom onset, NIHSS and order CT and lab work	Notify Stroke Team (including neurologic expertise)	Initiate CT scan	Interpret CT scan and labs; review patient eligibility for Activase	Activase (tPA) recommended	Review patient eligibility for Endovascular Reperfusion Therapy (Intraarterial Thrombolysis)	Give Activase bolus and initiate infusion in eligible patients
Goal Time:							
Feb 13 2016 11:26 PST	Feb 13 2016 11:36 PST	Feb 13 2016 11:41 PST	Feb 13 2016 11:51 PST	Feb 13 2016 12:11 PST	Feb 13 2016 12:11 PST	Feb 13 2016 12:26 PST	Feb 13 2016 12:26 PST
Actual Time:							
Feb 13 2016 11:26 PST	Feb 13 2016 11:30 PST	Feb 13 2016 11:31 PST	Feb 13 2016 11:45 PST	Feb 13 2016 11:53 PST	Feb 13 2016 11:45 PST	Feb 13 2016 11:40 PST	Feb 13 2016 12:01 PST
Difference:							
0 min	-6 min	-10 min	-6 min	-18 min	-26 min	-46 min	-25 min
Comments:							

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Mental Health Evaluation Timeline

Originating Physician:_____ Psychiatrist:_____ Originating Time:_____

Patient Name:_____ Age:_____ Date:_____ Hospital:_____

DOOR → **TREATMENT** → **DISCHARGE**

	 **0 min**	 **≤15 min**	 **≤30 min**	 **≤60 min**	 **≤90 min**	 **≤120 min**	 **≤4 hrs**	 **≤24 hrs**
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Goal								
Actual								
Difference								
Comments:								

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Indications for Telemental Health Consults (*When to Call)*

1. Substance abuse – intoxication, requests detox or rehabilitation center, drug seeking behavior
2. Psychosis – hallucinations, delusions, paranoid, bizarre behaviors, psychosis related agitation
3. Anxiety - anxiety attack, nervousness, restless, irritable, edgy, medication refill
4. Mood – depressed, sad, manic, euphoric, labile, pressured speech
5. Cognitive –confused, memory loss, dementia related agitation, dementia pt with chronic issues that will affect safe discharge
6. Organic – head injury, seizure activity, hyponatremia, delirium- related agitation
7. Other – rape, learning disability, childhood developmental disability (mental retardation or autism)
8. Personality – interpersonal difficulties, domestic violence, molestation

TELEMENTAL HEALTH CHECKLIST

- ❑ Provide the following to the Telepsychiatrist
  - ❑ Patient Name
  - ❑ Clinical Presentation/Hx
  - ❑ Vital Signs/Labs (as appropriate and/or needed)
  - ❑ Chief Complaint and/or requested needs of facility (legal eval/meds/etc…)
  - ❑ Current Medications and Allergies
  - ❑ Behaviors or language observed
  - ❑ Collateral information obtained and documented from family or guardian
  - ❑ If patient has a 5150 or 1799 be prepared to read it to Tele psychiatrist
  - ❑ Be prepared to inform the Telepsychiatrist who will be giving and receiving report

TELEMENTAL HEALTH CHECKLIST

- ❑ Prior to Consultation-
  - ❑ Robot is placed at the foot of the bed or where most appropriate
- ❑ Telepsychiatrist Beams in for consultation
- ❑ TelePsychiatrist will make recommendations in Clinical Apps, and they will be faxed to ED or sent to the EMR (for Cerner Sites only)

TelePsychiatrist recommendations will be used by ED Physician to manage disposition

- ❑Social Work or RN to Coordinate DC
- ❑DC Home or other facility
- ❑DC to Psychiatric Facility
- ❑Crisis Observation and Re-Evaluate

TELEMENTAL HEALTH ED WORKFLOW

Door to RMA < 30 minutes

ED Physician Triages Behavioral Health Patient)

MILD

MODERATE

SEVERE

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TELEMENTAL HEALTH ED WORKFLOW

