Purpose & Objective

- It takes too long to transition our patients to the appropriate level of care. Sometimes we do not have appropriate or timely access for our mental health patients.
- As our patients progress through the care continuum, there are GAPs and challenges for them including:
  - Boarding time for our patients waiting in the emergency department
  - Timely access to our inpatient units
  - Timely access to our outpatient providers and programs

Value Stream Journey-2.5 Years

- Initiated November of 2017. In-scope patient entrance into the E.D to discharge or inpatient admission. Inpatient admission to discharge
- Guiding Principles
  - Drive out waste for patient and staff
  - Team approach
  - Patient as a partner in care
- Initiated at 1 campus, spread to all metro and regional inpatient mental health units and all 12 Allina E.D.’s
Mental Health Value Stream Results

Status Period
November 2019

Executive Sponsor
Sara Criger

System Value Stream Leader(s)
Joe Clubb, Paul Goering, Mari Holt

PI/PM Lead(s)
Katie Thompson

Value Stream Objective(s)

- To deliver on the Allina Promise for the mental health & addiction population
- To enhance the patient & staff experience in the delivery of care
- To optimize timely access to care for mental health patients

System Design
Go Live- Nov 2019

ANW
UTD Design Go Live- Nov 2019
UNY
United
Unity Design
Abbott
Adult
Live
Child/Adol
Live
Need key stakeholders discussions
Geri
Live
A&R
Standard
Work
System
Standard
United
Live
Unity
Standard
Abbott
Standard
Regional
Standard
United
Standard
Unity
Standard
Abbott
Standard
Regional
Standard
Mercy
Live
Unity
Standard
Abbott
Standard
Regional
Standard
Mercy
Live
Unity
Standard
Abbott
Standard
Regional
Standard

Value Stream 2020

• Continued opportunities in inpatient and E.D. value stream.
• Expand scope to include Allina outpatient services (Partial Hospitalization Program, Day Treatment, Outpatient Addiction and Hospital Based Clinics & Primary Care Clinics)

Mental Health & Primary Care Integration

• Reduction in our lead time for our patients referred from primary care
• Increase collaboration and seamless transitions between primary care and mental health

Three year plan:
- More accurate referrals
- Clear pathways back into mental health for established patients
- Resources & collaboration to care for patients in primary care
2020 Measures of Success

<table>
<thead>
<tr>
<th>Pillar</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety &amp; Quality</td>
<td>Ensure IP Length of Stay meets budgeted targets</td>
</tr>
<tr>
<td>Experience</td>
<td>Reduce Potentially Preventable Readmissions</td>
</tr>
<tr>
<td>Reduce lead time into our provider for patients discharged from inpatient stays and our Emergency Departments</td>
<td></td>
</tr>
<tr>
<td>People</td>
<td>Reduce incidents of Workplace Violence experienced in the ED and IP Psychiatry Units</td>
</tr>
<tr>
<td>Growth and Value Delivery</td>
<td>Meet budgeted targets for IP Admission Volumes</td>
</tr>
<tr>
<td>Finance</td>
<td>Increase clinic capture rate of patients from our Emergency Department and Inpatient Services</td>
</tr>
<tr>
<td></td>
<td>Increase occupancy of Partial Hospitalization Programs &amp; Day Treatment</td>
</tr>
<tr>
<td></td>
<td>Increase number of unique patients served through Addiction Services</td>
</tr>
</tbody>
</table>

2020 Measures of Success

<table>
<thead>
<tr>
<th>Care Setting</th>
<th>First quarter</th>
<th>Second quarter</th>
<th>Third quarter</th>
<th>Fourth quarter</th>
<th>First quarter 2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Department</td>
<td>Continue to enhance ED-IP Process focusing on Child Adolescent and mental Health care lead in bed</td>
<td>Spread Dispo Huddle/DC Standard Work ANW</td>
<td>System go live Safety Planning</td>
<td>Spread Dispo Huddle/DC Standard Work - UTD</td>
<td></td>
</tr>
<tr>
<td>Inpatient Psychiatry</td>
<td>Implement Care Model</td>
<td>Improve completion time for comprehensive assessments</td>
<td>Design 2nd Opinion Consult for psychiatrically unstable patients</td>
<td>Enhance Referral Process for IRTS Patients</td>
<td>Improve AM Discharges and close our transportation gap</td>
</tr>
<tr>
<td>Outpatient Care</td>
<td>Design IP to Clinic w/in 7 days</td>
<td>Increase patients from IP to PHP w/in 7 days</td>
<td>Increase our capture rate from IVED to OP by 30%</td>
<td>Enhance communication between providers at all settings of care</td>
<td></td>
</tr>
</tbody>
</table>

The E.D. as the Safety Net

- Increase in the number of Group Homes discharging residents to hospital E.D.’s. Increased from monthly to weekly
- Increase in the number of children in child protection custody discharged from foster homes to E.D.’s
- Utilizing a high huddle structure bringing together Allina, County, Group Home Leaders and Contract Case Management agencies

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