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CAPITAL HEALTH SYSTEM - FULD CAMPUS - 3676609
Hospital-Wide Screening for Substance Use Disorder

CONTACTS:

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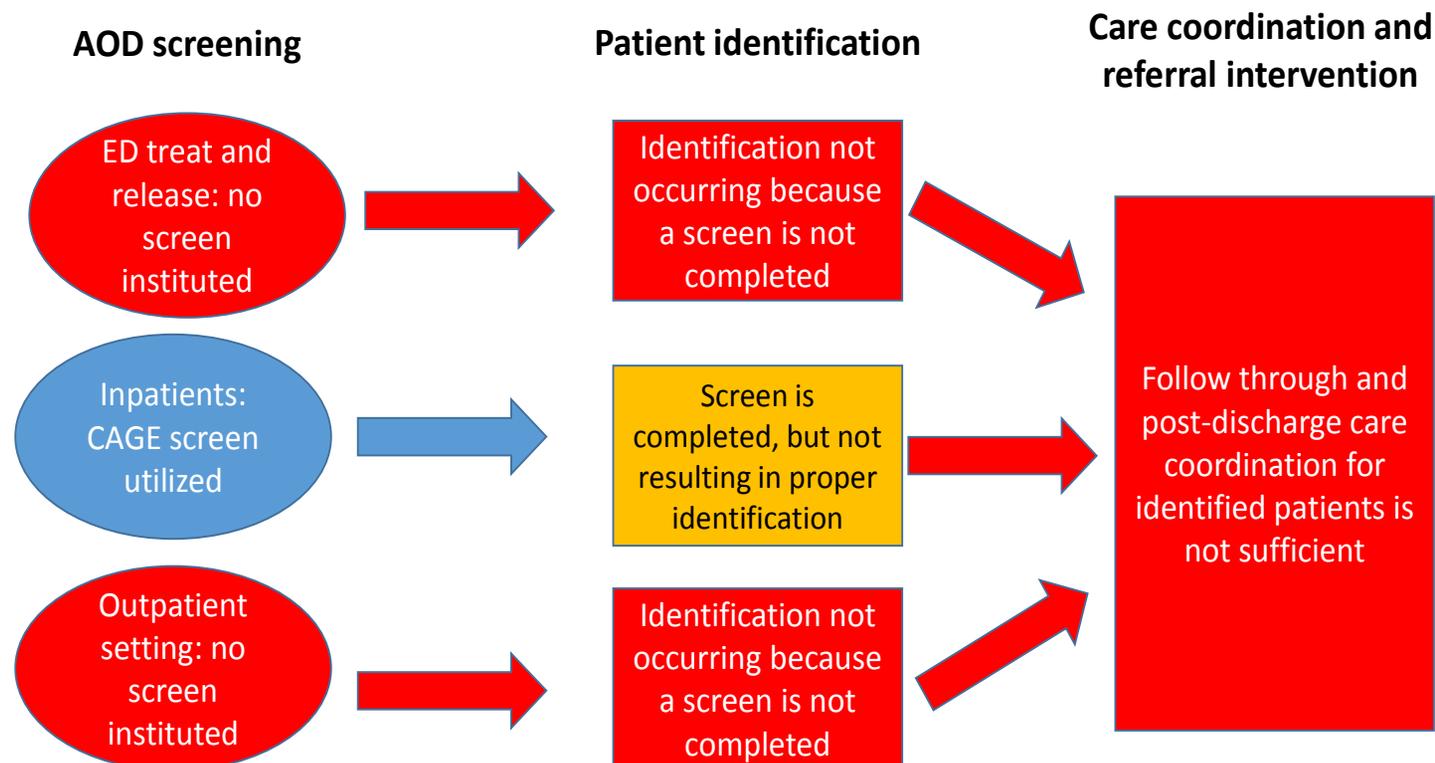
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High-Level Project Intervention Implementation



AOD Screening and Treatment Gap Analysis



RED represents a significant GAP in the care process
YELLOW represents a moderate GAP in the care process
BLUE represents no GAP in the care process



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PROGRAM GOALS

- Screen 100% of the individuals admitted to the hospital for **Substance Use Disorders (SUD)**
- Decrease length of stay (LOS) for patients admitted with a substance abuse diagnosis
- Decrease transfers to **Intensive Care Unit (ICU)** with **Delirium Tremors (DTs)** or other alcohol related complications