ED Physician directs patient disposition or TMH requests consult

Call DHTC @ 1(888) 637-2941

Consent patient

DHTC pages Telepsychiatrist on call–*Request to Call Back Time<5 min.*

DHTC "patches" Telepsychiatrist to Partner Site Physician via phone

Telepsychiatrist beams in – *Request to Beam in Time <60 minutes*

Telepsychiatrist provides recommendations to Partner Site Physician

Telepsychiatrist completes/signs consult note *<90 minutes*

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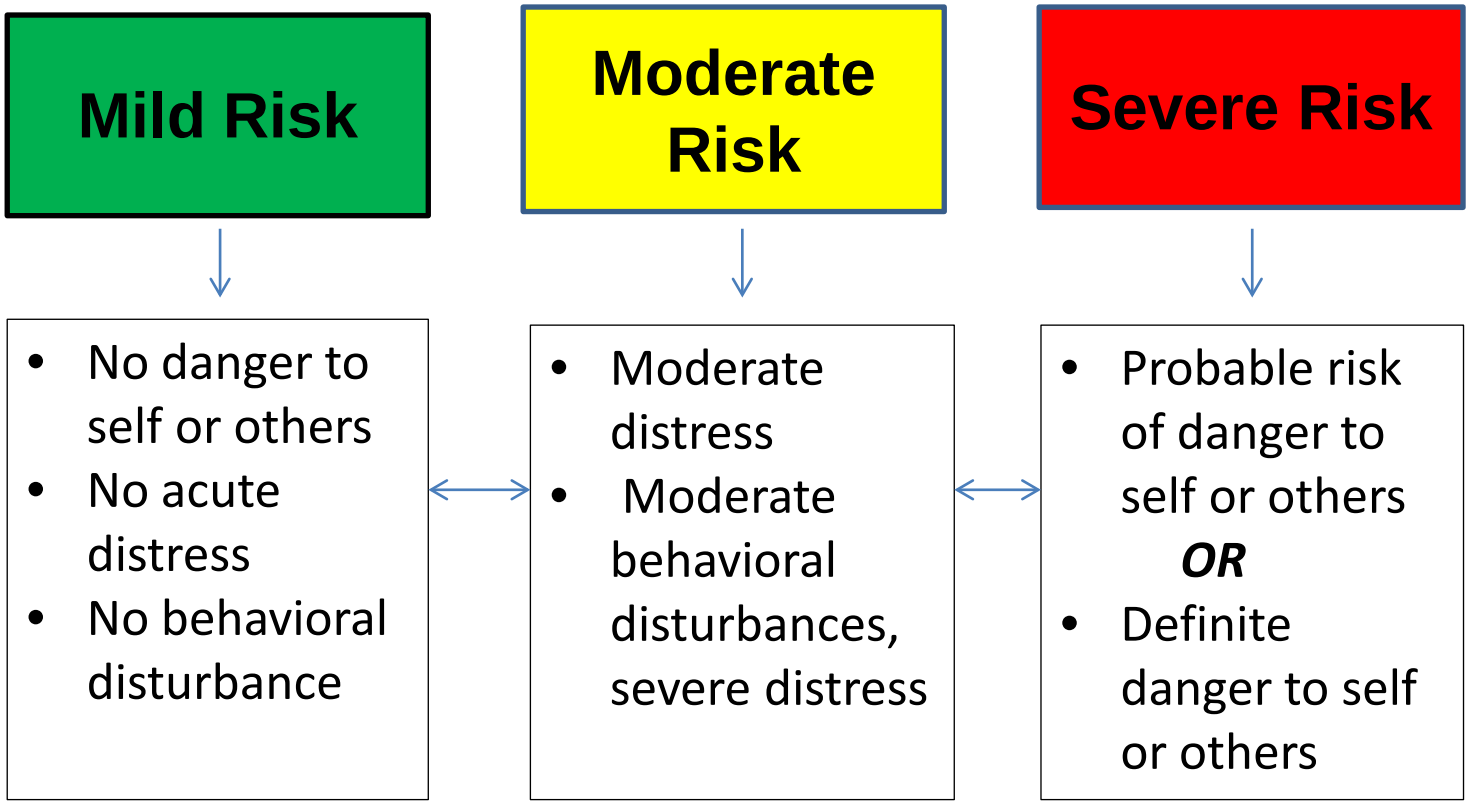
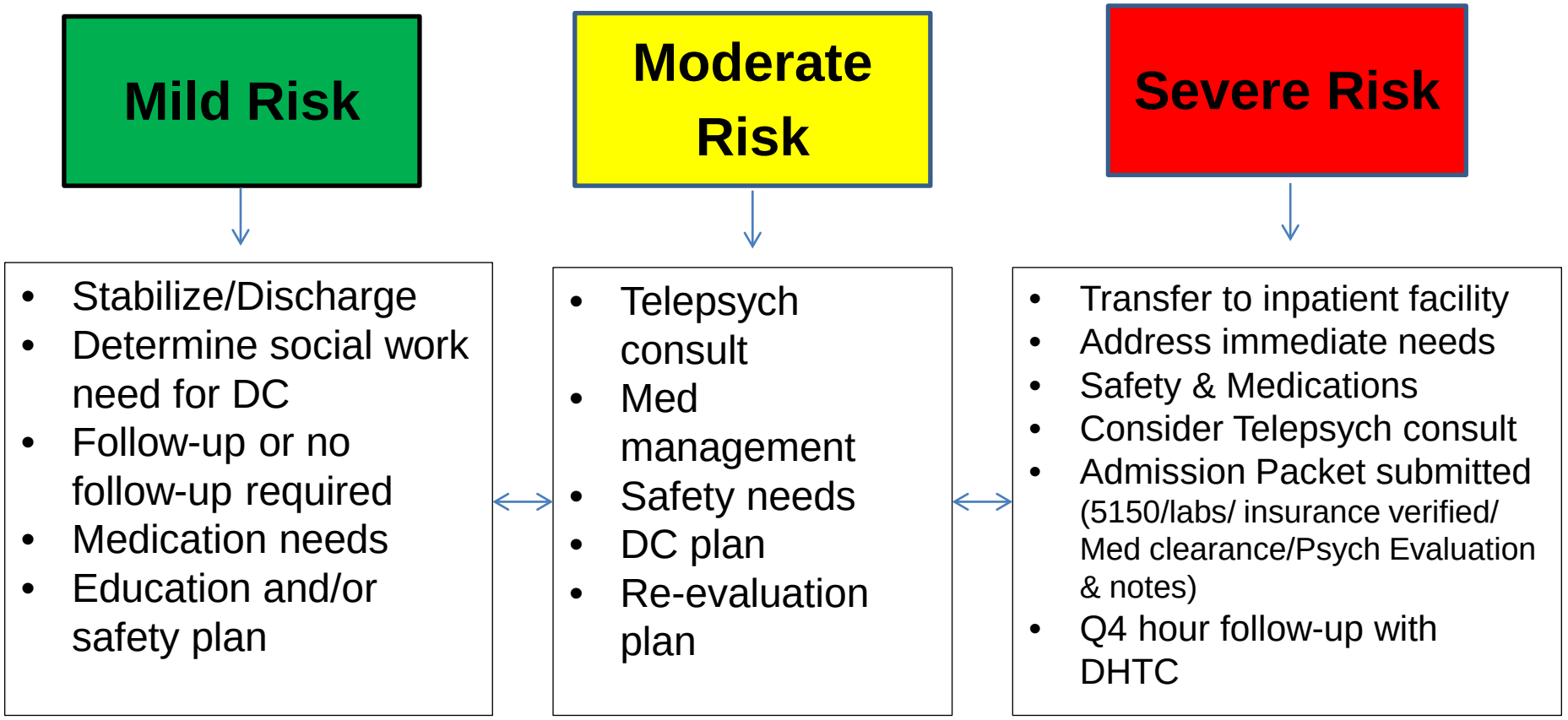
ASSESSMENT


