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

CONTACTS:
ROBERT REMSTEIN, D.O., M.D – VP, Accountable Care
BETH MIL- Director, Clinical Integration
PAMELA KELLY – DSRIP Coordinator
High-Level Project Intervention Implementation
AOD Screening and Treatment Gap Analysis

AOD screening

ED treat and release: no screen instituted

Inpatients: CAGE screen utilized

Outpatient setting: no screen instituted

Patient identification

Identification not occurring because a screen is not completed

Screen is completed, but not resulting in proper identification

Identification not occurring because a screen is not completed

Care coordination and referral intervention

Follow through and post-discharge care coordination for identified patients is not sufficient

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
DSRIP – RMC Project
CADC PROCESS:
(Certified Alcohol and Drug Counselors)

1. SCREENING
   CAGE screen (changed to Audit-C as of 2/2015) completed by RN’s upon patient’s admission via NTT (Mandatory Field)

2. Automatic Nursing Generated Referral

3. LIP Orders

4. CADC Review & Consult

5. Follow-up on Patient Engagement
   ✓ Linkage and coordination of care follow up with-in 7 days post discharge.
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
Project Observations, challenges and Successes
# CADC DATA for RMC
(Certified Alcohol and Drug Counselors)

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

<table>
<thead>
<tr>
<th>DATA</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>DT upgraded to ICU</td>
<td>14</td>
<td>17</td>
<td>10</td>
</tr>
<tr>
<td>% upgraded to ICU</td>
<td>8%</td>
<td>9%</td>
<td>4%</td>
</tr>
<tr>
<td>DTs, ETOH withdrawal, ETOH induced mental disorder Admission</td>
<td>175</td>
<td>186</td>
<td>208</td>
</tr>
<tr>
<td>Case Mix Index</td>
<td>1.55</td>
<td>1.306</td>
<td>1.565</td>
</tr>
<tr>
<td>Average LOS all patients</td>
<td>7.45</td>
<td>7.66</td>
<td>7.47</td>
</tr>
</tbody>
</table>

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.
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
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
Program Challenges

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

Questions???