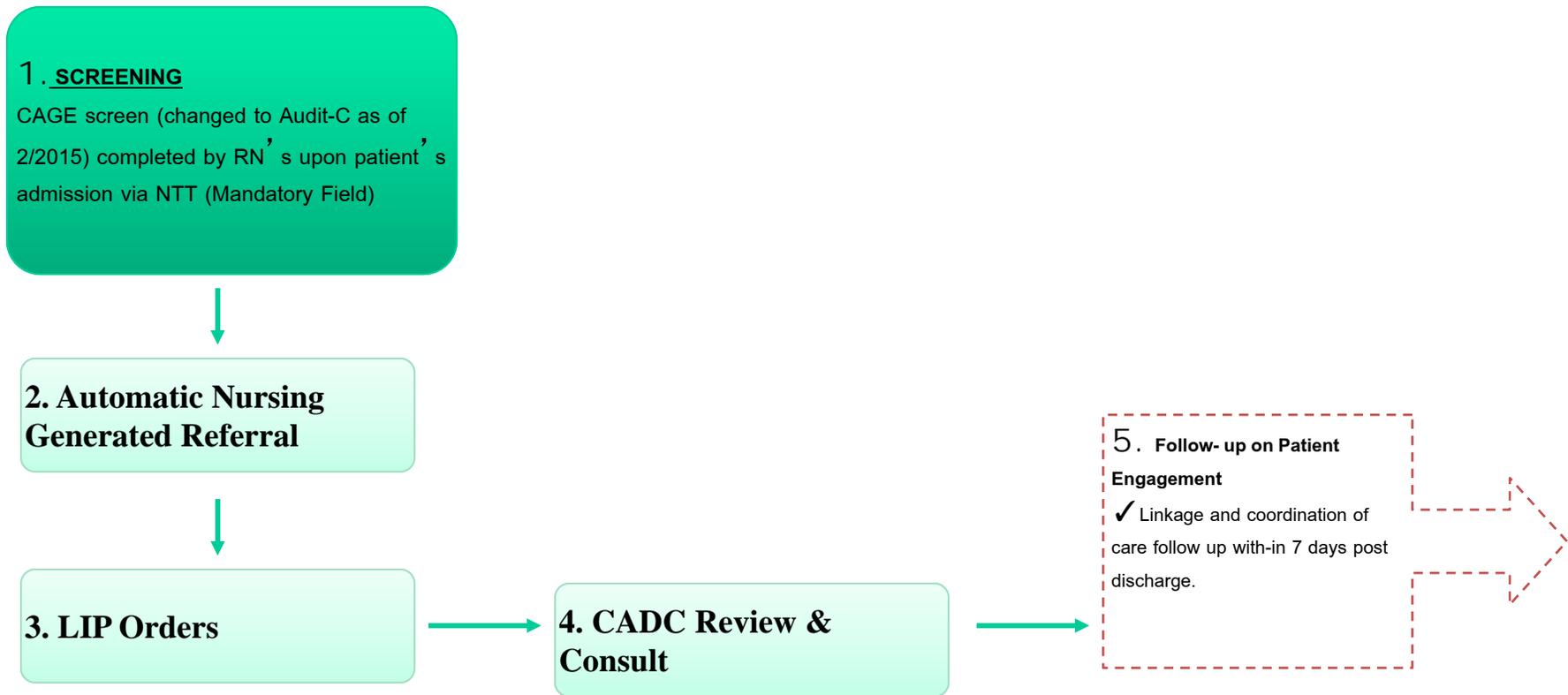
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DSRIP – RMC Project

CADC PROCESS:

(Certified Alcohol and Drug Counselors)



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Certified Alcohol & Drug Counselor (CADC)

- CADC consult is ordered
- Patient consents for assessment and referral
- Counselors link to treatment providers
- Patient Indicator for High Risk: CADC
- Staff collaborates with referring facilities
- Telephonic communication after discharge
 - Care Transitions: Education of red flags/triggers, transportation, collaboration with treatment providers



BROCHURE

HOW DOES THIS PROGRAM WORK?

Every patient admitted to the hospital will be screened for alcohol or drug use disorder (AOD/SUD). This allows patients to see a licensed and certified clinical alcohol and drug counselor. The counselors will ask questions, provide brief intervention and refer to local treatment centers.

WHAT WE DO

Our team will provide ongoing help to connect you to the right treatment after you leave the hospital.

Our team will provide support calls after you leave the hospital to help spot any obstacles you face in following your recovery plan.

Patients will learn how to spot high risk behaviors to help self-manage their disorders and prevent from happening again.



APPOINTMENT FOLLOW-UP INFORMATION

- 1 Facility: _____
Address: _____
Phone number: _____
Appointment time: _____
Contact person: _____
- 2 Facility: _____
Address: _____
Phone number: _____
Appointment time: _____
Contact person: _____

PROGRAM GOALS

Our goal is to help those who know they need substance use treatment. Our team screens those who need help soon before other serious health issues occur.

Our counselors connect those with substance use disorders to local treatment centers. We also support patients and loved ones to self-manage their disorders, rebuild their confidence, and go on to live independent, fulfilling lives.

QUESTIONS TO ASK YOURSELF

- Have you ever felt you should cut down on your drinking or drug use?
- Do people annoy you by judging your drinking or drug use?
- Have you ever felt bad or guilty about your drinking or drug use?
- Have you ever had a drink or taken drugs first thing in the morning to steady your nerves or get rid of a hangover?