Mild Risk
Moderate Risk
Severe Risk
• No danger to self or others
• No acute distress
• No behavioral disturbance
• Moderate distress
• Moderate behavioral disturbances, severe distress
• Probable risk of danger to self or others
OR
• Definite danger to self or others

PLAN


Mild Risk
Moderate Risk
Severe Risk
• Stabilize/Discharge
• Determine social work need for DC
• Follow-up or no follow-up required
• Medication needs
• Education and/or safety plan
• Telepsych consult
• Med management
• Safety needs
• DC plan
• Re-evaluation plan
• Transfer to inpatient facility
• Address immediate needs
• Safety & Medications
• Consider Telepsych consult
• Admission Packet submitted (5150/labs/ insurance verified/ Med clearance/Psych Evaluation & notes)
• Q4 hour follow-up with DHTC

Mental Health Evaluation Timeline

Originating Physician: Dr. Jones | Psychiatrist: Dr. Uddin | Originating Time: 1300

Patient Name: Doe, John | Age: 42 | Date: 5/1/16 | Hospital: Dominican Hospital

DOOR → TREATMENT → DISCHARGE

	0 min	≤15 min	≤30 min	≤60 min	≤90 min	≤120 min	≤4 hrs	≤24 hrs
	Patient Arrives to the ED 1200 **Patient Discharged from ED** 0930 5/2/16	**RN Triage** Chief complaint Initial safety plan Immediate bedding	**ED Physician Completes Order** Med (SMART) clearance Telemental health consult requested Psychiatric stratification • Mild (Green) • Moderate (Yellow) • Severe (Red)	**RN Completes Initial Assessment** Review demographics Medication reconciliation Patient registration	**Telepsychiatrist Consult** Recommendations provided to ED physician	**RN/LCSW Activate Treatment Plan** Discharge Transfer Observe	**RN/LCSW Initiates "TEAM" Assessment**	**Follow-up Assessment (if appropriate)** **Total Length of Stay** 21 Hrs
Goal	1215	1230	1300	1330	1400	1600	1200 5/2/16	
Actual	1208	1235	1255	1325	1700	1745	0900 5/2/16	
Difference	-7	+5	-5	-5	+120	+105	-3 Hrs	
Comments:		ED MD busy with Stroke Alert Stratification: Moderate		Dr. Katz at Bedside Call to consult: 25 min	Pt refused medication Treatment TEAM Eval needed	SW/RN/MD Plan: Follow Med plan, Observe and Re-eval in AM	Pt Cleared DC home with Out-Pt Follow up	

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Telemental Health Scorecard

Telemental Health Consult Volume
Request to consult (target < 60 min)
Sitter Hours
Crisis Team Cost
Patient Disposition
LOS ($140 savings per hour of bed time saved)

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Telemedicine Network

Hindawi Publishing Corporation
Emergency Medicine International
Volume 2012, Article ID 360308, 5 pages
doi:10.1155/2012/360308

The Impact of Psychiatric Patient Boarding in Emergency Departments

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admissions. The financial impact of psychiatric boarding accounted for a direct loss of ($1,198) compared to non-psychiatric admissions. Factoring the loss of bed turnover for waiting patients and opportunity cost due to loss of those patients, psychiatric patient boarding cost the department $2,264 per patient. *Conclusions.* Psychiatric patients awaiting inpatient placement remain in the ED 3.2 times longer than non-psychiatric patients, preventing 2.2 bed turnovers (additional patients) per psychiatric patient, and decreasing financial revenue.

FINANCIAL IMPACT

- Annual ED Visits = 30,000
- Estimated Mental Health Related Visits 3% = 900
  - Approx $2,200
- Annual Cost Mental Health Visit = $1,980,000
- Annual Reimbursement Mental Health Visit = $675,000
  - Approx $750

Total annual loss = $1,305,000

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Background - October 2015, "Partner" Hospital's ED averaged 181 patients visits per day
Average length of stay for Behavioral Health patients was 35.77 hours

Initiative Goals:

- Implemented the "first four-hour" timeline
- Fully leverage Telemental Health capabilities
- January 2016, "Partner" Hospital's ED averaged 198 patients visits per day
  Average length of stay for Behavioral Health patients dropped from 35.77 hours in October to 25.22 hours
- February 2016, "Partner" Hospital's ED averaged 208 patient visits per day
  Average length of stay for Behavioral Health patients dropped further to 21.06 hours
- ***$272,200 cost avoidance***

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JOINT COMMISSION STANDARDS

- **Patient flow through the emergency department**
- **Requirements**
- ***Standards LD.04.03.11 and PC.01.01.01 are revised standards that address an increased focus on the importance of patient flow in hospitals.***
- EP 6. This element of performance went into effect January 1, 2014: The hospital measures and sets goals for mitigating and managing the boarding of patients who come through the emergency department.

- ***Note:*** *Boarding is the practice of holding patients in the emergency department or another temporary location after the decision to admit or transfer has been made. The hospital should set its goals with attention to patient acuity and best practice****; it is recommended that boarding time frames not exceed 4 hours*** *in the interest of patient safety and quality of care.*

TELEMENTAL HEALTH

DISPOSITION OPTIONS

HOME

Opportunity

NAVIGATE TO CLINIC

FQHC opportunity

PSYCHIATRIC FACILITY

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Clinics

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BARRIERS

WHY

Because

EVERY

Patient Matters

Dignity Health™
Telemedicine Network

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Mercy Medical Center Redding
A Success Story

Dignity Health.
Telemedicine Network

Telepsychiatry- A Journey of Challenge and Change- Mercy Medical Center Redding

Deb Wedick RN, CNRN
Manager Telehealth NSSA
April 14, 2016

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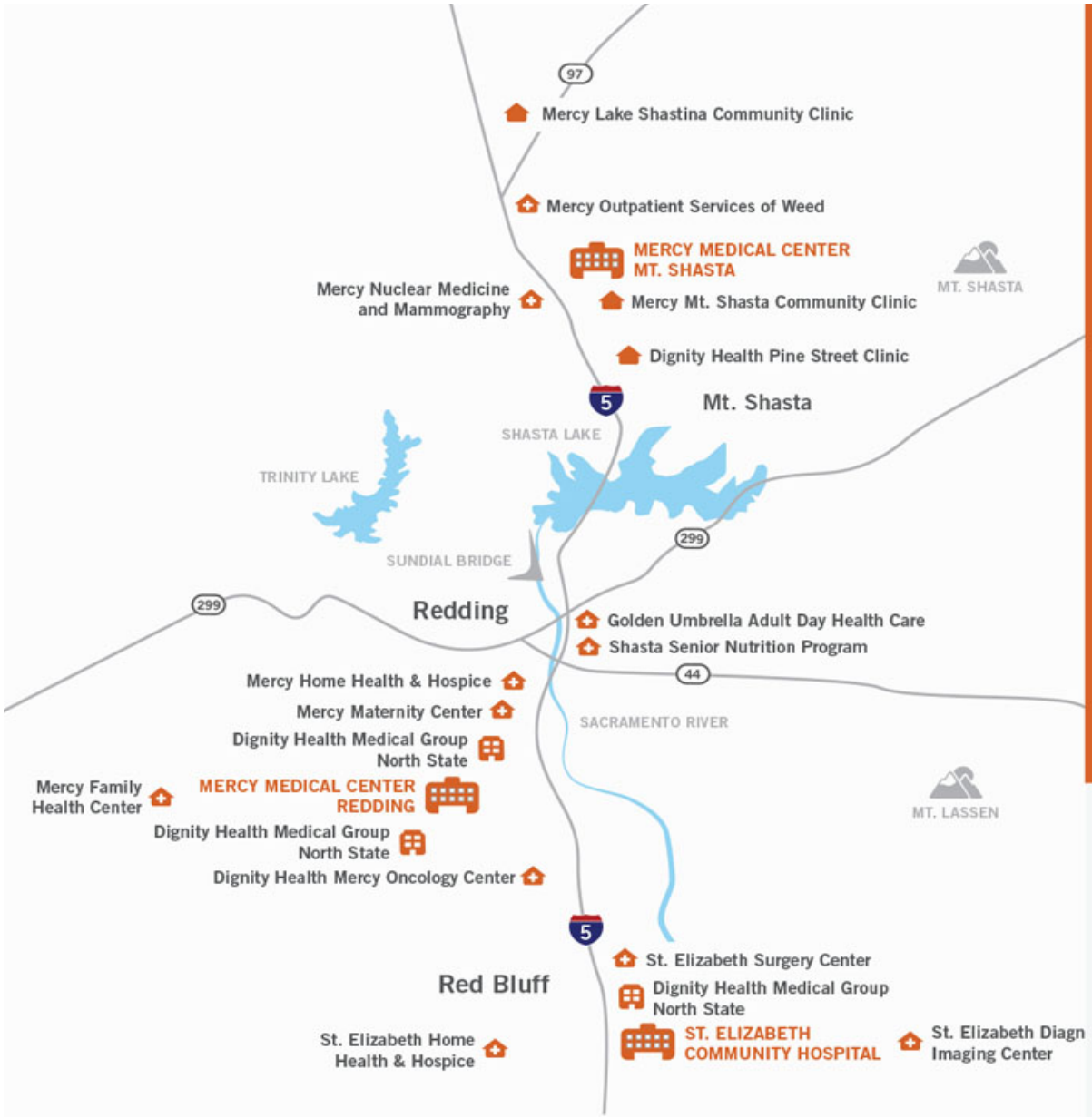
Mercy Medical Center
Redding

Hello humankindness.