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ALCOHOL AND SUBSTANCE USE PROGRAM



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Project Observations, challenges and Successes



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CADC DATA for RMC

(Certified Alcohol and Drug Counselors)

| CADC Orders | 4th quarter 2014 | 1 st quarter 2015 |
|---|------------------|------------------------------|
| Total CADC orders | 609 | 475 |
| Missed (D/C or AMA) | 82 | 45 |
| Total patient assessed | 527 | 430 |
| Refused assessment for screening | 68 | 64 |
| Did not meet Criteria - Inappropriate order | 3 | 4 |
| Change in Level of Care (SNF, nursing home patient, prisoner, etc) | 20 | |
| Patients accepted referral to treatment facility | 54 | 43 |
| Referral to other community resources: behavioral health, support groups, rescue mission, etc | | 14 |



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DSRIP RMC Project: Impact

| DATA | 2012 | 2013 | 2014 |
|--|------|-------|-------|
| DT upgraded to ICU | 14 | 17 | 10 |
| % upgraded to ICU | 8% | 9% | 4% |
| DTs, ETOH withdrawal, ETOH induced mental disorder Admission | 175 | 186 | 208 |
| Case Mix Index | 1.55 | 1.306 | 1.565 |
| Average LOS all patients | 7.45 | 7.66 | 7.47 |

Automatic AOD/SUD screening of all patients identified more quickly and accurately the numbers of admitted patients at risk for early withdrawal symptoms and prevent its progression into DTs or other serious health conditions.



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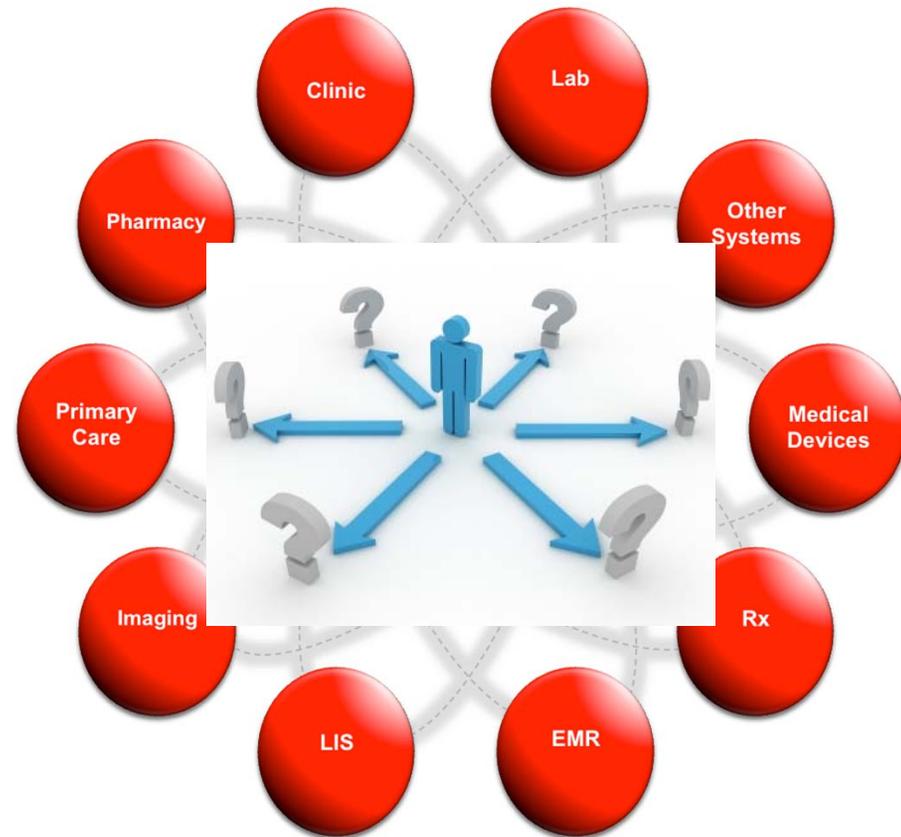
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Special Features

- ✓ Program is staffed with bilingual English/Spanish Health Educators
- ✓ Patient transportation is provided
- ✓ Shared Health Information Exchange (THIE)
- ✓ Labs, (Quest & Labcore) diagnostic studies
- ✓ Hospitals in THIE: 4 local hospitals
- ✓ Labs, consults, diagnostic studies
- ✓ Family Group Meeting (Patient selection Based on Criteria) – May 2015



Navigation of Care & Post Hospitalization Care Coordination of AOD/SUD In-Patients



- The goal of discharge planning is to ensure a **safe transition** and maintain continuity of care.

Post hospitalization

1. Self management
2. Knowledge of “red flags”
3. Medication self-management
4. Follow-up appointments
5. Telephonic communication for 30 days post discharge



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Program Challenges

- Nursing Staff CIWA Protocol knowledge
- Obtaining LIP orders for CADDC Orders
- Understanding insurance plan
- Medicaid providers
 - Limited providers
 - Treatment facility have limited Medicaid beds
- Transportation, Homeless, No telephones



Thank You!



Questions???



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