Mercy Medical Center Redding



North State Service Area overview.

QUICK FACTS

Hospitals:.....3

Outpatient Locations: 19

Inpatient Encounters in PSA (2014):..... 53.2%

The sole provider of many health care services (neonatal ICU, obstetrics, oncology, pediatrics, palliative care, and home health and hospice).

The only Level II trauma center in a geographic area that comprises roughly 25% of California.

LEGEND

= Rural Clinic

= Ambulatory Services

= Hospital

= Medical Groups

North State Service Area Dynamics

Our Performance

- Adjusted Admissions	16,890
- FY15 Operating EBITDA	$66,850M
- Increase in Employee Engagement	**4.7 points**

The largest increase in Dignity Health.

Competitive Landscape

- PSA Inpatient Encounters:
  - MMCR: 47.9%
  - SECH: 32.4%
  - MMCMS: 58.0%
- Competition:
  - SRMC Medical Group
  - Adventist Health in Corning
  - Sutter/Apogee Surgery Center

Demographics

Projected Population Increase:
< 1% over next 3years

Median HH Income:	$44,396
Unemployment Rate:	11%
Adults Age 65+:	19.42% of population

Dignity Health, County and City governments are the largest employers in the service area. The percentage of adults over 65 is 50% higher than the California average of 12.9%.

Payer Landscape:

Fee-for-service for all service except Partnership Health Primary Care Cap.

Commercial:	17.9% (0.3%) ▼
Medi-Cal:	29.8% (3.9%) ▲
Self Pay:	2.1% (1.9%) ▼

Mercy Medical Center Redding- Dignity Health

- 260 beds-Level II Trauma Center, Level III Nursery
  - 57,000 ED visits FY 2015
    - Regional service area for > 22 % of California geography.
      - Primary Stroke Center with Interventional capabilities July 2016
        - 8 bed Neuro Intensive Care Unit (virtual) July 2016
  - Early adopter of DHTN services.

    First services – Telestroke, January 2012

    Service Line Growth 2012- 2014 30%

    50% Market Share per FY 2014 data

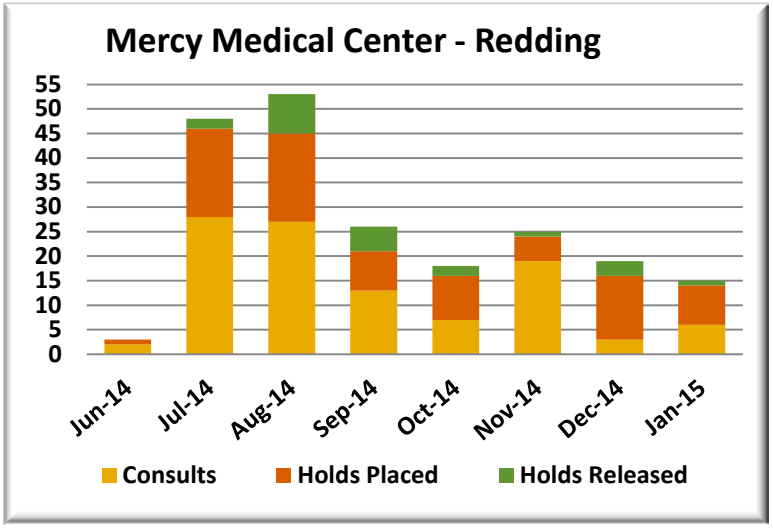
Behavioral Health Service Implementation- July 2014

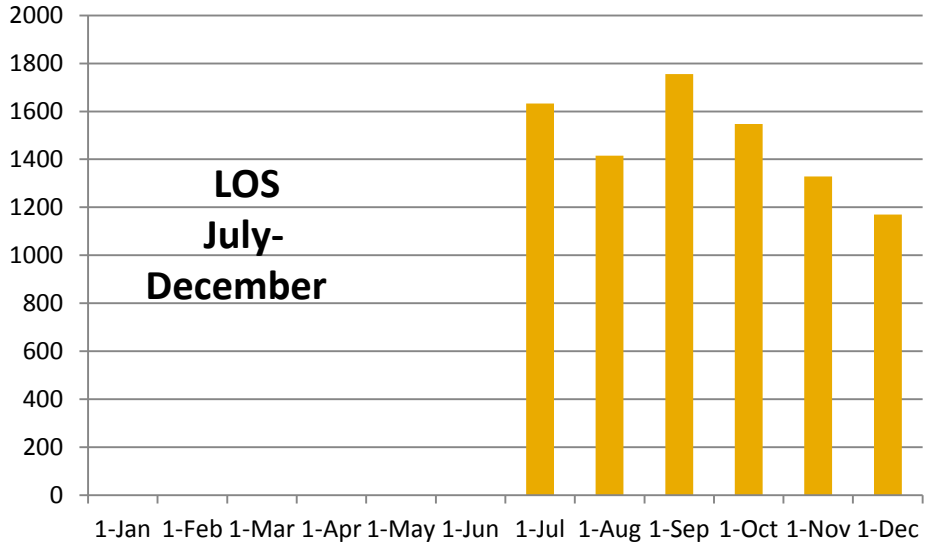
Project Goals: Year One

1. Decreased LOS for Behavioral Health patients.
2. Increased throughput in ED.
3. Increased Provider satisfaction with psychiatric management of anti-psychotic medications.

July –December, 2014- The Honeymoon

Telepsychiatry has a smooth adoption by the ED staff. Use is inconsistent at times, but rapidly accepted as a resource. DHTN provides an expert service line manager who participates in developmental activities and data sharing.





Reality Starts to Dawn – January-June 2015

The Telemental Health Program is working well:

- Consults 100% on time.
- All Quality Metrics for clinical evaluations are met.
- Used on all but mild cases- inpatient adoption initiated.
- Physician relationships are excellent- staff approval all around

BUT LENGTH OF STAY AND ED TIMES HAVE SKYROCKETED……
WHAT'S WRONG?

Californication Leads to Education

If you have seen one county- you have seen one county.

- Shortages of Behavioral Health Workers Delay Hold evaluations >72 hours
  - Patient and Community agitation over conditions
  - IP placement at glacial speeds due to bed shortages- insurance issues
  - No designated responsibility for Hospital- County conditions
  - No ownership of granular ED data and tracking- all anecdotal

A Community Up in Arms: May – Sept 2015

Finger pointing by most participants in the community's service providers.

Local media focus on lack of provider and county services for the area.

External experts invited to discuss their programs.

No reliable data to reflect a coherent portrait of the perceived crisis.

Silos- Real time data unavailable or not shared.

Genuine concern of all parties.

The Turning Point.....

47

503

It’s All About the Math

1 Patient stays 47 days.

47 x 24 = 1128 hrs.

Total MH patient hours per system report **503.5**

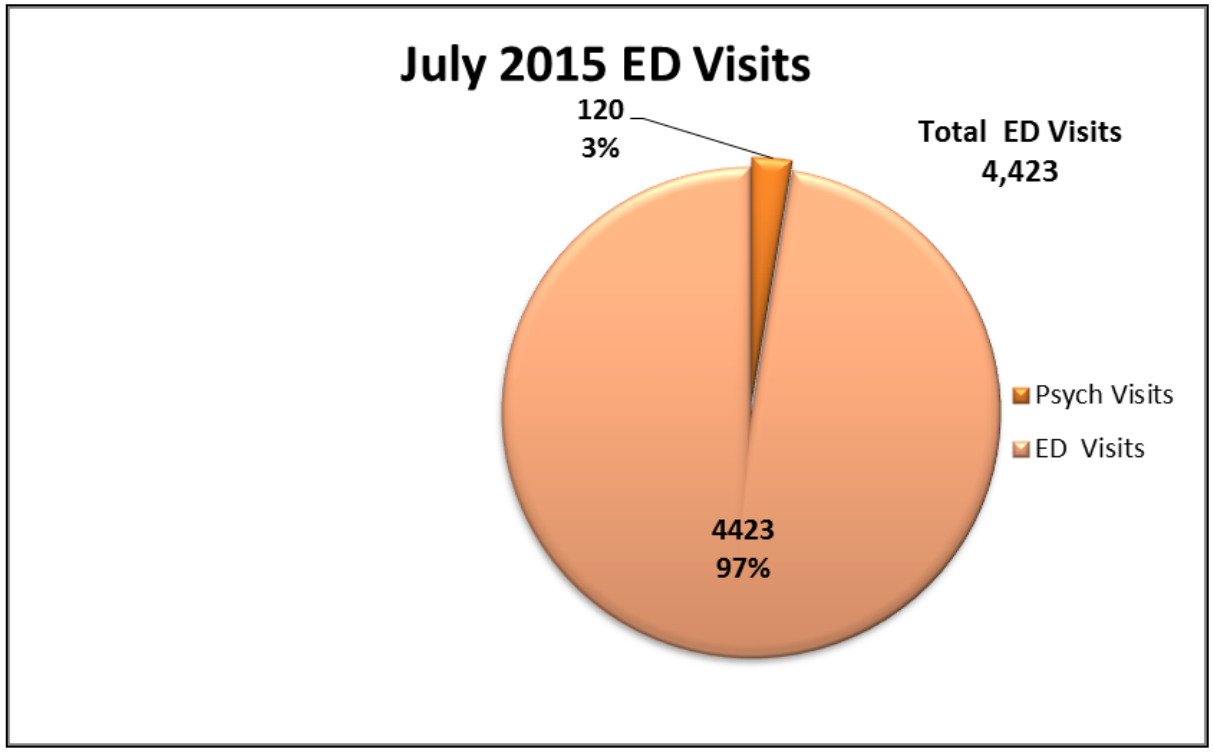
Data doesn't Lie- does it?

FY 16 thru Feb.-Sum of ED Patient Hrs by Month and type (from PMT data)

				This total excludes Mental Health Hrs
Row Labels	**Sum of Total ED Pt LOS discharged (hours) total**	**Sum of Total MH patients LOS (hours)**	**Sum of Admitted patients LOS (hours) total**	**Sum of Total Hrs for Admit and Discharge Patients(hrs)**
Jul/2015	12488.77	503.59	4146.88	16635.65
Aug/2015	12589.36	541.08	4992.4	17581.76
Sep/2015	12218	587.73	4696.37	16914.37
Oct/2015	11919.86	750.62	4551.94	16471.8
Nov/2015	11227.41	508.25	4026.92	15254.33
Dec/2015	12435.39	611.53	5202.73	17638.12
Jan/2016	13847.87	543.63	5281.79	19129.66
Feb/2016	13832.79	640.75	4872.52	18705.31

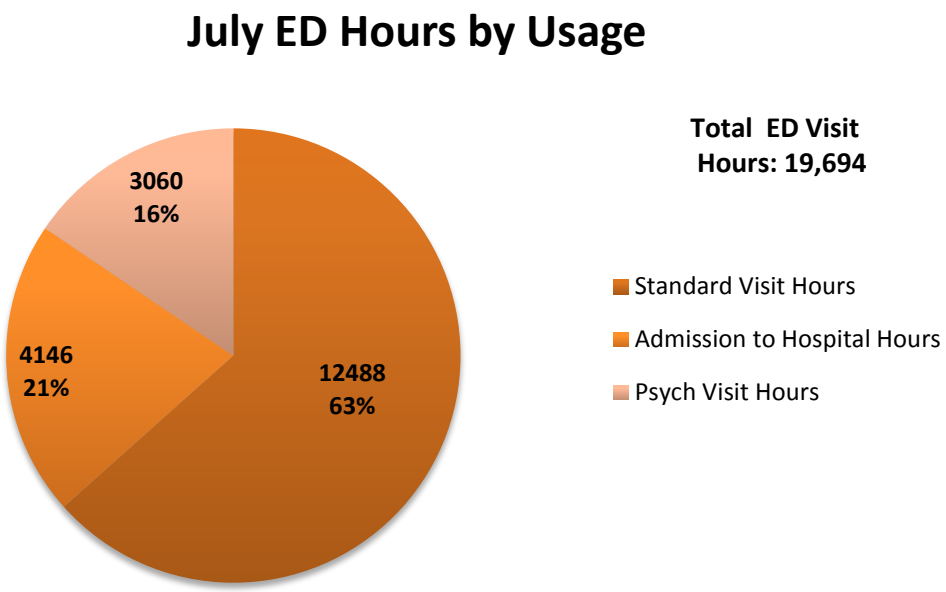
First Data Dive- Data from the source level.

MONTH	Psych Visits	ED Visits	Psych Rate	Tele Health Consults	Psych ED Hrs	Non-billable Psych Hrs	cost @ $135/hr
July	120	4423	2.7%	134	3060	2662	$359,370.00



Reality Check: 2.7% of visits using 16% of resources.

Total ED Visit Hours	Standard Visit Hours	Admission to Hospital Hours	Psych Visit Hours
19694	12488	4146	3060



FY 2015- Granular Data- A walk thru 56K + Charts

Encounters	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	FY15 Totals
# of BH patients	112	104	101	92	91	96	107	90	136	101	123	112	1265
# of Tconsults	48	107	27	20	25	19	15	32	65	121	122	98	699
AVG LOS min. all BH	1125	823	1339	1041	1009	1063	842	979	1246	1773	1150	1517	1159
over nite census	71	53	62	48	43	42	44	48	73	55	61	54	654
total ED hrs	18109	15830	15,750	16221	15367	15749	18635	18122	19938	17845	19003	17737	208306
total psych hrs	2100	1426	2365	1596	1530	1701	1502	1469	2825	2985	2359	2832	24690
% ED psych/total	11.6%	9.0%	15.0%	9.8%	10.0%	10.8%	8.1%	8.1%	14.2%	16.7%	12.4%	16.0%	11.9%

	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	FY15 Totals
total unbillable hrs	1605	1068	1963	1279	1088	1438	1141	1129	2354	2347	1904	2437	19753

Costs	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	FY15 Totals
boarding costs	$216,675	$144,247	$265,005	$172,665	$159,805	$194,130	$154,035	$152,415	$353,100	$305,110	$257,040	$328,995	$2,209,092
consult costs	$6,720	$14,560	$3,780	$2,800	$3,500	$2,660	$2,100	$4,480	$9,100	$16,940	$17,080	$13,230	$96,950
Total Cost	$223,395	$158,807	$268,785	$175,465	$163,305	$196,790	$156,135	$156,895	$362,200	$322,050	$274,120	$342,225	$2,306,042

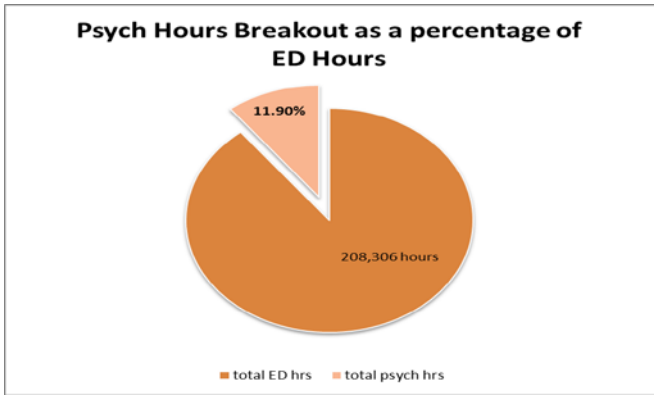
LOS	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	FY15 LOS Averages
# pts los <240 min	30	37	22	33	28	27	31	21	36	30	32	36	363
# of pts los >240 min	82	67	79	59	63	69	76	69	100	71	91	76	902
Total pts. Los - all	112	104	101	92	91	96	107	90	136	101	123	112	1265
% of pts los >240 min	73%	64%	78%	64%	69%	72%	71%	77%	74%	70%	74%	68%	71%

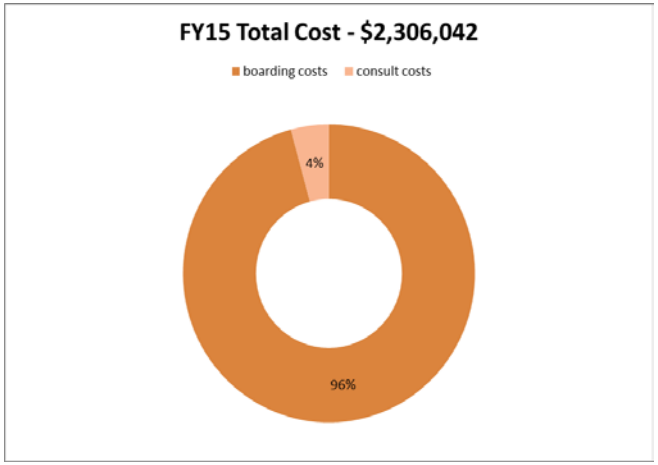
LOS	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	FY15 LOS >4hr Avg.
Avg LOS pts >4hrs in hrs	1414	1196	1731	1540	1276	1490	1141	1221	1652	2223	1495	2164	1545
	23.56	19.93	28.85	25.66	21.26	24.83	19.01	20.35	27.53	37.05	24.91	36.06	25.75

	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	FY15 Total
Pediatric pts	0	0	11	5	15	9	15	12	15	11	10	19	122

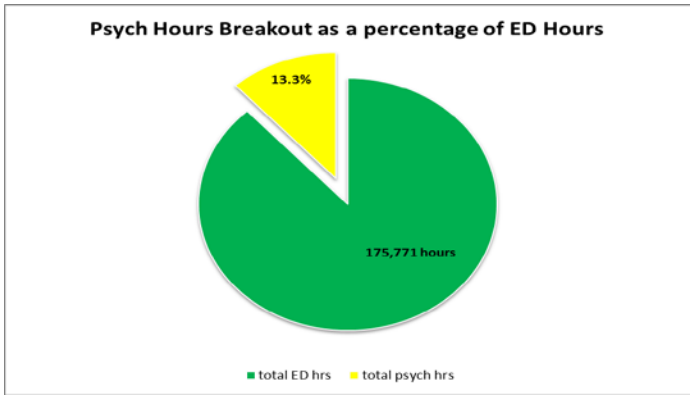
Validation- Does this model replicate?

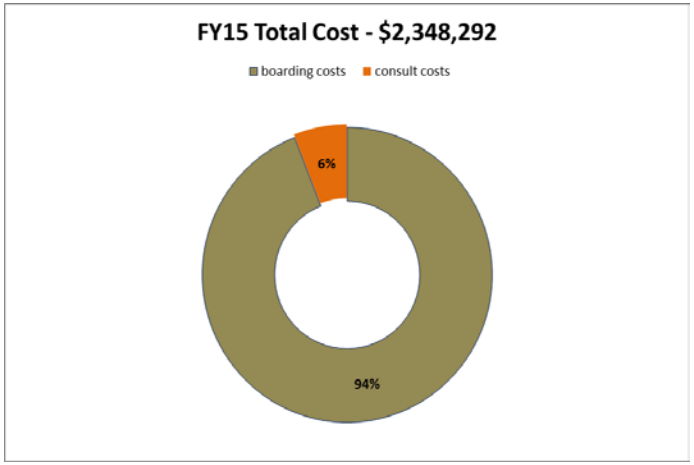
- MMCR





Hospital Across Town





Meaningful Change- Data driven strategy Dec. 2015

Two pronged plan going forward: Local

County Level

Introduction of a development plan

Grant for Innovations Walk- In Services

County Worker embedded in both EDs.

Partnership for 8 bed CSU

Enterprise Solutions

Recognition that the problem exists across the Dignity Health system in varying degrees.

Gap Analysis for all Dignity Health Hospitals.

Stratification for process and best practice in the ED to be integrated with other initiatives.

Automated data collection for stratified models that reflect granular data at a 95% or better confidence level.

Tool kit with applications effective system wide.

But What About Telepsychiatry ?

The addition of Telepsychiatry services led to a crucial evaluation of all of the components of Behavioral Health in the MMCR Emergency Department. All aspects of the provision of care were affected: bedside, process flow, staff morale, financial and physician services and county practices were re-examined after the introduction of this service.

The introduction of Telepsychiatry services has resulted in the delivery of care to over 1,000 patients in its' inaugural year and has had a marked effect on the quality of care rendered.

The Big 5 Ms…..

Telepsychiatry is a **TOOL** and must be used appropriately.

KEY FACTORS drive successful programs:

MOVEMENT- Defined process and flow.

MEASUREMENT- Identified and validated data tools.

MODESTY- Consensus of expectations and limits of use.

MONEY- Know your financials.

MIRTH- There's always something!

Thank You

Dignity Health.
Mercy Medical Center
Redding

Hello humankindness.